

Supporting Statement Part A
Dual Eligible Special Needs Plan Contract with the State Medicaid Agency
(CMS-10796, OMB 0938-1410)

Background

The Bipartisan Budget Act of 2018 (BBA of 2018) permanently authorized special needs plans (SNPs), including dual eligible special needs plans (D-SNPs). 42 CFR 422.2 defines special needs individuals and specialized MA plans for special needs individuals.

The BBA of 2018 also required the establishment of standards for integration of Medicare and Medicaid benefits provided to enrollees in D-SNPs, as well as the development of unified appeals and grievance processes for D-SNPs, beginning in CY 2021. CMS-4185-F, “Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021,” published in the Federal Register on April 16, 2019, modified and amended 42 CFR 422 to codify integration criteria for all D-SNPs and unified appeals and grievance processes for some D-SNPs (those defined as “applicable integrated plans”) beginning in CY 2021.

To operate in any given year, a D-SNP must have a state Medicaid agency contract in place prior to the beginning of the contract year. The contract must align with the entire D-SNP contract term.

The state Medicaid agency contract is approved under this package (CMS-10796; OMB 09381410) and any and all updates to burden regarding the state Medicaid agency contract will be made under this package.

As further explained in sections 12 and 15 of this Supporting Statement, we are updating our currently approved burden estimates and accounting for new burden given new requirements that are in effect beginning in contract year 2025.

A. Justification

1. Need and Legal Basis

Special needs plans (SNPs) are Medicare Advantage (MA) plans created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) that are specifically designed to provide targeted care and limit enrollment to special needs individuals. Under section 1859(b)(6) of the Act, D-SNPs restrict enrollment to individuals entitled to medical assistance under a state plan under title XIX of the Social Security Act (hereinafter referred to as the Act).

Section 1859(f)(3)(D) of the Act and 42 CFR 422.107 established the requirement for D-SNPs to have contracts with state Medicaid agencies in addition to other contracting requirements that

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that apply to all MA plans.

Section 50311(b) of the Bipartisan Budget Act of 2018 amended section 1859 of the Act to add new requirements for D-SNPs, beginning in 2021, including minimum integration standards, coordination of the delivery of Medicare and Medicaid benefits, and unified appeals and grievance procedures for integrated D-SNPs, the last of which we implemented through regulation to apply to certain D-SNPs with exclusively aligned enrollment, termed “applicable integrated plans.” These requirements, along with clarifications to existing regulations, were codified in the “Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021” final rule (April 16, 2019; 84 FR 15680) (hereinafter referred to as the April 2019 final rule).¹

The final rule, titled Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, (May 9, 2022; 87 FR 27704) (CMS-4192-F, RIN 0938-AU30) (hereinafter referred to as the May 2022 final rule)² finalized regulations related to the D-SNP contract with the state Medicaid agency. The rule codified new pathways through which states can use these contracts to require that certain D-SNPs with exclusively aligned enrollment (a) establish contracts that only include one or more D-SNPs within a state, and (b) integrate materials and notices for enrollees. Additionally, the rule expanded the universe of D-SNPs for which the unified appeals and grievance processes apply, requiring an update to the state Medicaid agency contract for the impacted D-SNPs. The rule also established that, beginning in contract year 2025, the FIDE and HIDE SNP’s capitated contract with the state Medicaid agency apply to the entire service area for the D-SNP.

2. Information Users

MA organizations with D-SNPs and states use the information in the contract to provide benefits, or arrange for the provision of Medicaid benefits, to which an enrollee is entitled. CMS reviews the D-SNP contract with the state Medicaid agency to ensure that it meets the minimum contract requirements at § 422.107(c)&(d). CMS uses the attestations and matrices in the appendices of this package to identify the types of D-SNPs an MA organization(s) offers and the location of the contract requirements in the document.

3. Improved Information Technology

In the state Medicaid agency contract submission process, technology is used in the collection, processing and storage of the data. Specifically, MA organizations with D-SNPs must submit the signed contract(s) and supporting documentation in appendices A through C through CMS’ Health Plan Management System (HPMS).

¹ See <https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf>.

² See <https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf>

The contract submission process has several sections that require the MA organizations with D-SNPs to respond to attestations and matrices based upon the level of D-SNP integration (i.e. fully integrated D-SNP (FIDE SNP), highly integrated D-SNP (HIDE SNP), applicable integrated plan, or coordination-only D-SNP.)

