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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS-2406-P]

RIN 0938-AT41

Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would amend the process for states to document whether Medicaid payments in fee-for-service systems are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with the statute. States have raised concerns over the administrative burden associated with the current requirements, particularly for states with high rates of Medicaid managed care enrollment. This proposed rule would provide burden relief and address those concerns.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [Insert date 60 days after date of publication in the **Federal Register**].

ADDRESSES: In commenting, please refer to file code CMS-2406-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to **http://www.regulations.gov**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2406-P,

P.O. Box 8016,

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2406-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Jeremy Silanskis, (410) 786-1592, Jeremy.Silanskis@cms.hhs.gov;

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period

are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments.

I. Executive Summary and Background

A. Executive Summary

1. Purpose

Current regulations at 42 CFR 447.203(b) require states to develop and submit to CMS an access monitoring review plan (AMRP) for Medicaid services provided through a fee-for-service (FFS) delivery system. The AMRP must be updated at least every 3 years and address the following categories of Medicaid services: primary care services (including those provided by a physician, federally qualified health center (FQHC), clinic or dental care); physician specialist services (for example, cardiology, radiology, urology); behavioral health services (including mental health and substance use disorder); pre- and post-natal obstetric services (including labor and delivery); and home health. 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; and changes in beneficiary service utilization. Additionally, when states reduce rates for other Medicaid services, they must add those services to the AMRP and monitor the effects of the rate reductions for 3 years. Section 447.204 requires states to undertake a public process and submit specific information regarding access to care when proposing to reduce or restructure Medicaid provider payment rates. This proposed rule would provide an exemption to the regulatory requirements in §§447.203(b)(1) through (6) and 447.204(a) through (c) for states with comprehensive, risk-based Medicaid managed care

enrollment rates above 85 percent of the total covered population under a state's Medicaid program, including managed care comprehensive risk contracts under a state's section 1115 Medicaid demonstration. The proposed rule would also provide an exemption to the regulatory requirements in §§447.203(b)(6) and 447.204(a) through (c) for states that submit state plan amendments (SPAs) to reduce rates or restructure payments where the overall reduction is 4 percent or less of overall spending within the affected state plan service category for a single state fiscal year (SFY) and 6 percent or less over 2 consecutive SFYs. Additionally, the proposed rule would modify the requirements in §447.204(b)(2) so that, for SPAs that reduce or restructure Medicaid payment rates, states would be required to submit to CMS an assurance that data indicates current access is consistent with requirements of the Social Security Act (the Act) instead of an analysis anticipating the effects of a proposed change in payment rates or structure.

B. 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." Until 2011, we had not defined through federal regulation a framework to guide states in meeting this statutory requirement and reviewed state proposals to reduce provider payment rates on a case-by-case basis. We historically relied on state certifications and available supporting information that reductions in Medicaid payments met the statutory standards.

In the November 2, 2015 **Federal Register** (80 FR 67576) we published the "Methods for Assuring Access to Covered Medicaid Services" final rule with comment period that outlined a data-driven process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with section

1902(a)(30)(A) of the Act. The final rule with comment period included a new §447.203(b)(1) through (8) and revisions to §447.204. These regulations established that states must develop and submit to CMS an AMRP, that is updated at least every 3 years, for the following services: (1) primary care (including those provided by a physician, FQHC, clinic or dental care); (2) physician specialist services (for example, cardiology, urology, radiology); (3) behavioral health services (including mental health and substance use disorder); (4) pre- and post- natal obstetric services, (including labor and delivery); (5) home health services; (6) any additional types of services for which a review is required under §447.203(b)(6) because of a proposed payment rate reduction or restructuring; (7) 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; and (8) additional types of services selected by the state.

The AMRP must document the state's consideration of access to care in setting and adjusting payment methodologies for Medicaid services and in informing state policies affecting access to Medicaid services. The state must address, through data driven analysis: 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 (including considerations for care, service and payment variations for pediatric and adult populations and for individuals with disabilities); and actual or estimated levels of provider payment available from other payers, including other public and private payers. Additionally, §447.203(b)(6) requires a state to add services to its AMRP when reducing payment rates or restructuring provider payment for such Medicaid services in circumstances when the changes could result in diminished access, as well as to develop a plan to monitor the effects of the rate reduction or restructuring for at least 3 years.

Furthermore, under §447.204(a) through (c), when proposing to reduce or restructure

Medicaid payment rates, states must consider the data collected through the AMRP and undertake a public process that solicits input on the potential impact of proposed reduction or restructuring of Medicaid payment rates on beneficiary access to care. States must submit related analysis to CMS along with any proposed rate reduction or restructuring SPA, and we may disapprove such a proposed SPA that does not include documentation supporting compliance with the required AMRP review and public process.

