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

Background

The CMS-2328-FC final rule (80 FR 67576), published on November 2, 2015, 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.

Current regulations at 42 CFR 447.203(b) require states to develop an access monitoring review plan (AMRP) that is updated at least every three years for: primary care services, physician specialist services, behavioral health services, 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 payment rates and rates paid by other public and private payers.

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. 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.

§ 447.203(b)(7) 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 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, § 447.205 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.

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 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. The NPRM, published on March 23, 2018 (83 FR 12696) attempts to address those states' concerns and provide an exemption to the regulatory requirements in §§ 447.203(b)(1) – (6) and 447.204(a) – (c) for states with comprehensive, risk-based Medicaid managed care enrollment rates above 85% of the total covered population under a state's Medicaid program. The proposed rule would also provide an exemption to the regulatory requirements in §§ 447.203(b)(6) and 447.204(a) – (c) for states that submit SPAs to reduce or restructure payments where the overall reduction is 4% or less of overall spending within the affected state plan service category for a single state fiscal year and 6% or less over two consecutive state fiscal years. 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 the requirements of the Social Security Act instead of an analysis anticipating the effects of a proposed change in payment rates or structure.

A. Justification

1. Need and Legal Basis

The November 2015 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 proposed rule requires, for states not meeting the regulatory exemptions, access reviews, beneficiary feedback forums and other processes, which are not associated with confidential information.

8. Federal Register/Outside Consultation

The March 23, 2018 (83 FR 12696) proposed rule (CMS-2406-P, RIN 0938-AT41) serves as the 60-day Federal Register notice. Comments are due by 5:00 pm on May 22, 2018.

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 (Total Hours & Costs)

Wages

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 (www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits and Overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operations Specialist	13-1000	35.14	35.14	70.28
Computer and Information Analyst	15-1120	45.10	45.10	90.20
General and Operations Manager	11-1021	59.35	59.35	118.70
Management Analyst	13-1111	44.92	44.92	89.84
Social Science Research Assistant	19-4061	23.57	23.57	47.14

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.

Information Collection Requirements and Associated Burden Estimates

12.1. ICRs Regarding Access Monitoring Review Plans (§447.203(b))
[Removed (see ICR 12.7., below)]

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

Section 447.203(b)(6)(ii) requires states to have procedures within the AMRP 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, 12 states will implement these rate changes based on the number of states that proposed such reductions in FY 2016.

We estimate that it will take, on average, **480 hr** to develop the monitoring procedures, **288 hr** to periodically review the monitoring results, and **36 hr** for review and approval of the monitoring procedures (**804 total hours**). We also estimate an average cost of $6,105.86 per state and a total of **$73,270.32**.

In deriving these figures we used the following hourly labor rates and time to complete each task: 40 hr at $89.84/hr for management analyst staff to develop the monitoring procedures, 24 hr at $89.84/hr for management analyst staff to periodically review the monitoring results, and 3 hr at $118.70/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	89.84	3,593.60
Periodically Review Monitoring Results	Management Analyst	24	89.84	2,156.16
Approve Monitoring Procedures	General and Operations Manager	3	118.70	356.10
Total Burden Per State…	……	67	…..	6,105.86

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

Anticipated Number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
12	804	6,105.86	73,270.32

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))
[No change]

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 $9,577.50 per state and a total of **$488,452.50**.

In deriving these figures we used the following hourly labor rates and time to complete each task: 100 hr at $89.94/hr for management analyst staff to develop the feedback effort and 5 hr at $118.70/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	89.84	8,984
Approve Feedback Effort	General and Operations Manager	5	118.70	593.50
Total Burden Per State…	……	105	…..	9,577.50

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)	9,577.50	488,452.50

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 $7,331.50 per state and a total of **$373,906.50**.

In deriving these figures we used the following hourly labor rates and time to complete each task: 75 hr at $89.84/hr for management analyst staff to monitor feedback results and 5 hr at $118.70/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	89.84	6,738.00
Oversee Feedback Effort	General and Operations Manager	5	118.70	593.50
Total Burden Per State…	……	80	…..	7,331.50

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)	7,331.50	373,906.50

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))
[No change]

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 $5,746.50 per

state and a total of **$57,465.00**.

In deriving these figures we used the following hourly labor rates and time to complete each task: 20 hr at $89.84/hr for management analyst staff to identify issues requiring corrective action, 40 hr at $89.84/hr for management analyst staff to develop the corrective action plans, and 3 hr at $118.70/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	89.84	1,796.80
Developing the Corrective Plan	Management Analyst	40	89.84	3,593.60
Approve Corrective Plan	General and Operations Manager	3	118.70	356.10
Total Burden Per State…	……	63	…..	5,746.50

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)	5,746.50	57,465.00

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)
[No change]

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 23 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 2016.

