Supporting Statement – Part A
Methods for Assuring Access to Covered Medicaid Services
Under 42 CFR 447.203 and 447.204
(CMS 10391, OMB 0938-NEW)

A. BACKGROUND

CMS 2328-P proposes a standardized process for States to follow to demonstrate that Medicaid beneficiaries have access to services covered under the Medicaid State plan to the extent that services are available to the general population in a geographic area. To meet the requirements of the proposal, States will need to measure a three-part framework of: enrollee needs, the availability of care and providers, and service utilization. The review would be conducted for a subset of covered services each year over five-year intervals and, specifically, for services for which a State intends to reduce or restructure payment rates within 12 months of reducing or restructuring the rates. The proposal also requires that States develop ongoing monitoring procedures after reducing or restructuring payments through which they periodically review measures of sustained access to care for the affected service(s). The periodic reviews are intended to help a State fulfill its ongoing responsibility to assure access to covered services consistent with the Act and form a solid, informed basis by which a State and CMS can consider how any proposed changes might affect access. In addition, States would need to have a mechanism for obtaining beneficiary feedback on access to care, such as hotlines, surveys, ombudsman or other equivalent mechanisms and institute a corrective action procedure should access issues be discovered through the access review and monitoring processes. Finally, when considering reductions to Medicaid payment rates the NPRM requires States undertake a public process that solicits input on the potential impact of the proposed reduction or restructuring of Medicaid service payment rates on beneficiary access to care.

B. JUSTIFICATION

1 . Need and Legal Basis

The proposed rule would implement Section 1902(a)(30)(A) of the act, which requires that States: "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"

2. Information Users

The information will be used by States to determine that access to care is provided in compliance with Section 1902(a)(30)(A) of the Act, to identify issues with access within a State's Medicaid program, and to inform any necessary programmatic changes to address issues with access to care. CMS will use the information to make informed approval

decisions on State plan amendments that propose to make Medicaid rate reductions or restructure payment rates and to provide the necessary information for CMS to monitor ongoing compliance with Section 1902(a)(30)(A). Beneficiaries, providers and other affected stakeholders will used the information to better understand voice access issues within the Medicaid program and work with State Medicaid agencies to address those issues.

3. Use of Information Technology

CMS anticipates that States will primarily utilize information technology to gather and analyze the data collected through this requirement. States will likely rely upon the State Medicaid Management Information Systems and other State databases to gather much of the data used to review access to care and may use statistical and other analytical software to analyze the information. CMS will work to develop an electronic template for States to issue the review electronically. The use of information technology should reduce the burden associated with this collection by 30%.

4. Duplication of Efforts

CMS states in the preamble to the proposed rule that the agency will coordinate internally and with other federal partners to ensure that there is no duplication as a result of this collection effort. CMS has reviewed the available universe of information currently available and these collection efforts are not currently conducted.

5. Small Businesses

CMS has determined that the information collected under the proposed rule would not have an impact on small businesses. The impact of the proposed rule would be on State governments.

6. Less Frequent Collection

If the information collection is not conducted, States and CMS will have no basis to determine if Medicaid rates are sufficient to provide for access to care as described in the Statute. As a result, Medicaid beneficiaries may not receive the care and services that they need. This is currently a pressing concern and the basis for issuing rule-making.

7. Special Circumstances

The collection does not necessitate any special circumstances. The proposed rule requires annual access reviews, beneficiary feedback forums and other processes, which are not associated with confidential information.

8. Federal Register/Outside Consultation

As discussed in the NPRM that published on May 6, 2011 (76 FR 26342; RIN 0938-AQ54), CMS is requesting public comment on the appropriate data and sources of data to demonstrate access to care. We have consulted with, and will continue dialogue, with States, the Medicaid and Chip Payment and Access Commission and federal partners. The NRPM allows states significant discretion to choose appropriate data sources to meet the requirements of the NPRM and CMS will partner with states to identify appropriate resources and reduce State burden.

