Supporting Statement – Part A
Methods for Assuring Access to Covered Medicaid Services
Under 42 CFR 447.203 and 447.204
(CMS-10391, OMB 0938-1134)

This information collection request is associated with a final rule that published on November 2, 2015 (80 FR 67576, RIN 0938-AQ54, CMS-2328-FC).

Background

The CMS-2328-FC final rule requires a transparent, data driven 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. This requirement is described under section 1902(a)(30)(A) of the Social Security Act whereby the final rule provides guidance to states on processes to meet the requirement.

Every three years, states must develop access to care monitoring review plans for: Primary Care, Physician Specialist, Behavioral Health Care, Pre and Post Natal Obstetric services (including labor and delivery), and Home Health Services. The reviews must include data on:

- the extent to which beneficiary needs are met;
- the availability of care and qualified providers;
- changes in beneficiary service utilization; and
- comparisons between Medicaid rates and rates paid by other public and private payers.

When states reduce rates for other Medicaid services, they need to add those services to the Medicaid access monitoring review plans and monitor the effects of the rate reductions for 3 years. If access issues are detected, a state must submit a corrective action plan to CMS within 90 days and work to address the issues within 12 months.

The rule requires that states have mechanisms to obtain ongoing beneficiary and provider feedback. This may include information gathered through hotlines, ombudsman programs, and/or the medical advisory committees. A state's mechanisms should promptly respond to public input citing specific access problems, with an appropriate investigation, analysis and response. A state is also required to maintain a record of data on public input and how the state responded to the input.

Prior to submitting proposals to reduce or restructure Medicaid service payment rates, states must receive input from beneficiaries, providers, and other affected stakeholders on the extent of beneficiary access to the affected services. States must maintain a record of the volume of public input and the nature of the response to the input.

Finally, the final rule allows states to issue public notice to providers through state websites. Previously states could only publish the public notice through state registers or newspapers, which could be costly and/or time-restricted.

A. Justification

1. Need and Legal Basis

The final rule implements 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." CMS has requested information from states to document access to care consistent with the statute as part of our state plan amendment review process. This information is particularly relevant when states propose to reduce or restructure provider payments in ways that may harm Medicaid access. We found states' approaches to documenting and monitoring access in Medicaid programs generally lacking and particularly insufficient in reviewing and monitoring data, addressing concerns from beneficiaries and providers and correcting access to care problems when they arise. The final rule describes processes the improve state and CMS oversight of these issues and provides better information for CMS to make informed SPA approval decisions when states propose to reduce provider payments or otherwise restructure payments in ways that may harm access to care.

2. Information Users

The information will be used by states to document 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 use the information to raise access issues to state Medicaid agencies and work with 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 and systems to gather much of the data used to review access to care and may use statistical and other analytical software to analyze the information. The use of information technology should reduce the burden associated with this collection by 30%.

4. Duplication of Efforts

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 this information collection request does not have an impact on small businesses. Rather, the impact is on state governments.

6. Less Frequent Collection

If the information collection is not conducted, states and CMS will have insufficient information to determine if Medicaid rates are sufficient to provide for access to care as described under the Act. 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 final rule requires access reviews, beneficiary feedback forums and other processes, which are not associated with confidential information.

8. Federal Register/Outside Consultation

The May 6, 2011 (76 FR 26342) proposed rule served as the 60-day notice for soliciting public comment. PRA-related comments were received whereby a summary of the comments and our response has been added to this PRA package as a separate document.

We received 181 timely public comments. Several comments, largely from state Medicaid agencies, noted that the access data reviews associated with §447.203(b)(1) through (4) would require considerable time and resources to develop. The commenters raised issues with the administrative burden associated with these provisions. After careful consideration of the comments, CMS modified the provisions in the final rule to focus ongoing access care review on: primary care, physician specialists, behavioral health, pre and post natal obstetric services (including labor and delivery), and home health services. Whereas the proposed rule required that states conduct ongoing access reviews for all Medicaid state plan covered services over five year cycles, the final rule focuses state reviews on select high priority service categories every three years. In addition to requiring state to have mechanism for ongoing beneficiary feedback as was proposed in the NPRM, the final rule requires states to have similar mechanism for providers to raise access to care concerns. These are the major substantial differences between the proposed and final rules and we anticipate that there is minimal change in the estimated burden as a result.