In the November 2, 2015 final rule with comment period, we solicited comments on §447.203(b)(5), concerning the access monitoring review plan timeframe. Specifically, we solicited comments on the scope of services that should be subject to ongoing review under the AMRP, the required elements of review, whether we should allow exemptions from certain requirements of the final rule based on state program characteristics (for example, high managed care enrollment), and the timeframe for submission. In response to the comments we received, in the April 12, 2016 **Federal Register** (81 FR 21479), we published the “Deadline for Access Monitoring Review Plan Submissions” final rule in which we extended the deadline for initial AMRP submissions to October 1, 2016. Although we received numerous comments on the issue of whether states with high managed care enrollment should be exempt from the requirements of the final rule, we did not include such an exemption in the April 12, 2016 final rule because we believed that further experience with the access monitoring review process was necessary to determine the appropriate circumstances for exemptions. We have considered the comments received in response to the November 2, 2015 final rule with comment period at (https://www.regulations.gov/document?D=CMS-2011-0062-0188) in the development of this proposed rule.

The initial AMRP submissions were due to us on October 1, 2016. We received AMRP submissions from all states, and the submissions are available on Medicaid.gov

(https://www.medicaid.gov/medicaid/access-to-care/review-plans/index.html). During the initial year of implementation, a number of states expressed concern regarding the administrative burden associated with the requirements of §447.203, particularly those states with a very high beneficiary enrollment in comprehensive, risk-based managed care and a limited number of beneficiaries receiving care through a fee-for-service delivery system. Based on our experience in reviewing the AMRPs and working with states with high beneficiary enrollment in comprehensive, risk-based managed care, we now believe we have sufficient experience to establish a threshold for such states to be exempt from meeting certain access monitoring review requirements, and are proposing additional modifications to the regulations to ease the administrative burden on states that are proposing certain payment rate reductions.

Although this proposed rule would establish such thresholds, states are still obligated by the statute to ensure Medicaid payment rates are sufficient to enlist enough providers to assure that beneficiary access to covered care and services is at least consistent with that of the general population in the same geographic area, particularly when reducing or restructuring Medicaid payment rates through SPAs. In lieu of the requirements set forth in §447.203(b)(6), we are proposing that states that meet the high managed care enrollment exemption threshold under this proposed rule would be permitted to submit alternate information and analysis, as determined by the state, when proposing payment rate reductions, to support compliance with section 1902(a)(30)(A) of the Act.

Our implementation experience has also created questions about the benefit of requiring states to conduct a public process and access analysis for every change in Medicaid payment rates or structure that results in a reduction to provider payments, including those nominal rate reductions that are unlikely to result in diminished access. We have worked with a number of states that, over the past 2 years, have proposed relatively small payment rate reductions and

have expended staff resources to add the services to the AMRP and complete the public process as required only to have received little or no feedback. Oftentimes, the impact on beneficiary access in FFS is limited due to the high managed care enrollment rates in states, and what little feedback might have been received through the public process has been related to how the proposed changes would impact managed care. These experiences have created additional confusion for states on how to address the rate reductions within the requirements of §§447.203 and 447.204. States have questioned the value of undertaking the rigorous process set out in those regulations when payment changes are nominal and unlikely to diminish access or when the actual impact of the changes is low relative to the overall program administration because most of the state's beneficiaries are enrolled with a comprehensive managed care entity. In those instances, this rule proposes to relieve states of the more rigorous regulatory processes, while reaffirming the need for states to offer alternative information supporting compliance with section 1902(a)(30)(A) of the Act when proposing payment reductions.

On November 16, 2017, we issued clarifying guidance to states through a State Medicaid Director Letter (SMDL # 17-004) interpreting the requirements at §447.203(b)(6) to apply only to payment changes that are more than nominal and that may result in circumstances that could diminish access to care. Within that guidance letter, we noted several payment changes that would likely not result in diminished access to care and, in the absence of information to the contrary (for example, high volume of access complaints), would be exempt from the *special provisions for proposed rate reductions or restructuring* procedures in §447.203(b)(6). These include: changes made to comply with other federal requirements, changes where Medicaid rates continue to be at or above Medicare or commercial payer rates, and changes consistent with those made by the Medicare program. We also described some nominal payment adjustments where it may be difficult for states to determine whether proposed SPA changes may result in

diminished access. For those changes, the SMDL advised states to rely on the public process described in §447.204(a) and the associated information received from stakeholders as an indicator of whether a change is likely to diminish access.

With this proposed rule, we are proposing to codify an exemption to the *special provisions for proposed rate reductions or restructuring* procedures in §447.203(b)(6) for all payment rate changes where the reduction within a state plan service category is less than 4 percent of overall spending on the category within a single SFY and less than 6 percent over 2 consecutive SFYs. For example, if a state implements a rate reduction of 3.5 percent in one SFY and proposes an additional reduction of 3 percent the following SFY, the proposed 3 percent reduction would not be considered to be nominal. As discussed in the SMDL, we generally believed changes below the 4 percent threshold to be nominal and unlikely to diminish access to care but suggested states rely on the public process to make the determination. Based on the feedback we have obtained through the SPA review process, we continue to believe that changes below 4 percent are generally nominal and have found that such changes do not typically result in significant access concerns being raised by providers and other stakeholders. As such, this proposed rule would go further by providing an exemption from all of the procedures described in §447.203(b)(6) for proposed payment rate reductions within the above thresholds, even if the state has not completed the public process described in §447.204(a).

