Clearance for Medicaid and CHIP State Plan, Waiver, and Program Submissions (CMS-10398, OMB 0938-1148)

Generic Information Collection #73 (Nonsubstantive Change)
Supplemental Payment Reporting under the Consolidated Appropriations Act, 2021

January 2022

Center for Medicaid and CHIP Services (CMCS)
Centers for Medicare & Medicaid Services (CMS)

CMS is implementing section 202 of the Consolidated Appropriations Act of 2021 by adding a new form to the CMS-64 in the MBES system for states to report all supplemental payments. CMS will add this additional form that states will fill out with the required information. The information collection will begin for quarter 1 of Federal Fiscal Year 2022 (October 1, 2021) and states will begin reporting these data on January 15, 2022.

A. Background

The Centers for Medicare & Medicaid Services (CMS) work in partnership with States to implement Medicaid and the Children's Health Insurance Program (CHIP). Together these programs provide health coverage to millions of Americans. Medicaid and CHIP are based in Federal statute, associated regulations and policy guidance, and the approved State plan documents that serve as a contract between CMS and States about how Medicaid and CHIP will be operated in that State. CMS works collaboratively with States in the ongoing management of programs and policies, and CMS continues to develop implementing guidance and templates for States to use to elect new options available as a result of the Affordable Care Act or to comply with new statutory provisions. CMS also continues to work with States through other methods to further the goals of health reform, including program waivers and demonstrations, and other technical assistance initiatives.

Through passage of Division CC, Title II, Section 202 of the CAA, Congress added subsection (bb) to section 1903 of the Act, which requires the Secretary of Health and Human Services to establish a system for states to submit reports on supplemental payments as defined in section 1903(bb)(2) of the Act, no later than October 1, 2021. States are required to submit "reports, as determined appropriate by the Secretary, on supplemental payment data, as a requirement for a State plan or State plan amendment [SPA] that would provide for a supplemental payment" as required by section 1903(bb)(1) of the Act.

CMS is implementing section 202 of the Consolidated Appropriations Act of 2021 by adding new screens to the CMS-64 in the MBES system for states to report all supplemental payments. The target release date of the new CMS-64 form is Dec. 31, 2021, and states will be expected to use the form starting for their first quarter Federal fiscal year 2022 expenditures beginning on 15 January 2022. The statute requires CMS to set up a data collection system for all state supplemental payments. CMS is starting the PRA process in order to be in compliance with the statute.

CMS is basing its authority on State Medicaid Director's Letter SMD# 21-006 New Supplemental Payment Reporting and Medicaid Disproportionate Share Hospital Requirements under the Consolidated Appropriations Act, 2021.

B. Description of Information Collection

In accordance with section 1903(bb) of the Act, and follow-up policy guidance by CMS in its SMDL #21-006, the 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands (54 entities, hereafter referred to as states) will be required to report the following information to CMS through the additional form being added to the CMS-64 expenditure reporting form in the MBES system, quarterly or 4 times per year.

Specifically, we will ask for the following 14 fillable items for each supplemental payment made, and 1 narrative item:

14 Fillable items: Provider name, National Provider Identification, Medicare Identification, Medicaid Identification, other state identification (if applicable), ownership category, service type, narrative category, CMS-64 form where supplemental payment is referenced, expenditure type, waiver type (if applicable), waiver number (if applicable), option to update prior period (if applicable), and supplemental payment amount.