Regarding the burden estimates, CMS made changes from the NPRM to update the wages and costs using the U.S. Bureau of Labor Statistics' May 2014 National Occupational Employment and Wage Estimates. In the NPRM, CMS relied upon the Office of Personnel Management General Schedule for the estimated wages. We also updated our recordkeeping and reporting requirement estimates to show the estimated wages and costs associated with one-time burden and ongoing burden requirements for each provision of the final rule. Finally, the tables were modified between the NPRM and final rule to accommodate changes to the regulatory text that were made based on public comments.

We did not estimate significant differences in the burden hours associated with requirements of the NPRM and those described in the final rule as most of the provisions are finalized without significant modification; however there were overall increases in total estimated burden costs associated with the requirements of the final rule. The increases were primarily associated with the considerations for both one-time burden and ongoing burden and also with the more precise wage data available through the BLS tables. We also increased the estimated hours and costs associated with the access review monitoring plan activities. These estimates increased even though we reduced the scope of services that states must review ongoing within the final rule. Based on public comments in response to the NPRM, we believed that there were concerns that we had under estimated the burden associated the proposed data review activities and, although the overall scope of services under review is decreased in the final rule, the timeframe for conducting reviews also changed and could have some increased effect on 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)

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2014 National Occupational Employment and Wage Estimates for all salary estimates (www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operations Specialist	13-1000	33.69	33.69	67.38
Computer and Information Analyst	15-1120	42.25	42.25	84.50
General and Operations Manager	11-1021	56.35	56.35	112.70
Management Analyst	13-1111	43.68	43.68	87.36
Social Science Research Assistant	19-4061	20.71	20.71	41.42

We adjusted our employee hourly wage estimates by a factor of 100 percent. This is 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 is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

12.1. ICRs Regarding Access Monitoring Review Plans (§447.203(b))

Section 447.203(b) requires that states develop and make public an access monitoring review plan that considers, at a minimum: beneficiary needs, the availability of care and providers, utilization of services, characteristics of the beneficiary population, and provider payment rates. States are also required under this provision to monitor data and beneficiary and provider input on an ongoing basis and address known access issues through corrective action.

The final rule with comment period provides states with the discretion to determine appropriate data sources that will be used to conduct the review. We believe most of the data that will be used to inform access is available to states and may already be collected by states as part of Medicaid program reviews and payment rate-setting procedures. We also note that states have flexibility to compare Medicaid rates to one or more of Medicare rates,

commercial rates, or Medicaid cost, as may be appropriate to the service under review. The burden associated with these requirements is the time and effort associated with analyzing this information, making it available to the public, and periodically updating the information relative to activities states are already undertaking. We have attempted to mitigate any new burden by identifying data that states are likely to currently possess, identifying other data sources that might be informative to state access reviews, and limiting the categories of services states will be required to review.

a. Access Monitoring Review Plan Timeline

Section 1902(a)(30)(A) of the Act requires states to ensure that Medicaid beneficiaries have access to care and services that is equivalent to care provided to the general population within a geographic area. Based on public comments received we are revising the requirements of §447.203(b) to limit the scope of Medicaid services that states must review on an ongoing basis.

The final rule with comment period stipulates that states must develop an access monitoring review plan for the specified service categories and update the plan every 3 years. States will also be required to develop an access monitoring review plan when a state submits a SPA to reduce or restructure payment rates in circumstances where the changes could result in access issues for the service or services affected by the SPA. In this way, states would consider the impact that such proposals may have on access to care and demonstrate compliance with section 1902(a)(30)(A) of the Act. States may complete this review within the prior 12 months of the SPA submission.

b. Access Monitoring Review Plan Framework

The data analysis activities described in the final rule with comment period are claimable as administrative claiming activities and are reimbursable at the general 50 percent FFP rate for administrative expenditures, insofar as they are necessary for the proper and efficient administration of the Medicaid state plan as described at section 1903(a)(7) of the Act. More specifically, utilization review is identified as an allowable Medicaid administrative activity in guidance that was issued in the form of a SMD letter dated December 20, 1994 (www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD122094.pdf). We also believe that states may be collecting some of this information as part of current review efforts for various purposes, including program administration and oversight, quality activities, integrity and payment, and as part of other performance standards and measures required under the Affordable Care Act.