In addition to the proposed thresholds described above, we are proposing to make an additional modification to the regulations based on our implementation experience. Currently, when a state submits a SPA to us proposing to reduce or restructure Medicaid provider payment rates in circumstances when the changes could result in diminished access, the state must submit an analysis of the changes' effect on access. States have found considerable difficulty in anticipating the effects of rate changes on Medicaid beneficiaries' access to care. Our

experience has shown that uncertainties inherent in these analyses have limited their accuracy and hence their usefulness. Moreover, the regulations at §§447.203(b)(6)(ii) and 447.203(b)(8) include considerable protections through requirements for monitoring and corrective actions by states to ensure that access remains undiminished after a payment rate change goes into effect (see 80 FR 67595 through 67596), and the utility of an anticipatory analysis has not been demonstrated. Recognizing that it is challenging for states to accurately predict the effects of many Medicaid payment rate changes on beneficiary access to care, we are proposing to modify this requirement and, instead, require states to submit an assurance that current access is consistent with requirements of the Act at the time of the SPA submission, and the baseline data that supports this assurance. We will also rely in part on the information received through the public input process to help understand the potential effects of proposed rate changes that exceed the thresholds proposed in this proposed rule, and the states' ongoing monitoring activities to ensure beneficiary access to care is maintained.

Importantly, while the SMDL provided relief to states for the rate reduction procedures in the regulations, neither the SMDL nor the policies discussed in this proposed rule, if finalized, would exempt states from their overall obligation to ensure that Medicaid rates are consistent with section 1902(a)(30)(A) of the Act, the public notice requirements in §447.205, or the public process for determining institutional provider payment rates in section 1903(a)(13)(A) of the Act. As part of the SPA review process, we retain the discretion to request that states provide information that would allow us to compare the Medicaid population's access to care with that of the general population in the same geographic area and we will continue to document whether states have met applicable public notice and process requirements in our administrative records. Additionally, for states that do not meet the managed care exemption threshold, we will use the ongoing AMRP process to help identify and address potential access issues.

We are still interested in developing and adopting meaningful access measures that could apply consistently regardless of the service delivery approach used by the state. Our ultimate goal is to better measure, monitor and ensure Medicaid access across state programs and delivery systems. While there is a longstanding requirement in 42 CFR 431.16 that states are obligated to provide all reports required by the Secretary and must follow the Secretary's instructions regarding the form and content of such reports, we are using this opportunity to state that, in the future and informed by stakeholder feedback, we may look to adopt a more standardized form and content for the states' AMRP submissions.

II. Provisions of the Proposed Regulations

A. Exemption for States with High Managed Care Enrollment

We are proposing to amend §447.203(b) to establish a comprehensive, risk-based managed care enrollment rate threshold for which states above the threshold would be exempt from meeting the requirements of §447.203(b)(1) through (6). The threshold for exemption would be calculated to include services provided under comprehensive risk contracts between a state and a managed care organization as defined under §438.2 and any entities required under the special terms and conditions of an 1115 demonstration to comply with part 438 in the same manner as a managed care organization. We are proposing an 85 percent threshold, meaning that states with an overall comprehensive, risk-based managed care enrollment rate of 85 percent or greater would be exempt from the specified requirements and would not be required to develop an AMRP or conduct an access analysis or add services to the AMRP when reducing or restructuring provider payment rates. We chose the 85 percent threshold based on comments received in response to the November 2, 2015 final rule with comment period in which states suggested thresholds ranging from 75 percent to 95 percent. We are seeking comment on whether an 85 percent overall threshold is appropriate, or if the threshold should be higher, or

lower but stratified across eligibility categories (for example, a 70 percent overall threshold with at least a 50 percent managed care enrollment rate across all eligibility categories).

We are proposing to require states with a comprehensive, risk-based managed care enrollment rate at or above the threshold to submit to us an attestation by January 1 of each year. Because managed care enrollment rates fluctuate, we are proposing to require states to attest to meeting the threshold every year. The attestation would include the state's Medicaid managed care enrollment rate as of July 1st of the previous year. States that meet the managed care exemption threshold would not be required to comply with the requirements for development and updating the AMRP for the services otherwise subject to the requirements for ongoing review or the special provisions for proposed provider rate reductions in §447.203(b)(1) through (b)(6) during that calendar year.

Consistent with the proposed changes to §447.203(b)(1) through (6), we are also proposing changes to §447.204, redesignating paragraph (d) to new paragraph (e), and adding a new paragraph (d), for states that meet the 85 percent managed care enrollment threshold. When proposing to reduce or restructure Medicaid payment rates, these states would be exempt from the requirements to consider the data collected through the AMRP and undertake a public process that solicits input on the potential impact of the proposed rate reduction or restructuring SPA, and accordingly, would not be required to include documentation supporting compliance with the AMRP review and public process otherwise required under §447.204(a) through (c) with the SPA submission. However, states are not exempt from the statutory requirements and, when proposing to reduce or restructure Medicaid payment rates in circumstances that may diminish access, would be required to present alternative data and analysis, determined at the discretion of the state, to support compliance with section 1902(a)(30)(A) of the Act. As such, we are proposing to include the requirement for states to submit such alternative data in

§447.204(d). We are requesting comments on the types of alternative data and analysis that states may present to support compliance with section 1902(a)(30)(A) of the Act, which we may use to inform future sub-regulatory guidance to states.