4. Duplication of Similar Information

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

There is no significant impact on small businesses.

6. Less Frequent Collection

This information collection requires an MA organization with D-SNPs to submit the contract with the state Medicaid agency or a letter of good standing with a previously executed contract from the state annually. This annual contract submission requirement aligns with the annual contract submission required for all MA-PD contracts. We believe a less frequent collection would not provide CMS with enough information to confirm D-SNPs meet CMS requirements.

7. Special Circumstances

There are no special circumstances to report, and no statistical methods will be employed. More specifically, this collection:

- Does not require respondents to report information to the agency more often than quarterly;
- Does not require respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Does not require respondents to submit more than an original and two copies of any document;
- Does not require respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Is not connected with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Does not require the use of a statistical data classification that has not been reviewed and approved by OMB;
- Does not 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

- Does not require respondents to 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 Notice/Outside Consultation

The 60-day Federal Notice (89 FR 92690) published in the Federal Register on 11/22/2024.

We received several comments on this package in reference to the instruments themselves, as well as to the underlying SMAC. While some comments addressed areas that we believe are outside of the scope of what our regulations allow, we did make one minor change as a result of a comment regarding the use of an incorrect word in the Attestation instrument. This change is further discussed in section 15 below. We thank all the commenters for their helpful feedback.

The 30-day Federal Notice (90 FR) published in the Federal Register on TBD.

9. Payments/Gifts to Respondents

While there are no gifts associated with this collection, the state Medicaid agency contract with the D-SNP is required for the MA organization to receive a government contract for a D-SNP.

10. Confidentiality

Consistent with Federal government and CMS policies, CMS will protect the confidentiality of the requested proprietary information. Specifically, only information within a submitted D-SNP contract with the state Medicaid agency (or attachments thereto) that constitutes a trade secret, privileged or confidential information, (as such terms are interpreted under the Freedom of Information Act and applicable case law), and is clearly labeled as such by the applicant, and which includes an explanation of how it meets one of the expectations specified in 45 CFR Part 5, will be protected from release by CMS under 5 U.S.C. 552(b)(4). Information not labeled as trade secret, privileged, confidential or does not include an explanation of why it meets one or more of the Freedom of Information Act exceptions in 45 CFR Part 5 will not be withheld from release under 5 U.S.C. 552(b)(4).

11. Sensitive Questions

No questions of a sensitive nature will be asked.

12. Collection of Information Requirements and Associated Burden Estimates

12.1 Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2023 National Occupation 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, our estimated cost of fringe benefits and overhead (calculated at 100 percent of salary), and our adjusted wage.

National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Median Hourly Wage (\$/hr)	Fringe Benefits and Overhead (\$/hr)	Adjusted Hourly Wage (\$/hr)
Business Operation Specialists, All Other	13-1199	38.26	38.26	76.52
Occupation Title	Occupation Code	Median Hourly Wage (\$/hr)	Fringe Benefits and Overhead (\$/hr)	Adjusted Hourly Wage (\$/hr)
Lawyer	23-1011	70.08	70.08	140.16
Software Developers	15-1252	63.59	63.59	127.18

12.2 Requirements and Associated Burden Estimates

The contract between D-SNP and a state Medicaid agency is a formal written agreement between an MA organization sponsor offering a D-SNP and the state Medicaid agency documenting each entity's roles and responsibilities with regard to dually eligible individuals. The sponsors offering a D-SNP submit the contract with the state Medicaid agency in July prior to each contract year of the D-SNP operation. When applicable, the D-SNP can submit the existing contract with a letter of good standing from the state.

The burden associated with this requirement is the time and effort put forth by each MA organization offering a D-SNP and the state Medicaid agency to sign the contract or letter of good standing and for the D-SNP to submit the contract or letter through CMS' Health Plan Management System (HPMS).

(A) Annual State Burden For D-SNP Contract

Section 1903(a)(7) of the Act requires the federal government to pay a match rate for administrative expenses. Since cost is split between the state Medicaid agency and the federal government, we halve the total costs in this section, half of which the states incur and half of which the federal government incurs, associated with administering the Medicaid program. The federal government's cost is presented in the Section 14 of this collection.

In our experience, the state³ drafts the contract for the D-SNPs in its market and applies the same contract to all MA organizations with D-SNPs. While each state may include a different level of Medicare and Medicaid integration with the D-SNPs in their market, resulting in differing levels of effort to draft a contract, we estimate that on average, the burden for state staff to draft a contract with D-SNPs is 40 hours at \$140.16/hr. This time estimate is based on the collaborative work for the 2023 contract year between states and the CMS Medicare-Medicaid Coordination Office and its contractor, the Integrated Care Resource Center.