The provisions at §447.203(b)(1) through (3) require that states develop and make publically 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. Consistent with the statutory requirement, we have clarified that states

demonstrate access to care within specific geographic regions. After careful consideration of the comments received, we are finalizing the review framework with some modifications in an effort to minimize the administrative burden associated with the requirement. Though we recognize that no methodology to gauge access to care is flawless, we believe that the framework, as supported by state data sources, is appropriate to inform whether the Medicaid access requirements are met.

Sections 447.203(b)(1) and (2) describe the minimum factors that states must considered when developing an access review monitoring plan. Specifically, we require the review to include feedback 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 recommend that states use existing provider feedback mechanism such as medical advisory committees described in §431.12 to ease burden on states rather than create new requirements.

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. This requirement was modified based on comments received to allow states maximum flexibility in comparing Medicaid payment rates to the rates of other payers.

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 and complete its access monitoring review plan the data review and make the information available to the public through accessible public records or web sites on an on-going basis for the following categories of services: primary care, physician specialist services, behavioral health, maternity and related care, home health, and additional services as determined necessary by the state or CMS. The initial access monitoring review plans are to be completed by July 1 after the effective date of this final rule with comment period. The plan must be updated at least every 3 years, but no later than July 1 of the update year. We estimate that the requirements to develop and make the access monitoring review plans publically available under §447.203(b)(1) through (4) will affect all states. We have defined specific categories of services that states must develop access monitoring review plans for, while allowing states to include additional service categories as necessary. We assume states will conduct reviews in the context of rate reductions or restructuring payment rates and we consider the burden associated with rate reduction or restructuring reviews as part of the ongoing estimated burden.

The one-time burden associated with the requirements under §447.203(b)(1) through (5) is the time and effort it would take, on average, each of the 50 state Medicaid programs and the District of Columbia (51 total respondents) to develop and make publically available an access monitoring review plan for the specific categories of Medicaid services. The uniform nature of the initial menu of services required for the access monitoring review plans are the reason we present average impacts.

We estimate that it will take 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). We also estimate a cost of $22,631,80 per state and a total of $1,154,221.80.

In deriving these figures we used the following hourly labor rates and time to complete each task: 80 hr at $41.42/hr for a research assistant staff to gather data, 80 hr at $84.50/hr for an information analyst staff to analyze the data, 100 hr at $87.36/hr for management analyst staff to develop the content of the access monitoring review plan, 40 hr at $67.38/hr for business operations specialist staff to publish the access monitoring review plan, and 10 hr at $112.70/hr for managerial staff to review and approve the access monitoring review plan.

TABLE 1: Access Monitoring Review Plan – 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	41.42	3,313.60
Analyzing Data	Computer and Information Analyst	80	84.50	6,760
Developing Content of Access Review Monitoring Plan	Management Analyst	100	87.36	8,736
Publishing Access Review Monitoring Plan	Business Operations Specialist	40	67.38	2,695.20
Reviewing and Approving Access Review Monitoring Plan	General and Operations Manager	10	112.70	1,127.00
Total Burden Per State…	……	310	…	22,631.80

TABLE 2: Access Monitoring Review Plan—One-Time Total Burden

Anticipated Number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
51	15,810 (310 hr x 51 reviews)	22,631.80	1,154,221.80

Annualized over the three-year reporting period, we estimate 17 responses, 5,270 hr, $7,543.93 (per state), and $384,740.60 (aggregate). We are annualizing the one-time requirements since we do not expect any additional burden after OMB's 3-year approval period expires.

The ongoing burden associated with the requirements under §447.203(b)(1) through (5) is the time and effort it would take each of the 50 state Medicaid programs and the District of Columbia (51 total respondents) to develop and make publically available an access monitoring review plan for the specific categories of Medicaid services. The access monitoring review plans must be updated at least every 3 years.

We anticipate that the average initial and ongoing burden is likely to be the same 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 it will take 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). We also estimate a cost of $22,631,80 per state and a total of $1,154,221.80.