B. Exemption for Payment Rate Changes

We are proposing to amend §§447.203(b)(6) and 447.204 to set a threshold for nominal payment rate changes that are below 4 percent for a Medicaid service category in total within a single SFY and 6 percent over two consecutive SFYs. For purposes of this proposed rule, service categories are those generally defined under sections 1905(a)(1) through (29) of the Act (that is, inpatient hospital services, outpatient hospital services, other laboratory and X-ray service, etc.) and other applicable sections that specify categories of services eligible for medical assistance under the State plan. Such nominal payment rate changes will not be subject to the *special provisions for rate reductions or restructuring* procedures in §447.203(b)(6), and similarly, states would not be subject to the requirements of §447.204(a) through (c) when submitting a SPA for such changes. Additionally, since states may make rate changes in consecutive years, we are proposing to limit the exemption threshold to a 6 percent reduction in spending for a Medicaid service category over 2 consecutive SFYs.

We are requesting comments to determine whether the nominal threshold should be higher or lower than 4 percent for a single SFY and 6 percent for 2 consecutive SFYs, recognizing that state legislatures need sufficient flexibility to manage budgets and make adjustments to Medicaid spending that are unlikely to result in diminished access to care for program beneficiaries. We are proposing to limit the 4 percent threshold exemption over a state fiscal year, rather than apply the 4 percent to a single SPA submission, and to apply the 6 percent threshold as a cumulative threshold over 2 consecutive SFYs. This means that state payment rate changes would be exempted from the *special provisions for proposed rate reductions or*

restructuring in §447.203(b)(6) and the SPA submission requirements in §447.204(a) through (c) as long as they do not exceed 4 percent in total spending for a service category within a single SFY and 6 percent over 2 consecutive SFYs. We believe this policy would provide state legislatures sufficient leeway to make nominal Medicaid payment changes that, considering the cumulative effects of the proposed year-over-year changes, would be unlikely to have adverse impacts on Medicaid beneficiaries' access to care. We seek comment on these proposals, including on the potential impacts of cumulative rate reductions over more than 2 consecutive SFYs, as well as on potential alternatives to the 6 percent threshold and on the 2 consecutive SFYs timeframe from consideration of cumulative impacts of year-over-year changes.

In conjunction with the proposed changes to §447.203(b)(6), we are also proposing changes to §447.204, to include in the new paragraph (d) an exemption for states that are proposing payment rate reductions below the threshold of 4 percent within a single SFY (6 percent over 2 consecutive SFYs). When submitting such nominal payment rate reductions, such states would not be required to consider the data collected through the AMRP and undertake a public process that solicits input on the potential impact of the proposed rate reduction or restructuring SPA, and accordingly, would not be required to include documentation supporting compliance with the AMRP review and public process otherwise required under §447.204(a) through (c) with the SPA submission. Although we are proposing this exemption from the regulatory requirements at §§447.203(b)(6) and 447.204(a) through (c) for the proposed SPAs that would implement nominal payment rate reductions, states are not exempt from the statutory requirements and, when proposing to reduce or restructure Medicaid payment rates in circumstances that may diminish access, would be required to present alternative analysis and supporting data, determined at the discretion of the state, to demonstrate compliance with section 1902(a)(30)(A) of the Act. Accordingly, we are proposing to include the requirement for states

to submit such alternative data in §447.204(d). We are requesting comments on the types of alternative analysis and supporting data that states may present to demonstrate compliance with section 1902(a)(30)(A) of the Act, which we may use to inform future sub-regulatory guidance to states.

C. Modification of Payment Rate Change SPA Submission Information

We are proposing to amend §447.204(b)(2) to remove the requirement that states submit an analysis of the effect the change in payment rates will have on access and instead require that states submit an assurance and baseline data that supports the state's conclusion that current access is sufficient for the services impacted by the rate change. The data will be used as part of the state's plan to monitor the effects of the rate reduction for 3 years following implementation, when required under §447.203(b)(6). We are proposing this change because we have determined that the current requirement of having states provide an analysis of the effect that a proposed payment rate reduction might have on access is of limited usefulness due to many uncertainties inherent to such analyses. Therefore, we believe that having the state submit baseline data on access to services will be more helpful to CMS in ensuring that a state's proposed payment rate reductions are consistent with section 1902(a)(30)(A) of the Act.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 et seq.) we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

● The need for the information collection and its usefulness in carrying out the proper functions of our agency.

● The accuracy of our estimate of the information collection burden.

● The quality, utility, and clarity of the information to be collected.

● Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain proposed information collection requirements:

● Exemption for States with High Managed Care Penetration (§§447.203(b) and 447.204(a) through (c))

● Exemption for Payment Rate Changes (§§447.203(b) and 447.204(a) through (c))

● Modification of Payment Rate Change SPA Submission Information (§447.204(b)(2))

<u>A. Wage Estimates</u>

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2016 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, Table 1 presents the mean hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

TABLE 1: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operations Specialist	13-1000	34.54	34.54	69.08
Computer and Information Analyst	15-1120	44.36	44.36	88.72
General and Operations Manager	11-1021	58.70	58.70	117.40
Management Analyst	13-1111	44.19	44.19	88.38
Social Science Research Assistant	19-4061	22.51	22.51	45.02

We adjusted our employee hourly wage estimates by a factor of 100 percent. This was necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there was no practical alternative and we believed that doubling the hourly wage to estimate total cost was a reasonably accurate estimation method.