9. Payments/Gifts to Respondents

No payments or gifts are made to respondents.

10. Confidentiality

Confidential information will not be required as part of the information collection.

11. Sensitive Questions

Responses to sensitive questions will not be required for solicitation as part of the information collection.

12. Burden Estimates (Hours & Wages)

Documentation of Access to Care and Service Payment Rates (§447.203(b)(1) – (3))

We estimate that the requirements to review and make publically available, data trends and factors that measure: enrollee needs, availability of care and providers, utilization of services, and Medicaid rate comparisons under §447.203(b)(1) through (3) would affect all States. We have allowed States the flexibility to choose the services that they review annually based on available resources and State priorities. As such, we assume that States will conduct reviews in the context of rate reductions or restructuring payment rates as part of their annual ongoing reviews and we consider the burden associated with rate reduction reviews as part of the ongoing estimate burden.

An employee equivalent to the Federal Salary Classification of GS 13 Step 1 could be responsible for gathering review data and developing and publishing the content of the data review. An employee equivalent to the Federal Salary Classification of a GS 15 Step 1 would be responsible for overseeing and approving the data review. We have taken these employee assumptions and utilized the corresponding employee hourly rates for the locality pay area of Washington, DC as published by the U.S. Office of Personnel Management, to calculate our cost estimates. We have also calculated the cost by assuming that a State expends 36 percent of an employee's hourly wages on benefits for the employee. We have concluded that a 36 percent expenditure on benefits is an appropriate estimate because it is the routine percentage used by HHS for contract cost estimates.

Monitoring Access (§447.203(b)(3)(ii))

We estimate that the requirement under §447.203(b)(3)(ii) would affect all States that implement a rate reduction or restructure payment rates. We are estimating that approximately 22 States will implement these rate changes based on the number of States that proposed such reductions in FY 2010. An employee equivalent to the Federal Salary Classification of a GS 13 Step 1 could develop the monitoring procedures and periodically review the monitoring results. An employee equivalent to the Federal Salary Classification of a GS 15 Step 1 would be responsible for overseeing and approve the monitoring process. We have taken these employee assumptions and utilized the corresponding employee hourly rates for the locality pay area of Washington, DC as published by the U.S. Office of Personnel Management, to calculate our cost estimates. We have also calculated the cost by assuming that a State expends 36 percent of an employee's hourly wages on benefits for the employee. We have concluded that a 36 percent expenditure on benefits is an appropriate estimate because it is the routine percentage used by HHS for contract cost estimates.

Beneficiary Feedback (§447.203(b)(4))

Section 447.203(b)(4) would require States to have a mechanism for obtaining beneficiary feedback on access to care, such as hotlines, surveys, ombudsman or other equivalent mechanisms.

We estimate that the requirement under §447.203(b)(4) would affect all States that do not currently have a means of beneficiary feedback. Since we currently do not know which States have implemented these mechanisms, we are assuming in our estimate that all States will need to develop new mechanisms. An employee equivalent to the Federal Salary Classification of a GS 9 Step 1 could develop and oversee the feedback effort. An employee equivalent to the Federal Salary Classification of a GS 15 Step 1 would be responsible for approving the feedback effort. We have taken these employee assumptions and utilized the corresponding employee hourly rates for the locality pay area of Washington, DC as published by the U.S. Office of Personnel Management, to calculate our cost estimates. We have also calculated the cost by assuming that a State expends 36 percent of an employee's hourly wages on benefits for the employee. We have concluded that a 36 percent expenditure on benefits is an appropriate estimate because it is the routine percentage used by HHS for contract cost estimates.

Corrective Action Plan (§447.203(b)(5))

Section 447.203(b)(5) would institute a corrective action procedure that requires States to submit to CMS a remediation plan should access issues be discovered through the access review or monitoring processes. The requirement is intended to ensure that States will oversee and address any future access concerns.