In deriving these figures we used the following hourly labor rates and time to complete each task: 80 hr at $41.42/hr for a research assistant staff to gather data, 80 hr at $84.50/hr for an information analyst staff to analyze the data, 100 hr at $87.36/hr for management analyst staff to update the content of the access review monitoring plan, 40 hr at $67.38/hr for business operations specialist staff to publish the access monitoring review plan, and 10 hr at $112.70/hr for managerial staff to review and approve the access monitoring review plan.

TABLE 3: Access Monitoring Review Plan–Ongoing Burden Per State (annual)

Requirement	Occupation Title	Burden Hours	Adjusted Hourly Wage ($/hr)	Cost Per Monitoring Plan ($/State)
Gathering Data	Social Science Research Assistant	80	41.42	3,313.60
Analyzing Data	Computer and Information Analyst	80	84.50	6,760

Updating Content of Access Monitoring Review Plan	Management Analyst	100	87.36	8,736
Publishing Access Monitoring Review Plan	Business Operations Specialist	40	67.38	2,695.20
Reviewing and Approving Access Monitoring Review Plan	General and Operations Manager	10	112.70	1,127.00
Total Burden Per State…	……	310	…	22,631.80

TABLE 4: Access Monitoring Review Plan—Ongoing Total Burden (annual)

Anticipated Number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
51	15,810 (310 hr x 51 reviews)	22,631.80	1,154,221.80

This section has no associated attachments such as information collection/reporting instruments, SPA templates/preprints, or instructions/guidance related to the collection/reporting of information.

12.2. ICRs Regarding Monitoring Procedures (§447.203(b)(6)(ii))

Section 447.203(b)(6)(ii) requires states to have procedures within the access review monitoring 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 a SPA that reduces or restructures payment rates.

The ongoing burden associated with the requirements under §447.203(b)(6)(ii) is the time and effort it would take each of the 50 state Medicaid programs and the District of Columbia to monitor continued access following the implementation of a SPA that reduces or restructures payment rates. The requirements will affect all states that implement a rate reduction or restructure payment rates. We estimate that in each SPA submission cycle, 22 states will implement these rate changes based on the number of states that proposed such reductions in FY 2010. Please note that we are using FY 2010 as the basis for our estimate because of the unusual high volume of rate reduction SPAs that states submitted during this period. By basing our estimate on FY 2010 data, we anticipate the highest potential for burden associated with this final rule with comment period.

We estimate that it will 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 estimate an average cost of $5,929.14 per

state and a total of $130,441.08.

In deriving these figures we used the following hourly labor rates and time to complete each task: 40 hr at $87.36/hr for management analyst staff to develop the monitoring procedures, 24 hr at $87.36/hr for management analyst staff to periodically review the monitoring results, and 3 hr at $112.70/hr for management staff to review and approve the monitoring procedures.

TABLE 5: 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	87.36	3,494.40
Periodically Review Monitoring Results	Management Analyst	24	87.36	2,096.64
Approve Monitoring Procedures	General and Operations Manager	3	112.70	338.10
Total Burden Per State…	……	67	…..	5,929.14

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

Anticipated Number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
22	1,474	5,929.14	130,441.08

This section has no associated attachments such as information collection/reporting instruments, SPA templates/preprints, or instructions/guidance related to the collection/reporting of information.

12.3. ICRs Regarding Ongoing Input (§447.203(b)(7))

Section 447.203(b)(7) requires that states have a mechanism for obtaining ongoing beneficiary, provider and stakeholder input on access to care issues, such as hotlines, surveys, ombudsman, or other equivalent mechanisms. States must promptly respond to public input with an appropriate investigation, analysis, and response. They must also maintain records of the beneficiary input and the nature of the state response.

We estimate that the requirement will 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.

The one-time burden associated with the requirements under §447.203(b)(7) is the time and effort it would take, on average, for each of the 50 state Medicaid programs and the District of Columbia (51 total respondents) to develop and implement beneficiary feedback mechanisms.

We estimate that it will take an average of 5,100 hr to develop the feedback effort and 255 hr to approve the feedback effort (5,355 total hours). We also estimate an average cost of $9,299.50 per state and a total of $474,274.50.