B. Proposed Information Collection Requirements (ICRs)

1. ICRs Regarding Exemption for States with High Managed Care Enrollment (§§447.203(b) and 447.204(a) through (c))

Current provisions at §447.203(b)(1) through (3) require that states develop and make publicly available an access monitoring review plan using data trends and factors that considers: beneficiary needs, availability of care and providers, and changes in beneficiary utilization of covered services.

Section 447.203(b)(1) and (2) describes the minimum factors that states must consider when developing an access monitoring review plan. Specifically, we require the review to include: input from both Medicaid beneficiaries and Medicaid providers, an analysis of Medicaid payment data, and a description of the specific measures the state will use to analyze access to

care. We require that states use existing provider feedback mechanisms, such as medical advisory committees described in §431.12, rather than create new requirements, to avoid placing unnecessary burden on states.

Section 447.203(b)(3) requires that states include aggregate percentage comparisons of Medicaid payment rates to other public (including, as practical, Medicaid managed care rates) or private health coverage rates within geographic areas of the state.

Section 447.203(b)(4) describes the minimum content that must be in included in the monitoring plan. States are required to describe: the measures the state uses to analyze access to care issues, how the measures relate to the overarching framework, access issues that are discovered as a result of the review, and the state Medicaid agency's recommendations on the sufficiency of access to care based on the review.

Section 447.203(b)(5) describes the timeframe for states to develop the access monitoring review plan and complete the data review for the following categories of services: primary care, physician specialist services, behavioral health, pre- and post-natal obstetric services including labor and delivery, home health, any services for which the state has submitted a state plan amendment to reduce or restructure provider payments which changes could result in diminished access, and additional services as determined necessary by the state or CMS. While the initial access monitoring review plans have been completed, the plan must be updated at least every 3 years, but no later than October 1 of the update year.

In our currently approved information collection request (CMS-10391; OMB 0938-1134), we estimated that the requirements to develop and make the access monitoring review plans publically available under §447.203(b)(1) through (4) for the specific categories of Medicaid services will affect each of the 50 state Medicaid programs and the District of Columbia (51 total respondents). We estimated it will take a one-time effort of 5,100 hr to

develop the access monitoring review plan, 8,160 hr to collect and analyze the data, and 2,040 to publish the plan and 510 hr for a manager to review and approve the plan (15,810 total hours at a cost of $1,197,194.40, or $23,474.40 per state). Since the initial one-time requirement has been met, and since the policies in this proposed rule would create exemptions from certain current requirements, we are now estimating this proposed rule as a burden reduction.

In deriving these figures we used the following labor rates and time to complete each task: 80 hr at $45.02/hr for a research assistant staff to gather data, 80 hr at $88.72/hr for an information analyst staff to analyze the data, 100 hr at $88.38/hr for management analyst staff to update the content of the access review monitoring plan, 40 hr at $69.08/hr for business operations specialist staff to publish the access monitoring review plan, and 10 hr at $117.40/hr for managerial staff to review and approve the access monitoring review plan.

TABLE 2: Access Monitoring Review Plan: Reduced One-time Burden (Per State)

Requirement	Occupation Title	Burden Hours	Adjusted Hourly Wage ($/hr)	Cost Per Monitoring Plan ($/State)
Gathering Data	Social Science Research Assistant	(80)	45.02	(3,601.60)
Analyzing Data	Computer and Information Analyst	(80)	88.72	(7,097.60)
Developing Content of Access Review Monitoring Plan	Management Analyst	(100)	88.38	(8,838.00)
Publishing Access Review Monitoring Plan	Business Operations Specialist	(40)	69.08	(2,763.20)
Reviewing and Approving Access Review Monitoring Plan	General and Operations Manager	(10)	117.40	(1,174.00)
TOTAL		(310)	varies	(23,474.40)

TABLE 3: Access Monitoring Review Plan: Reduced One-Time Burden (Total)

Anticipated Number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
(51)	(15,810) [-310 hr x 51 reviews]	(23,474.40)	(1,197,194.40)

Based on this rule's proposed exemption for states with managed care enrollment rates at or above 85 percent, we are adjusting our on-going access monitoring review plan burden by

reducing the number of states (and DC) by 17, from 51 to 34 states, because as of July 2016, we estimate that 17 states had a managed care enrollment rate of at least 85 percent and would therefore meet the threshold for an exemption based on high managed care enrollment. We relied on data from the Kaiser Family Foundation website (https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/) to arrive at the estimates, although we note that we will rely upon state attestations of meeting or exceeding the enrollment rate threshold to administer the exemption. Consistent with our currently approved estimates, we continue to anticipate that the average ongoing burden is likely to be the same as the average initial burden estimates since states will need to re-run the data, determine whether to add or drop measures, consider public feedback, and write-up new conclusions based on the information they review. In this regard, we estimate that the exemption would reduce our estimates by 5,270 hr (from 15,810 hr to 10,540 hr) and $399,064.80.