The vast majority of states already having an existing D-SNP contract (48 state, territory, and the District of Columbia Medicaid agencies). In our experience, states update their contract with D-SNPs annually; however, each state spends a different amount of time depending on the update. On average, we believe states spend 40 hours annually to update the contract, resulting in a total burden of 1,840 hours at a cost of \$134,554 (48 states x 40 hr x \$140.16/hr x 0.5).

(B) Annual MA Organization Burden For D-SNP Contract

As noted in section 12(A), each contract with the state Medicaid agency has a different level of Medicare and Medicaid integration with the D-SNPs, resulting in differing levels of effort for a D-SNP to review a contract, therefore our estimates are based on an average experience for D-SNPs. Based our experience providing technical assistance to D-SNPs and reviewing contract submissions, we estimate it takes an MA organization offering a D-SNP 30 hours to review, sign, and submit a contract annually at a cost of \$76.52/hr. This estimate includes completing the D-SNP matrices in Appendix A and submit the matrices and contract to HPMS. We believe this time allows for variation between the level of complexity in a contract and between a new or existing contract.

For the 2025 plan year, 328 MA organizations submitted 500 D-SNP contracts with the state Medicaid agency in compliance with the requirement at § 422.107.⁴ We used this data to estimate the annual burden for MA organizations at 15,000 hours (500 D-SNP contracts x 30 hr/contract) at a cost of \$1,147,800 (15,000 hr x \$76.52/hr).

(C) Additional Opportunities for Integration through State Medicaid Agency Contracts (§ 422.107(e))

For states that opt to require the contract requirements at § 422.107(e), states and plans will need to modify the existing state Medicaid agency contract. These modifications will document the D-SNP's responsibility to only enroll dually eligible individuals who receive coverage of Medicaid

³ We use the term "state" to refer to a state, territorial, or District of Columbia Medicaid agency

⁴ Please see "Integration Status for Contract Year 2025 D-SNPs (XLSX)", retrieved from <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-MedicaidCoordination-Office/D-SNPs>

benefits from the D-SNP, integrate member materials, and request that CMS establish an MA contract limited to D-SNPs within the state.

(I) State Burden

For each state Medicaid agency, it will take a total of 24 hours at \$140.16/hr for state staff to update the state Medicaid agency's contract with the D-SNPs in its market to address the changes in this final rule. This estimate includes the burden to negotiate with the D-SNPs on contract changes and engage with CMS to ensure contract changes meet the requirements that we are finalizing at § 422.107(e).

Based on our experience, we expect that each state Medicaid agency will establish uniform contracting requirements for D-SNPs operating in their market. Based on our previous work with states as part of the capitated FAI demonstration and implementing the D-SNP integrations requirements established by the BBA of 2018, we estimated over the contract years 2022-2025, as few as five and as many as 20 states may have opted to make these changes in their contracts with D-SNPs and their administration of their programs. Based on the number of states currently collaborating with CMS on Medicare and Medicaid integration and the states likely to transition from Medicare-Medicaid Plan-based to D-SNP-based integrated care approaches, we believed there would be 12 states that implement this option. We projected that states would implement this one-time change during contract year 2025, the first year we anticipate states and plans can implement § 422.107(e). Over the contract years 2026-2029, we believe seven additional states will opt to implement this one-time change.

Section 1903(a)(7) of the Act requires the federal government to pay half of the states' administrative costs. For contract years 2026-2029, in aggregate, we estimate a one-time burden of 168 hours (7 states x 24 hr/state) at a cost of \$11,773 (168 hr x \$140.16/hr x 0.5).

(II) MA Organization Burden

To implement § 422.107(e) for each state that exercises this option, we expect that for each affected D-SNP, it will take 8 hours at \$169.68/hr for a lawyer to update the contract with the state Medicaid agency to reflect the revised and new provisions in addition to annual contract updates estimated in Section 12(B). Based on our assumptions of states likely to opt to require the contract changes at § 422.107(e) for contract years 2026-2029, we estimate between 25 to 60 MA organizations would be impacted. Since we are uncertain of which extreme to use, we use the average, 40 MA organizations. While we expected the updates to be completed in contract year 2025 for the first group of states to implement this option at § 422.107(e), we expect that the next group of states will complete updates associated with this provision by contract year 2029. In aggregate, for this burden estimate, we estimate a one-time burden of 320 hours (40 MA organizations x 8 hr) at a cost of \$44,851 (320 hr x \$140.16/hr).