In deriving these figures we used the following hourly labor rates and time to complete each task: 100 hr at $87.36/hr for management analyst staff to develop the feedback effort and 5 hr at $112.70/hr for managerial staff to review and approve the feedback effort.

TABLE 7: Beneficiary Feedback Mechanism-—One-time Burden Per State

Requirement	Occupation Title	Burden Hours	Adjusted Hourly Wage ($/hr)	Cost Per Data Review ($/State)
Developing Feedback Effort	Management Analyst	100	87.36	8,736
Approve Feedback Effort	General and Operations Manager	5	112.70	563.50
Total Burden Per State…	……	105	…..	9,299.50

TABLE 8: Beneficiary Feedback Mechanism—One-time Total Burden

Anticipated Number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
51	5,355 (105 hr x 51 reviews)	9,299.50	474,274.50

Annualized over the three-year reporting period, we estimate 17 responses, 1,785 hr, $9,299.50 (per state), and $158,091.50 (aggregate per year). We are annualizing the one-time requirements since we do not expect any additional burden after OMB's 3-year approval period expires.

The ongoing burden associated with the requirements under §447.203(b)(7) is the time and effort it would take each of the 50 state Medicaid programs and the District of Columbia (51 total respondents) to monitor beneficiary feedback mechanisms.

The overall effort associated with monitoring the feedback will primarily be incurred by analysts who will gather, review and make recommendations for and conduct follow-up on the feedback. We do not estimate that the approval of the recommendations will not require as significant effort from managers. We estimate that it will take an average of 3,825 hr to monitor the feedback results, and 255 hr to approve the feedback effort (4,080 total hours). We also estimate an average cost of $7,115.50 per state and a total of $362,890.50.

In deriving these figures we used the following hourly labor rates and time to complete each task: 75 hr at $87.36/hr for management analyst staff to monitor feedback results and 5 hr at $112.70/hr for managerial staff to review and approve the feedback effort.

TABLE 9: Beneficiary Feedback Mechanism—Ongoing Burden Per State (annual)

Requirement	Occupation Title	Burden Hours	Adjusted Hourly Wage ($/hr)	Cost Per Data Review ($/State)
Monitoring Feedback Results	Management Analyst	75	87.36	6,552.00
Oversee Feedback Effort	General and Operations Manager	5	112.70	563.50
Total Burden Per State…	……	80	…..	7,115.50

TABLE 10: Beneficiary Feedback Mechanism—Ongoing Total Burden (annual)

Anticipated Number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
51	4,080 (80 hr x 51 reviews)	7,115.50	362,890.50

This section has no associated attachments such as information collection/reporting instruments, SPA templates/preprints, or instructions/guidance related to the collection/reporting of information.

12.4. ICRs Regarding Corrective Action Plan (§447.203(b)(8))

Section 447.203(b)(8) institutes a corrective action procedure that requires states to submit to CMS a corrective action plan should access issues be discovered through the access monitoring processes. The requirement is intended to ensure that states will oversee and address any future access concerns.

This is a new requirement and thus we have no past data to use to determine how many states will identify access issues as they conduct their data reviews and monitoring activities. We assume that many states currently have mechanisms in place to monitor access to care and

identify issues. While we are careful not to under-estimate the burden associated with this provision, we believe that a maximum of 10 states may identify access issues per year. The one-time burden associated with the requirements under §447.203(b)(7) is the time and effort it would take 10 state Medicaid programs to develop and implement corrective action plans.

We estimate that it will take an average of 200 hr to identify issues requiring corrective action, 400 hr to develop the corrective action plans, and 30 hr to review and approve the corrective action plans (630 total hours). We also estimate an average cost of $5,579.70 per state and a total of $55,797.00.

In deriving these figures we used the following hourly labor rates and time to complete each task: 20 hr at $87.36/hr for management analyst staff to identify issues requiring corrective action, 40 hr at $87.36/hr for management analyst staff to develop the corrective action plans, and 3 hr at $112.70/hr for managerial staff to review and approve the corrective action plans.