1 Narrative item describing the supplemental payment, to include the following information (per service category (9 possibilities) and ownership type (3 possibilities), or about 27 possible narratives per quarterly report):

- An explanation of how supplemental payments made under the state plan or a state plan amendment will result in payments that are consistent with section 1902(a)(30)(A) of the Act, including standards with respect to efficiency, economy, quality of care, and access, along with the stated purpose and intended effects of the supplemental payment.
- The criteria used to determine which providers are eligible to receive the supplemental payment.
- A comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including:
    - data on the amount of the supplemental payment made to each eligible provider, if known, or if the total amount is distributed using a formula for one or more fiscal years, data on the total amount of supplemental payments for the fiscal year(s) available to all providers eligible to receive a supplemental payment;
    - if applicable, the specific criteria with respect to Medicaid service, utilization, or cost data to be used as the basis for calculations regarding the amount or distribution of the supplemental payment; and
    - the timing of the supplemental payment made to each eligible provider.
    - (if applicable) an assurance that the total Medicaid payments made to an inpatient hospital provider, including the supplemental payment, will not exceed upper payment limits, as applicable.

The collection instrument will be an Excel type spreadsheet in an online format, which will create one report per quarter, and be a part of the MBES system.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

The total approved burden ceiling of the generic ICR is 154,104 hours, and CMS previously requested to use 116,020 hours, leaving our burden ceiling at 38,084 hours.

Wage Estimates

To derive average costs, we are using data from the U.S. Bureau of Labor Statistics' May 2020 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents BLS' mean hourly wage, and our estimated cost of fringe benefits and overhead (calculated at 100 percent of salary), and our adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage	Fringe Benefits and Overhead	Adjusted Hourly Wage
Data Entry Keyers	43-9021	$17.24/hr	$17.24/hr	$34.48/hr
General and Operations Managers	11-1021	$60.45/hr	$60.45/hr	$120.90/hr
Social Science Research Assistants	19-4061	$25.75/hr	$25.75/hr	$51.50/hr

As indicated, we are adjusting 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, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Collection of information Requirements and Associated Burden

The collection instrument will be an Excel type spreadsheet in an online format, which will create one report per quarter.

We think most of the data will be available in the state's IT data systems and able to be queried and downloaded into the spreadsheets, much like the required Upper Payment Limit (UPL) demonstrations, which are estimated at 40 hours per year for 1 annual report. The UPL demonstrations cover most of the service types where we are aware and require general reporting of supplemental payments, however, there are other services like ground emergency medical transportation where we are aware of supplemental payments, but we have never collected information on individual providers. We estimate about a quarter of all providers in the UPL demonstrations receive supplemental payments in a year, but we recognize that there are additional services and providers that receive supplemental payments. We therefore estimate the

burden for each report to be more than a quarter of the UPL demonstrations' burden, or 15 hours per quarterly report, for a total of 60 hours per year per state.

There is a potential universe of 54 respondents submitting one response. CMS has determined that the Commonwealth of the Northern Marianas Islands and American Samoa are exempt from reporting due to their Medicaid J waivers. In aggregate, we estimate a burden of 3,240 hours (60 hr/year x 54 responses/year).

CMS expects that there will be three separate steps for a state to complete one response. We expect that a Data Entry Keyers would need 50 hours at $34.48/hr to complete the reports, a Social Science Research Assistant would need 9 hours at $51.50/hr to complete the reports, and a General and Operations Manager would need 1 hour at $120.90/hr to complete the reports.

In aggregate, we estimate an annual cost of $124,654 [54 states x ((50 hr x $34.48/hr) + (9 hr x $51.50/hr) + (1 hr x $120.90/hr))].

Information Collection Instruments and Instruction/Guidance Documents

1. CMS-64.SPVNarr Mockup (new)
2. CMS-64 Payment detail Form Mockup (new)
3. CMS-64 Provider Info Mockup (new)
4. SMDL 21-006: New Supplemental Payment Reporting and Medicaid Disproportionate Share Hospital Requirements under the Consolidated Appropriations Act, 2021 (see https://www.medicaid.gov/federal-policy-guidance/downloads/smd21006.pdf)

E. Timeline

This collection of information request was approved by OMB on December 14, 2021. Since the reporting requirements are associated with an SMDL, it was submitted to OMB ahead of the publication of the 14-day Federal Register notice.

The 14-day notice published in the Federal Register on January 7, 2022. Comments are due 14 days from the date of publication in the Federal Register.