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.

Our July 15, 2019 (84 FR 33722) NPRM (CMS-2406-P2, RIN 0938-AT41) proposes to remove the regulatory text that sets forth the current required process for states to document whether Medicaid payments in fee-for-service systems are sufficient to enlist enough providers to assure beneficiary access to covered care and services consistent with the Medicaid statute. As a result we are proposing to discontinue all of the requirements that are currently approved under this control number and zero out such burden.

A. Justification

1. Need and Legal Basis

Regulations at 42 CFR Part 447.203 and 447.204 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." The regulations describe processes to be used by states and CMS to demonstrate compliance with 1902(a)(30)(A) 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 is used by states to document that access to care is 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 uses 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 may 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 use 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 may have insufficient information to determine if Medicaid rates are sufficient to provide for access to care as described under the Act.

7. Special Circumstances

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study;
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register/Outside Consultation

Serving as the 60-day notice, the NPRM (CMS-2406-P2, RIN 0938-AT41) published on July 15, 2019 (84 FR 33722).

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. The collection requires access reviews, beneficiary feedback forums and other processes, which are not associated with confidential information.

11. Sensitive Questions

There are no sensitive questions associated with this collection. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

12. Burden Estimates (Total Hours & Costs)

Our July 15, 2019 (84 FR 33722), rule proposes to remove the regulatory text that sets forth the current required process for states to document whether Medicaid payments in fee-for-service systems are sufficient to enlist enough providers to assure beneficiary access to covered care and services consistent with the Medicaid statute. States have raised concerns over the administrative burden associated with the current regulatory requirements. While we believe the process described in the current regulatory text is a valuable tool for states to use to demonstrate the sufficiency of provider payment rates, we believe mandating states to collect the specific information as described excessively constrains state freedom to administer the program in the manner that is best for the state and Medicaid beneficiaries in the state.

As a result we are proposing to discontinue all of the requirements that are currently approved under this control number and zero out such burden.

13. Capital Costs

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

14. Cost to Federal Government

There is no additional cost to the federal government associated with the extension 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

Our July 15, 2019 (84 FR 33722), rule proposes to remove the regulatory text that sets forth the current required process for states to document whether Medicaid payments in fee-for-service systems are sufficient to enlist enough providers to assure beneficiary access to covered care and services consistent with the Medicaid statute. As a result we are proposing to discontinue all of the requirements that are currently approved under this control number and zero out such burden as follows:

Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2017 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. 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)(1) through (5)

Section 447.203(b) requires states to develop a medical assistance access monitoring review plan. Sections 447.203(b)(1) through (5) specify certain content that states must include within the access monitoring review plan and an analysis of: the extent to which beneficiary needs are fully met; the availability of care through enrolled providers to beneficiaries in each geographic area; changes in beneficiary utilization of covered services in each geographic area; the characteristics of the beneficiary population (including considerations for care, service, and payment variations for pediatric and adult populations and for individual with disabilities); and actual or estimated levels of payment available from other payers, including public and private payers, by provider type and site of service. The initial AMRPs were developed by states and submitted to CMS on October 1, 2016 and must be updated by October 1 on a triennial basis. The on-going burden associated with the requirements under §447.203(b)(1) through (5) 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 update the access monitoring review plans with new data to meet the triennial submission requirement.

We estimate that it will take, on average, **310 hr** to update access monitoring review plans

that states initially developed for October 1, 2016 (15810). We also estimate an average cost of **$23,969.40** per state and a total of **$1,222,439.40**.

In deriving these figures we used the following hourly labor rates and time to complete each task: 80 hr at $47.14/hr for social science research assistant staff to gather data, 80 hr at $90.20/hr for computer and information analyst staff to analyze the data, and 100 hr at $89.84/hr for management staff to update the content of the access monitoring review plan, 40 hr at $70.28/hr for business operations specialists staff to publish the access monitoring review plan, and 10 hr at 118.70/hr for general and operations manager staff to review and approve the access monitoring review plan.