(D) HIDE and FIDE SNP Service Area Requirements

In the May 2022 final rule, we codified a requirement at § 422.2 that each FIDE SNP's and HIDE SNP's capitated contract with the state Medicaid agency apply to the entire service area for the D-SNP for plan year 2025 and subsequent years. Because this is a regulatory requirement

for HIDE and FIDE SNPs beginning in contract year 2025, starting for contract year 2026, plans that have HIDE or FIDE SNPs will be required to submit with their SMAC information that identifies the service area for the corresponding Medicaid plan. We believe that including this additional information should take 15 minutes per contract, as the information on service area for the accompanying Medicaid plan should be accounted for in existing documentation, such as the Medicaid contract itself, or public facing information on the state's website. We do not anticipate that the inclusion of such information should be more laborious than identifying and uploading the correct documentation.

We estimate that there will be 300 HIDE or FIDE SNP PBPs in contract years 2026-2029 and on average, we believe this will be an annual burden that will take one business analyst an additional 15 minutes to complete within the SMAC application upload, resulting in a total annual burden of \$5,739 ($76.52 \times 300 \times .25$).

12.3 Burden Summary

Table 1: Summary of Annual Burden Estimates

Section in Title 42 of the CFR	Item	Respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Hourly Labor Cost(\$/hr)	Total Cost First Year (\$)	Total Cost Subsequent years (\$)
422.107	Contracting with D-SNPs	48 States	48	40	1,920	140.16	134,554*	134,554*
422.107(e)	Updating contract	7 States	7	24	168	140.16	11,773*	-
Subtotal (State)		48 States **	55	<i>Varies</i>	2,008	<i>Varies</i>	146,327	134,554
422.2	Affiliated Medicaid plan service area	300 D-SNP PBPs	300	.25	75	76.52	5,739	5,739
422.107	Reviewing and submitting contract	500 D-SNP contracts	500	30	15,000	76.52	1,147,800	1,147,800

422.107(e)	Updating contract	40 D-SNPs	40	8	320	140.16	44,851	-
Subtotal (Private Sector)		840 D-SNPs/ D-SNP PBP	840	<i>Varies</i>	15,395	<i>Varies</i>	1,198,390	1,153,539
TOTAL		886	893	<i>Varies</i>	17,403	<i>Varies</i>	1,344,717	1,288,093

*

For state burdens, reflects 50 percent reduction to Federal Matching program.

** Some states or D-SNPs will be a respondent on more than one item.

12.4 Collection of Information Instruments and Instruction/Guidance Documents

Starting with the contract submission for the 2024 plan year, Medicare Advantage sponsors that offer D-SNPs complete and upload the following appendices into HPMS with the completed and signed contract with the state Medicaid agency. These appendices serve as a checklist for D-SNPs to ensure the required elements are included in the contract with the state Medicaid agency. The appendices also aid federal reviewers in identifying the locations of the required elements in the contract.

Appendix A “D-SNP State Medicaid Agency(ies) Contract(s): Attestations” Appendix

B “Basic D-SNP State Medicaid Agency Contract Requirements Matrix”

Appendix C “HIDE, FIDE, and AIP Contract Requirements Matrix”.

13. Capital Costs

There are no capital costs.

14. Cost to the Federal Government

Section 1903(a)(7) of the Act requires the federal government pay a match rate for administrative expenses. Since cost is split between the state Medicaid agency and the federal government, we split in half the total costs for states to update and sign the contract with D-SNPs, half of which the states incur and half of which the federal government incurs, associated with administering the Medicaid program. The federal government’s cost for the D-SNP contract with the state Medicaid agency is presented in the Table 2: Federal Government Match Rate for Administrative Expenses Associated with the D-SNP contract with the State Medicaid Agency.

