James L. Madara, MD  
American Medical Association  
25 Massachusetts Ave., NW  
Washington, DC 20001

Dear Dr. Madara:

Thank you for your letter regarding changes in reimbursement rates for laboratory services on the Medicare Clinical Laboratory Fee Schedule. Your letter discusses the reductions to Medicare rates implemented under section 216 of the Protecting Access to Medicare Act of 2014 (PAMA) and the effects the reductions may have on Medicaid payment rates in various states.

Specifically, your letter raises concerns over the impact the Medicare changes may have on access to care in the Medicaid program, since many states pay for Medicaid laboratory services based on the Medicare rate schedule, either paying the Medicare rate or some percentage thereof. You correctly note that section 1902(a)(30)(A) of the Social Security Act (the Act) requires states to set Medicaid payment rates at amounts sufficient to enlist enough providers so that care and services are available to Medicaid beneficiaries at least to the extent that such care and services are available to the general population in the geographic area. Further, you request that CMS disapprove any state plan amendment (SPA) that proposes to implement rates for laboratory services below the Medicare rates established consistent with the PAMA.

States have broad flexibility to administer their Medicaid programs, including setting payment rates, within the parameters of federal statute and regulation. For clinical diagnostic laboratory services, section 1903(i)(7) of the Act limits Medicaid payment to the amount that Medicare would pay for the service for an individual enrolled under Medicare Part B. Consistent with this statutory requirement, states must establish Medicaid payment rates for the clinical diagnostic laboratory services affected by the PAMA that do not exceed the Medicare fee schedule rates for such services.

In the event a state submits a SPA that proposes to reduce Medicaid clinical diagnostic laboratory services payment rates below the relevant Medicare fee schedule rate, CMS would rely on the processes defined in regulations in 42 CFR part 447, subpart B to ensure compliance with section 1902(a)(30)(A) of the Act. These regulations require states to develop and submit to CMS an Access Monitoring Review Plan (AMRP) for certain services and update the AMRP at least every three years. When states seek to reduce or restructure Medicaid payment rates in circumstances when the changes could result in diminished access, they are required to submit an access review for each affected service with the proposed SPA to demonstrate current, sufficient access for the affected services. Additionally, states must add the affected services to the AMRP and develop a plan to monitor the effects of the rate reductions for at least three years.
To document compliance with section 1902(a)(30)(A) of the Act, the regulations require states to submit with a rate reduction SPA: the most recent AMRP (revised as may be needed to include the services proposed to be subject to rate reduction or restructuring), an analysis of the effect of the change in payment rates on access and a specific analysis of the information and concerns expressed in input from affected stakeholders.

We have worked closely with states to ensure that they are aware of and follow these procedures and have an adequate AMRP in place before CMS approves a rate reduction SPA. Additionally, the federal regulations require states to maintain ongoing feedback mechanisms to understand access to care concerns raised by stakeholders on a real-time basis. We believe that these processes provide for sufficient methods for states and CMS to understand and address access to care issues as they may arise in Medicaid programs.

Thank you for raising this important issue. I hope that this response helps address your concerns. Please share this response with the organizations who co-signed your letter.

Sincerely,

Seema Verma