We estimate that it will take an average of **460 hr** to develop the public process and **69 hr** for review and approval of the public process (**529 total hours**). We also estimate an average cost of $2,152.90 per state and a total of **$49,516.70**.

In deriving these figures we used the following hourly labor rates and time to complete each task: 20 hr at $89.84/hr for management analyst staff to develop the public process and 3 hr at $118.20/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	89.84	1,796.80
Approve Public Process	General and Operations Manager	3	118.70	356.10
Total Burden Per State…	……	23	…..	2,152.90

TABLE 14: Public Process—One-Time Total Burden

Anticipated number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
23	529	2,152.90	49,516.70

The ongoing burden associated with the requirements under §447.204 is the time and effort it would take 23 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 **920 hr** to oversee the public process and **69 hr** for review and approval of the public process (**989 total hours**). We also estimate an average cost of $3,949.70 per state and a total of **$90,843.10**.

In deriving these figures we used the following hourly labor rates and time to complete each task: 40 hr at $89.84/hr for management analyst staff to oversee the public process and 3 hr at $118.70/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	89.84	3,593.60
Approve Public Process	General and Operations Manager	3	118.70	356.10
Total Burden Per State…	……	43	…..	3,949.70

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

Anticipated number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
23	989	3,949.70	90,843.10

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)
[No change]

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

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.

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

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)(7) (one-time requirement)	51	51	100	5,100	89.84	458,184.00	0	458,184
			5	255	118.70	30,268.50	0	30,269
subtotal	*51*	*51*	*105*	*5,355*	*varies*	*488,452.50*	*0*	*488,453*
447.203(b)(8) (one-time requirement)	10	10	60	600	89.84	53,904.00	0	53,904
			3	30	118.70	3561.00	0	3561
subtotal	*10*	*10*	*63*	*630*	*varies*	*57,465.00*	*0*	*57,465*
447.204(a)(1) and (2) (one-time requirement)	23	23	20	460	89.84	41,326.40	0	41,326
			3	69	118.70	8,190.30	0	8,190
subtotal	*23*	*23*	*23*	*529*	*varies*	*49,516.7*		*49,516*
SUBTOTAL #1	**51**	**84**	**varies**	**6,514**	**varies**	**595,434.20**	**0**	**595,434**

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) and 447.204(a) through (c)) (on-going requirement)	17	17	0.5	8.5	117.40	997.90	0	998
Subtotal	*17*	*17*	*0.5*	*8.5*	*117.40*	*997.90*	*0*	*998*
447.203(b)(6)(ii) (on-going requirement)	10	10	64	640	89.84	57,497.60	0	57,498
			3	30	118.70	3,561	0	3,561
Subtotal	*10*	*10*	*67*	*670*	*varies*	*61,058.60*	*0*	*61,059*
447.203(b)(7) (on-going	51	51	75	3,825	89.84	343,638.00	0	343,638
			5	255	118.70	30,268.50	0	30,269

Subtotal	*51*	*51*	*80*	*4,080*	*varies*	*373,906.50*	*0*	*373,907*
447.204(a)(1) and (2) (on-going requirement)	23	23	40	920	89.84	82,652.80	0	82,653
			3	69	118.70	8,190.30	0	8,190
Subtotal	*23*	*23*	*43*	*989*	*varies*	*90,843.10*	*0*	*90,843*
SUBTOTAL #2	**51**	**101**	**varies**	**5,747.5**	**varies**	**526,806.10**	**0**	**526,807**

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 ($)	Total Cost ($)
Subtotal #1 (One-time requirements)	51	84	varies	6,514	Varies	595,434.20	0	595,435
Subtotal #2 (On-going requirements)	51	101	varies	5,748	Varies	526,806.10	0	526,806
GRAND TOTAL	**51**	**185**	**varies**	**12,262**	**varies**	**1,122,240.30**	**0**	**1,122,240**

13. Capital Costs

There are no estimated capital cost increases associated with this information collection request. 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 this information collection request. 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

The following sets out the information collection requirements (ICRs) that we are proposing under CMS-2406-P (RIN 0938-AT41):

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 (last approved by OMB on 4/29/2016), 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.

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)

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.

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.

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

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 (last approved by OMB on 4/29/2016), 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.

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.

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)

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.

Summary of Proposed Information Collection Requirements and Burden

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)

16. Publication/Tabulation Dates

    Section 447.203(b) requires states to make the results of the data reviews available to the public for at least 30 days prior to submitting the review to CMS. 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 will display the expiration date.

18. Certification Statement

    There are no exceptions requested to the certification statements.