We estimate that the requirement under §447.203(b)(5) would affect all States that identify access issues. We are estimating that approximately 10 States will identify access issues and submit corrective action plans to CMS. This is a new requirement and we have no basis to determine how many States will identify access issues as they conduct the data reviews and monitoring activities. We assume that many States currently have mechanisms in place to

monitor access to care and identify issues. However, we are careful not to under-estimate the burden associated with this provision and we believe that a maximum of 10 States may identify access issues per year. An employee equivalent to the Federal Salary Classification of a GS 13 Step 1 could identify issues that require corrective action and develop the plan to submit to CMS. An employee equivalent to the Federal Salary Classification of a GS 15 Step 1 would be responsible for review and approving the plan. We have taken these employee assumptions and utilized the corresponding employee hourly rates for the locality pay area of Washington, DC as published by the U.S. Office of Personnel Management, to calculate our cost estimates. We have also calculated the cost by assuming that a State expends 36 percent of an employee's hourly wages on benefits for the employee. We have concluded that a 36 percent expenditure on benefits is an appropriate estimate because it is the routine percentage used by HHS for contract cost estimates.

Public Process to Engage Stakeholders (§447.204(a)(1) and (2)

We are estimating that approximately 22 States will implement these rate changes that would require a public process based on the number of States that proposed such reductions in FY 2010. An employee equivalent to the Federal Salary Classification of a GS 9 Step 1 could develop and oversee the public process effort. An employee equivalent to the Federal Salary Classification of a GS 15 Step 1 would be responsible for approving the public process effort. We have taken these employee assumptions and utilized the corresponding employee hourly rates for the locality pay area of Washington, DC as published by the U.S. Office of Personnel Management, to calculate our cost estimates. We have also calculated the cost by assuming that a State expends 36 percent of an employee's hourly wages on benefits for the employee. We have concluded that a 36 percent expenditure on benefits is an appropriate estimate because it is the routine percentage used by HHS for contract cost estimates.

Regulation Section(s)	OMB Control No.	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($)	Total Labor Cost of Reporting ($)	Total Capital/ Maintenance Costs ($)	Total Cost ($)
447.203(b)(1) – (3)	0938-NEW	50	50	300	15,000	58.01	870,150	0	870,150
				10	500	80.65	40,325	0	40,325
Subtotal				310	15,500	_	910,475	0	910,475
447.203(b)(3)(ii)	0938-NEW	22	22	64	1,408	58.01	81,678.08	0	81,678.08
				3	66	80.65	5,322.90	0	5,323.90
Subtotal				67	1,474	_	87,000.98	0	87,000.98
447.203(b)(4)	0938-NEW	50	50	124	6,200	33.64	208,568	0	208,568
				5	250	80.65	20,162.50	0	20,162.50
Subtotal				129	6,450	_	228,730.50	0	228,730.50
447.203(b)(5)	0938-NEW	10	10	60	600	58.01	34,806	0	34,806
				3	30	80.65	2,419.50	0	2,419.50
Subtotal				63	630	_	37,225.50	0	37,225.50
447.204(a)(1) and (2)	0938-NEW	22	22	60	1,320	33.64	44,404.80	0	44,404.80
				3	66	80.65	5,322.90	0	5,322.90
Subtotal				63	1,386	_	49,727.70	0	49,727.70
TOTAL		154	154	632	25440	--	1313159.68	0	1313159.68

13. Capital Costs

    There are no estimated capital cost increases associated with the NPRM. States may conduct the access reviews and other related processes proposed under the NPRM through existing capital resources.

14. Cost to Federal Government

    There is no additional cost to the federal government associated with the NPRM. The information gathered and reviewed by States will aid CMS in making State plan amendment approval decisions, which is a part of current operations.

15. Changes to Burden

    This is a new ICR.

16. Publication/Tabulation Dates

    The NPRM requires that States make the results of the data reviews available to the public by January 1 of each year. The result may be available through public records or State websites.

17. Expiration Date

    CMS would like an exemption from displaying an expiration date.

18. Certification Statement

    There are no exceptions requested to the certification statements.