Table 2: Federal Government Match Rate for Administrative Expenses Associated with the D-SNP contract with the State Medicaid Agency

Section in Title 42 of the CFR	Total Federal Cost First Year (\$)	Total Federal Cost Subsequent years (\$)
§422.107	134,554	134,554
§422.107(e)	11,773	0
TOTAL	146,327	134,554

15. Program/Burden Changes

(A) Additional Burden for the Notification Requirement at § 422.107(d)

In previous packages, we accounted for new additional one-time burden estimates on account of finalized provisions in previous regulations. One of these burden estimates was for the provision codified at § 422.107(d): Effective on January 1, 2021, a D-SNP that is not a fully integrated or highly integrated dual eligible special needs plan (FIDE SNP or HIDE SNP) must have in its contract the requirement to notify the state, or the state’s designated entity, of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals, identified by the state Medicaid agency, codified at § 422.107(d). CMS does not collect these data. For the information burden associated with this requirement, we estimated the time and effort for the following two components:

- I. State Medicaid agencies implement a one-time update to their systems
- II. Plans implement a one-time update to their systems

We noted that 47 state, territory, and District of Columbia Medicaid agencies and the non-FIDE SNP or HIDE SNP D-SNPs within their markets had already made the one-time update to systems to comply with this requirement. We described the burden estimates for any state that newly offers D-SNPs in its market. Because this burden was estimated to be a one-time burden, we have removed it from any ongoing burden in this current package.

(B) Additional Burden for Applicable Integrated Plans (§§ 422.107(c)(9) and 422.561)

When a D-SNP qualifies as an applicable integrated plan as defined at § 422.561, the D-SNP is required to follow integrated organization determination and grievance procedures under §§ 422.629 – 422.634 and include these requirements in the D-SNP contract with the state Medicaid agency (§ 422.107(c)(9)). We estimated a one-time burden for each new applicable integrated plan to update its policies, procedures, and the D-SNP contract with the state Medicaid agency to reflect the new integrated organization determination and grievance procedures. Because this

burden was estimated to be a one-time burden, we have removed it from any ongoing burden in this current package.

(C) Changes in Wage Data Associated with Updated BLS Data

In this package, we are updating wage data from 2021 data to 2023 data, which is the most recent wage data out of the Bureau of Labor Statistics.

(D) HIDE and FIDE SNP Service Area Requirements

As noted above in section 12, in the May 2022 final rule, we codified a requirement at § 422.2 that each FIDE SNP's and HIDE SNP's capitated contract with the state Medicaid agency apply to the entire service area for the D-SNP for plan year 2025 and subsequent years. Because this is a regulatory requirement for HIDE and FIDE SNPs beginning in contract year 2025, starting for contract year 2026, plans that have HIDE or FIDE SNPs will be required to submit with their SMAC information that identifies the service area for the corresponding Medicaid plan. We believe that including this additional information should take 15 minutes per contract, as the information on service area for the accompanying Medicaid plan should be accounted for in existing documentation, such as the Medicaid contract itself, or public facing information on the state's website. We do not anticipate that the inclusion of such information should be more laborious than identifying and uploading the correct documentation.

We estimate that there will be 300 HIDE or FIDE SNP PBPs in contract years 2026-2029 and on average, we believe this will be an annual burden that will take one business analyst an additional 15 minutes to complete within the SMAC application upload, resulting in a total annual burden of \$5,739 (76.52 x 300 x .25).

Table 1: Summary of Annual Burden Estimates

Section in Title 42 of the CFR	Item	Respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Hourly Labor Cost(\$/hr)	Total Cost First Year (\$)	Total Cost Subsequent years (\$)
422.2	Affiliated Medicaid plan service area	300 D-SNP PBPs	300	.25	75	76.52	5,739	5,739
TOTAL		300	300	.25	75	76.52	5,739	5,739

Changes made to this collection of information between the 60-day package published at 89 FR 92690 and the subsequent 30-day package

We made one minor change as a result of a comment regarding the use of an incorrect word in the instrument titled “Attestations.” The commenter noted that Attestation 4 stated that the submission of the Basic D-SNP State Medicaid Agency Contract Matrix would be before the SMAC submission deadline. We are making an amendment to the language so that it reads that the submission of the Basic D-SNP State Medicaid Agency Contract Matrix is required “by the SMAC submission deadline” to align with current policy requirements that the matrix be submitted by the deadline, not before.

16. Publication/Tabulation Dates

CMS does not intend to publish data related this collection of information.

17. Expiration Date

CMS will display the expiration date and OMB approval number on the CMS website. The appendices will appear on the HPMS for plans to access for the 2027 plan year application.

18. Certification Statement

No exception to any section of OMB Form 83-I is requested.

B. Collections of Information Employing Statistical Methods

This collection does not employ statistical methods.