TABLE 11: Corrective Action Plan--Burden Per State

Requirement	Occupation Title	Burden Hours	Adjusted Hourly Wage ($/hr)	Cost Per Data Review ($/State)
Identifying Issues for Action	Management Analyst	20	87.36	1,747.20
Developing the Corrective Plan	Management Analyst	40	87.36	3,494.40
Approve Corrective Plan	General and Operations Manager	3	112.70	338.10
Total Burden Per State…	……	63	…..	5,579.70

TABLE 12: Corrective Action Plan--Total Burden

Anticipated Number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
10	630 (63 hr x 10 reviews)	5,579.70	55,797.00

This section has no associated attachments such as information collection/reporting instruments, SPA templates/preprints, or instructions/guidance related to the collection/reporting of information.

12.5. ICRs Regarding Public Process to Engage Stakeholders (§447.204)

Sections 447.204(a)(1) and (a)(2) require that states consider (when proposing to reduce or

restructure Medicaid payment rates) the data collected through §447.203 and 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. In §447.204(b), we have also clarified that we may disapprove a proposed rate reduction or restructuring if the SPA does not include or consider the data review and a public process. As an alternative, or additionally, we may take a compliance action in accordance with §430.35.

We are estimating that for each SPA revision approximately 22 states, annually, will develop and implement these rate changes that would require a public process based on the number of states that proposed such reductions in FY 2010. Again, we are using FY 2010 as the estimate due to the high number of rate reduction proposals submitted by states in that year.

We estimate that it will take an average of 440 hr to develop the public process and 66 hr for review and approval of the public process (506 total hours). We also estimate an average cost of $2,085.30 per state and a total of $45,876.60.

In deriving these figures we used the following hourly labor rates and time to complete each task: 20 hr at $87.36/hr for management analyst staff to develop the public process and 3 hr at $112.70/hr for managerial staff to review and approve the public process.

TABLE 13: Public Process—One-Time Burden Per State Per SPA

Requirement	Occupation Title	Burden Hours	Adjusted Hourly Wage ($/hr)	Cost Per SPA ($)
Develop the Public Process	Management Analyst	20	87.36	1,747.20
Approve Public Process	General and Operations Manager	3	112.70	338.10
Total Burden Per State…	……	23	…..	2,085.30

TABLE 14: Public Process—One-Time Total Burden

Anticipated number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
22	506	2,085.30	45,876.60

The ongoing burden associated with the requirements under §447.204 is the time and effort it would take 22 state Medicaid programs to oversee a public process.

The overall effort associated with developing the public process will primarily be incurred by analysts who develop and initiate public process activities. We do not estimate that efforts

associated with review and approval of the activities will increase for overseeing managers. We estimate it will take an average of 880 hr to oversee the public process and 66 hr for review and approval of the public process (946 total hours). We also estimate an average cost of $3,832.50 per state and a total of $84,315.00.

In deriving these figures we used the following hourly labor rates and time to complete each task: 40 hr at $87.36/hr for management analyst staff to oversee the public process and 3 hr at $112.70/hr for managerial staff to review and approve the public process.

TABLE 15: Public Process—Ongoing Burden Per State

Requirement	Occupation Title	Burden Hours	Adjusted Hourly Wage ($/hr)	Cost Per SPA ($)
Oversee the Public Process	Management Analyst	40	87.36	3,494.40
Approve Public Process	General and Operations Manager	3	112.70	338.10
Total Burden Per State…	……	43	…..	3,832.50

TABLE 16: Public Process—Ongoing Total Burden (annual)

Anticipated number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
22	946	3,832.50	84,315.00

This section has no associated attachments such as information collection/reporting instruments, SPA templates/preprints, or instructions/guidance related to the collection/reporting of information.

12.6. ICRs Regarding Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates (§447.205)

The provisions at §447.205 clarify when states must issue public notice to providers and allow for the electronic publication of those notices. Section 447.205(d)(2)(iv)(A) through (D) allow those notices to be published on the single state Medicaid agency or other state-developed and maintained web site that is accessible to the general public via the Internet. The burden associated with developing and issuing public notice at §447.205 is not affected by this requirement since the revision would simply address an additional (in this case, electronic) means of notification. Consequently, we do not include the electronic notice activity in our burden analysis.

This section has no associated attachments such as information collection/reporting instruments, SPA templates/preprints, or instructions/guidance related to the collection/reporting of information.