TABLE 1: Access Monitoring Review Plan–Ongoing Burden Per State (triennial)

Requirement	**Occupation Title**	**Burden Hours**	**Adjusted Hourly Wage ($/hr)**	**Cost Per Monitoring Plan ($/State)**
Gathering Data	Social Science Research Assistant	80	47.14	3771.20
Analyzing Data	Computer and Information Analyst	80	90.20	7216.00
Updating Content of Access Monitoring Review Plan	Management Analyst	100	89.84	8984.00
Publishing Access Monitoring Review Plan	Business Operations Specialist	40	70.28	2811.20
Reviewing and Approving Access Monitoring Review Plan	General and Operations Manager	10	118.70	1187.00
Total Burden Per State…	……	310	…	23,969.40

TABLE 2: Access Monitoring Review Plan—Ongoing Total Burden (triennial)

Anticipated Number of State Reviews	**Total Hours**	**Cost of Review per State ($)**	**Total Cost Estimate ($)**
51	15,810 (310 hr x 51 reviews)	23,969.40	1,222,439.40

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 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 FYs 2016 and 2017.

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 3: Access Monitoring Procedures Following Rate Reduction SPA—Ongoing 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 4: Access Monitoring Procedures Following Rate Reduction SPA—Ongoing Total Burden (annual)

Anticipated Number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
12	804 (67 hr x 12 reviews)	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))

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.

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 estimate that the approval of the recommendations will not require a 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 5: 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 6: 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))

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.

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 7: Corrective Action Plan—One-time Burden Per Corrective Plan (annual)

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 8: Corrective Action Plan – One-time Total Burden (annual)

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)

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. § 447.204(b), clarifies that CMS 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, CMS 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 39 of these rate changes that would require a public process based on the number of states that proposed such reductions in FY 2017.

We estimate that it will take an average of **780 hr** to develop the public process and **117 hr** for review and approval of the public process (**897 total hours**). We also estimate an average cost of $2,152.90 per state and a total of **$83,963.10**.

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 9: 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 10: Public Process—One-Time Total Burden

Anticipated number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
39	897 (23 hr x 39 changes)	2,152.90	83,963.10

The ongoing burden associated with the requirements under §447.204 is the time and effort it would take the 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 **1,560 hr** to oversee the public process and **117 hr** for review and approval of the public process (**1,677 total hours**). We also estimate an average cost of $3,949.70 per state and a total of **$154,038.30**.

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 11: 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 12: Public Process—Ongoing Total Burden (annual)

Anticipated number of State Reviews	Total Hours	Cost of Review per State ($)	Total Cost Estimate ($)
39	1,677 (43 hr x 39 reviews)	3,949.70	154,038.30

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.

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 Cost ($)
447.203(b)(8) (one-time requirement)	10	10	60	600	89.84	53,904.00	53,904
			3	30	118.70	3561.00	3561
subtotal	*10*	*10*	*63*	*630*	*varies*	*57,465.00*	*57,465*
447.204(a)(1) and (2) (one-time requirement)	23	39	20	780	89.84	70,075.20	70,075
			3	117	118.70	13887.90	13,888
subtotal	*23*	*39*	*23*	*897*	*varies*	*83,963.10*	*83,963*
SUBTOTAL #1	**23**	**49**	**varies**	**1,527**	**varies**	**141,428.10**	**141,428**

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 C
447.203(b)(1) through (5)	51	51	310	15,810	47.14	192331.20	192,
					90.20	368016.00	368,
					89.84	458184.00	458,
					70.28	143371.20	143,
					118.70	60537	60,5
subtotal	*51*	*51*	*310*	*15,810*	*Varies*	*1,222,439.40*	*1,222*
447.203(b)(6)(ii) (on-going requirement)	12	12	64	768	89.84	68997.12	68,9
			3	36	118.70	4273.20	4,2
subtotal	*12*	*12*	*67*	*804*	*varies*	*73270.32*	*73,2*
447.203(b)(7) (on-going requirement)	51	51	75	3,825	89.84	343,638.00	343,
			5	255	118.70	30,268.50	30,2
subtotal	*51*	*51*	*80*	*4,080*	*varies*	*373,906.50*	*373,*

447.204 (on-going requirement)	*39*	*39*	*40*	*1,560*	*89.84*	*140150.40*	*140,*
			3	*117*	*118.70*	*13887.90*	*13,8*
subtotal	*39*	*39*	*43*	*1,677*	*varies*	*154,038.30*	*154,*
SUBTOTAL #2	**51**	**153**	**Varies**	**22,371**	**varies**	**1,823,654.52**	**1,823**

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 Cost ($)
Subtotal #1 (One-time requirements)	23	49	varies	1,527	varies	141,428.10	141,428
Subtotal #2 (On-going requirements)	51	153	varies	22,371	varies	1,823,654.52	1,823,654
TOTAL	**51**	**202**	**varies**	**23,898**	**varies**	**1,965,082.62**	**1,965,082**

16. Publication/Tabulation Dates

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.