TABLE 4: Access Monitoring Review Plan: Reduced On-Going Burden

Anticipated Number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
(17)	(5,270) (-310 hr x 17 reviews)	(23,474.40)	(399,064.80)

In lieu of developing and updating the access monitoring review plan for the services subject to the ongoing review or for proposed provider rate reductions or payment restructurings that could result in diminished access, this rule proposes that states seeking an exemption from those requirements based on having a comprehensive risk-based managed care enrollment rate at or above 85 percent must submit an annual attestation of its Medicaid managed care enrollment rate as of July 1 of the previous year to CMS. We anticipate states will use the same enrollment data required to be monitored under §438.66 and included in the currently approved information collection request (CMS-10108; OMB 0938-0920) as a basis for the annual attestation. As such, we estimate the burden associated with the annual attestation to be 0.5 hr at $117.40/hr for a

General and Operations Manager to develop the attestation document and submit it to CMS. In aggregate, we estimate an annual burden of 8.5 hr (0.5 hr x 17 respondents) at a cost of $997.90 (8.5 hr x $117.40/hr) or $58.70 per respondent.

TABLE 5: Annual Attestation On-Going Burden

Anticipated Number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
17	8.5 (0.5 hr x 17 reviews)	58.70	997.90

The revised requirements and burden will be submitted to OMB for approval under control number 0938-1134 (CMS-10391).

2. ICRs Regarding Exemption for Payment Rate Changes (§§447.203(b)(6) and 447.204(a) through (c))

Section 447.203(b)(6)(ii) requires states to have procedures within the access monitoring review plan to monitor continued access after implementation of a SPA that reduces or restructures payment rates. The monitoring procedures must be in place for at least 3 years following the effective date of the SPA. The ongoing burden associated with the requirements under §447.203(b)(6)(ii) is the time and effort it would take each of the state Medicaid programs to monitor continued access following the implementation of a SPA that reduces or restructures payment rates.

For provider rate reductions to a service category that are below 4 percent per state fiscal year, and below 6 percent across two consecutive state fiscal years, the proposed changes to §447.203(b)(6)(i) would exempt states from the analysis and monitoring procedures described in §447.203(b)(6)(ii).

In our currently approved information collection request (CMS-10391; OMB 0938-1134), we estimated that in each SPA submission cycle, states would submit 22 SPAs to

implement rate changes or restructure provider payments based on the number of submissions received in FY 2010.

We estimated that it would take, on average, 880 hr to develop the monitoring procedures, 528 hr to periodically review the monitoring results, and 66 hr for review and approval of the monitoring procedures (1,474 total hours). We also estimated an average cost of $6,008.52 per state and $132,187.44 (total).

In deriving these figures we used the following labor rates and time to complete each task: 40 hr at $88.38/hr for management analyst staff to develop the monitoring procedures, 24 hr at $88.38/hr for management analyst staff to periodically review the monitoring results, and 3 hr at $117.40/hr for management staff to review and approve the monitoring procedures.

TABLE 6: Access Monitoring Procedures Following Rate Reduction SPA--Burden Per State (annual)

Requirement	**Occupation Title**	**Burden Hours**	**Adjusted Hourly Wage ($/hr)**	**Cost Per Data Review ($/State)**
Develop Monitoring Procedures	Management Analyst	40	88.38	3,535.20
Periodically Review Monitoring Results	Management Analyst	24	88.38	2,121.12
Approve Monitoring Procedures	General and Operations Manager	3	117.40	352.20
TOTAL		67	varies	6,008.52

We are revising our estimates based on more current data that we collected during the 2016 submission cycle and reducing the burden hours to account for the proposed managed care enrollment rate exemption and threshold for payment rate reductions. During the 2016 submission cycle, we received approximately 23 payment rate change submissions from nine states that would have fallen under the monitoring procedure’s information collection burden, which is generally consistent with our currently approved burden estimates.

Of the 23 submissions, 9 would meet the exemption criteria for states with managed care enrollment rates at or above 85 percent. For the remaining 14 submissions, we believe 4 may have fallen below the 4 percent threshold for overall spending within the service category exemption for a single state fiscal year, and 6 percent for two consecutive state fiscal years based on information provided by the state during the SPA review process. Based on the proposed exemptions process, we are reducing our original estimated number of SPA submissions from 22 to 10. We note that there is some variability in state SPA submissions from year-to-year and the number of rate reduction SPAs that states submit to CMS for approval.

TABLE 7: Revised Access Monitoring Procedures Following Rate Reduction SPA—Total Burden (annual)

Anticipated Number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
(12)	(804) [-67 hr x 12 responses]	(6,008.52)	(72,102.24)

The revised requirements and burden will be submitted to OMB for approval under control number 0938-1134 (CMS-10391).

3. ICRs Regarding Modification of Payment Rate Change SPA Submission Information (§447.204(b)(2))

Section 447.204(b)(2) requires states to include specific documentation to demonstrate access when submitting a SPA that proposes to reduce or restructure payment rates. Included in the documentation, states are required to submit a copy of its most recent access monitoring review plan that includes the services for which payment is being reduced or restructured and an analysis of the effect of the changes in payment rates on access. The burden associated with such submission is included under §447.203(b)(1) (see above) for ongoing access monitoring review plan (reduction of 10,540 hr).