12.7 Summary of Annual Burden Estimates

One-time Reporting and Recordkeeping Requirements

Regulation Section(s)	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($/hr)	Total Labor Cost of Reporting ($)	Total Capital/ Maintenance Costs ($)	Total Cost ($)
447.203(b)(1) - (5) (one-time requirement)	51	17	80	1,360	41.42	56,331.20	0	56,331
			80	1,360	84.5	114,920.00	0	114,920
			100	1,700	87.36	148,512.00	0	148,512
			40	680	67.38	45,818.40	0	45,818
			10	170	112.7	19,159.00	0	19,159
subtotal	*51*	*17*	*310*	*5,270*	--	*384,740.60*	*0*	*384,741*
447.203(b)(7) (one-time requirement)	51	17	100	,1700	87.36	148,512.00	0	148,512
			5	85	112.7	9,579.50	0	9,580
subtotal	*51*	*17*	*105*	*1785*	_	*158,091.50*	*0*	*158,092*
447.203(b)(8) (one-time requirement)	10	10	60	600	87.36	52,416.00	0	52,416
			3	30	112.7	3,381.00	0	3,381
subtotal	*10*	*10*	*63*	*630*	_	*55,797.00*	*0*	*55,797*
447.204(a)(1) and (2) (one-time requirement)	22	22	20	440	87.36	38,438.40	0	38,438
		3	3	66	112.7	7,438.20	0	7,438
subtotal	*22*	*22*	*23*	*506*	--	*45,876.60*		*45,877*
SUBTOTAL	**--**	**66**	**501**	**8,191**	**--**	**644,505.70**	**0**	**644,507**

On-going Reporting and Recordkeeping Requirements

Regulation Section(s)	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($/hr)	Total Labor Cost of Reporting ($)	Total Capital/ Maintenance Costs ($)	Total Cost ($)

447.203(b)(1) - (5) (on-going requirement)	51	51	80	4,080	41.42	168,993.60	0	168,994
			80	4,080	84.5	344,760.00	0	344,760
			100	5,100	87.36	445,536.00	0	445,536
			40	2,040	67.38	137,455.20	0	137,455
			10	510	112.7	57,477.00	0	57,477
subtotal	*51*	*51*	*310*	*15,810*	_	*1,154,221.80*	*0*	*1,154,222*
447.203(b)(6)(ii) (on-going requirement)	22	22	64	1,408	87.36	123,002.88	0	123,003
			3	66	112.7	7,438.20	0	7,438
subtotal	*22*	*22*	*67*	*1,474*	_	*130,441.08*	*0*	*130,441*
447.203(b)(7) (on-going requirement)	51	51	75	3,825	87.36	334,152.00	0	334,152
			5	255	112.7	28,738.50	0	28,739
subtotal	*51*	*51*	*80*	*4,080*	_	*362,890.50*	*0*	*362,891*
447.204(a)(1) and (2) (on-going requirement)	22	22	40	880	87.36	76,876.80	0	76,877
			3	66	112.7	7,438.20	0	7,438
subtotal	*22*	*22*	*43*	*946*	_	*84,315.00*	*0*	*84,315*
SUBTOTAL	**--**	**146**	**433**	**22,310**	**--**	**1,731,868.38**	**0**	**1,731,868**

Total Burden

Regulation Section(s)	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($/hr)	Total Labor Cost of Reporting ($)	Total Capital/ Maintenance Costs ($)	Total Cost ($)
GRAND TOTAL	**--**	**212**	**934**	**30,501**	**--**	**2,376,374.08**	**0**	**2,376,375**

13. Capital Costs

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

14. Cost to Federal Government

There is no additional cost to the federal government associated with the final rule. 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

Not applicable. This is a new collection.

16. Publication/Tabulation Dates

The final rule requires that States make the results of the data reviews available to the public by July 1 after the effective date of the final rule. Ongoing reviews are conducted every three years for certain services and states will monitor access to care for services subject to payments reductions or where access concerns are raised by beneficiaries and providers for a period for three years. The reviews will be published and made available for public review.

17. Expiration Date

CMS would like an exemption from displaying an expiration date as these forms are used on a continuing basis.

18. Certification Statement

There are no exceptions requested to the certification statements.