We are proposing to modify the requirement in §447.204(b)(2) so that states will no

longer be required to predict the effect the payment rate change will have on access, and will instead be required to submit to CMS an assurance that data indicates current access is consistent with requirements of the Act. We do not anticipate there will be any changes in burden based on the proposal since it would merely change the expectation for the type of conclusion that the state will draw using its analysis from one that anticipates future access to one that infers access is currently sufficient.

The revised requirement will be submitted to OMB for approval under control number 0938-1134 (CMS-10391).

C. Summary of Proposed Information Collection Requirements and Burden

TABLE 8: Proposed Annual Recordkeeping and Reporting Requirements Under OMB Control Number 0938-1134 (CMS-10391)

Regulatory Section(s) in Title 42 of the CFR	Respondents	Responses	Burden per Response (hr)	Total Annual Burden (hr)	Labor Cost ($/hr)	Total Cost ($)
§447.203(b)(1) - (4) (one time requirement)	(51)	(51)	(310)	(15,810)	varies	(1,197,194)
§447.203(b)(1) – (4) (on-going requirement)	(17)	(17)	(310)	(5,270)	varies	(399,065)
§447.203(b) (attestation)	17	17	0.5	8.5	117.40	998
§447.203(b)(6) (monitoring following rate reduction/ restructuring)	(12)	(12)	(67)	(804)	varies	(72,102)
TOTAL	(34)	(34)	(561.5)	(21,808.5)	varies	(1,667,363)

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. The requirements are not effective, if finalized, until they have been approved by OMB.

We invite public comments on these information collection requirements, and particularly on submission frequency and burden hours per response. If you wish to comment, please identify the rule (CMS-2406-P) and, where applicable, the ICR's CFR citation, CMS ID

number, and OMB control number.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' Web Site address at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html.

2. E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov.

3. Call the Reports Clearance Office at (410) 786-1326.

See this rule's DATES and ADDRESSES sections for the comment due date and for additional instructions.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Statement of Need

This proposed rule impacts states' documentation of compliance with section 1902(a)(30)(A) of the Act. This proposed rule would provide burden relief to states with comprehensive, risk-based managed care enrollment rates above 85 percent of the total covered Medicaid population within a state's Medicaid program and states making rate reductions to services below a threshold of 4 percent of overall Medicaid spending within a service category (for example, physician services) within a single SFY and 6 percent over 2 consecutive SFYs by

exempting them from certain processes described in §§447.203 and 447.204. This proposed rule also would modify the requirements at §447.204(b)(2) so that states must submit to CMS with SPAs that reduce or restructure Medicaid payment rates an assurance that the current baseline data indicates access is consistent with the Act, rather than an analysis anticipating the effects of a proposed change in payment rates.

B. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)) and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a rule: (1) having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants,

user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This proposed rule is not economically significant with an overall estimated reduced economic reporting burden of $449,961.

C. Anticipated Effects

1. Effects on State Medicaid Programs

We anticipate effects on state Medicaid programs that have high comprehensive, risk-based managed care enrollment rates and that make adjustments to their Medicaid payment rates that are unlikely to diminish access to care. States with comprehensive, risk-based managed care enrollment rates of 85 percent or above would no longer be required to maintain and update the access monitoring review plans required under the regulations. In addition, states that make nominal changes to their Medicaid payment rates, defined below 4 percent for a SFY and 6 percent for 2 consecutive SFYs, would no longer be required to conduct monitoring activities described in the regulations related to those SPA changes. Importantly, the provisions of this proposed rule provide exemptions to the regulatory procedure requirements for demonstrating access to care. However, states are not exempt from the statutory requirements described at section 1902(a)(30)(A) of the Act and must have alternative approaches to ensure access is consistent with the Act when reducing Medicaid payment rates.

2. Effects on Small Business and Providers

We anticipate some effects on small businesses and providers that reside in states that meet the exemption criteria described in the proposed rule but only to the extent that we would have disapproved a SPA based on the information required for submission through the

regulations. As the exemptions proposed in the proposed rule are either for states with relatively low fee-for-service delivery (and related expenditures) and for nominal payment rate changes, we do not anticipate the effects will be significant.

3. Effects on the Medicaid Program

The estimated fiscal impact on the Medicaid program from the implementation of the proposed rule is estimated to be a net savings to Medicaid state agencies. These estimates are based on our estimation that 17 states will no longer be required to maintain and update the AMRPs and the approximate number annual SPAs requiring access monitoring will be reduced by 11. This will have a relatively minor effect on state administrative expenditures, with a total anticipated reduction in spending of $1,667,363. However, states have raised significant concerns over the administrative burden and associated benefits to complying with the regulatory requirements both when the majority of Medicaid beneficiaries are served through managed care and when making minor adjustments to Medicaid payments that they believe are unlikely to diminish access to care.

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $7.5 million to $38.5 million in any one year). Individuals and states are not included in the definition of a small entity. As previously stated, we do not anticipate any effect on small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes

of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2017, that threshold is approximately $148 million. This rule does not contain mandates that will impose spending costs on state, local, or tribal governments in the aggregate, or by the private sector, in excess of the threshold.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This rule does not have a substantial impact on state or local governments.

D. Alternatives Considered

In developing this rule, the following alternatives were considered:

1. We considered proposing a managed care enrollment exemption threshold at or above 70 percent but, in reviewing programmatic data, we discovered that the rate of managed care coverage can vary significantly based on category of Medicaid eligibility. For instance, while many states would meet the 70 percent threshold, the rate of managed care coverage for certain populations may fall well below 50 percent. This is frequently the case for individuals who are eligible based on a combination of income and age or as a result of disability. The disproportion of coverage based on eligibility appears significantly less with an exemption threshold at or above 85 percent, therefore the proposed rule would set such a limit. However, we are

requesting comments on the exemption threshold and whether additional considerations, discussed in more detail above, may be applied to allow a lower threshold.

2. In codifying the 4 percent exemption for access monitoring, we considered whether the exemption percentage was too low or too high. As described in our SMDL on this matter, we believe that rate changes below a 4 percent threshold are unlikely to diminish access to care and generally the benefits of monitoring access for such reductions are not consistent with the administrative burden associated with monitoring. We are requesting comment on whether 4 percent is too high or low, but determine 4 percent to be appropriate for purposes of the proposed rule. We also considered applying the 4 percent exemption threshold annually but, in evaluating the potential cumulative effects of year-over-year rate reductions, proposed a 6 percent threshold over 2 SFYs. We request comment on consideration of cumulative impacts, including the 6 percent threshold amount and 2 SFYs timeframe.

E. Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. This proposed rule is expected to be an EO 13771 deregulatory action. Details on the $1.66 million estimated cost savings of this rule can be found in the preceding analyses.

G. Conclusion

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs-health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, and Rural areas.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 447—PAYMENTS FOR SERVICES

1. The authority citation for part 447 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 447.203 is amended by revising paragraphs (b) introductory text, (b)(6)(i) and (ii) to read as follows:

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

* * * * *

(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 and with procedures established by CMS. 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. States that have for all eligibility groups combined at least 85 percent of beneficiaries enrolled in Medicaid managed care organizations, as defined in §438.2 of this chapter, and including section 1115 demonstration populations enrolled under such comprehensive risk contracts, are not required to meet the requirements under paragraphs (b)(1) through (6) of this section. Any state seeking an exemption based on an overall Medicaid managed care enrollment of 85 percent or higher must submit an annual attestation of its Medicaid managed care enrollment rate as of July 1 of the previous year to CMS. In lieu of the requirements under paragraph (b)(6) of this section, States that have overall Medicaid managed care enrollment of at least 85 percent for the calendar year, must submit an alternative analysis and certification, including the data and other information on which the analysis and certification

are based, that demonstrate compliance with section 1902(a)(30)(A) of the Act.

* * * * *

(6) * * *

(i) *Compliance with access requirements.* The State shall submit with any State plan amendment that proposes to reduce provider payments by greater than 4 percent in overall service category spending in a State fiscal year or greater than 6 percent across two consecutive State fiscal years, 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, for any State plan amendment that reduces provider payment greater than 4 percent in overall service category spending in a State fiscal year or greater than 6 percent across two consecutive State fiscal years, or restructures provider payments in circumstances when the changes could result in diminished access, the 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.

* * * * *

3. Section 447.204 is amended by—

a. Revising paragraphs (a) introductory text, (b) introductory text, (b)(2), and (c).

b. Redesignating paragraph (d) as paragraph (e).

c. Adding new paragraph (d).

The revisions and addition read as follows:

§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. Except as provided in paragraph (d) of this section, 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:

* * * * *

(b) Except as provided in paragraph (d) of this section, the State must submit to CMS with any such proposed State plan amendment affecting payment rates:

* * * * *

(2) An assurance that access to care is sufficient in accordance with section 1902(a)(30)(A) of the Act, and baseline data to support this conclusion; and

* * * * *

(c) Except as provided in paragraph (d) of this section, CMS may disapprove a proposed state plan amendment affecting payment rates if the state does not include in its submission the supporting documentation described in paragraph (b) of this section, for failure to document compliance with statutory access requirements. Any such disapproval would follow the procedures described at part 430 Subpart B of this title.

(d) Paragraphs (a) through (c) of this section shall not apply in the case of a state that is not required to meet the requirements of §447.203(b)(1) through (b)(6) because the state has Medicaid managed care enrollment of at least 85 percent, as described in §447.203(b), or in the case of a proposed State plan amendment that reduces provider payment rates by no more than 4 percent in any State fiscal year, and no more than 6 percent across two consecutive State fiscal years. In lieu of the requirements under paragraphs (a) though (c) of this section, States that are not required to meet these requirements pursuant to this paragraph must submit to CMS an alternative analysis, along with supporting data, to demonstrate compliance with section 1902(a)(30)(A) of the Act when submitting a state plan amendment that proposes to reduce or restructure Medicaid service payment rates in circumstances that may diminish access to care.

* * * * *

Dated: March 1, 2018.

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: March 16, 2018.

Alex M. Azar II,

Secretary,

Department of Health and Human Services.

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