OMB Approved # 0938-0067

Supporting Statement for Form CMS-64
Quarterly Medicaid Statement of Expenditures
for the Medical Assistance Program

A. BACKGROUND

The form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, has been used since January 1980 by the Medicaid State Agencies to report their actual program benefit costs and administrative expenses to the Centers for Medicare & Medicaid Services (CMS). CMS uses this information to compute the Federal financial participation (FFP) for the State's Medicaid Program costs. The form CMS-64 has been modified over the years to incorporate legislative, regulatory, and operational changes.

Certain schedules of the CMS-64 form are used by States to report budget, expenditure and related statistical information required for implementation of the Medicaid portion of the State Children's Health Insurance Programs, Title XXI of the Social Security Act (the Act), established by the recently enacted Balanced Budget Act of 1997 (BBA).

B. JUSTIFICATION

1. Need and Legal Basis

Section 1903 of the Social Security Act provides the authority for collecting this information. States are required to submit the form CMS-64 quarterly to CMS no later than 30 days after the end of the quarter being reported. These submissions provide CMS with the information necessary to issue the quarterly grant awards, monitor current year expenditure levels, determine the allow ability of State claims for reimbursement, develop Medicaid financial management information provide for State reporting of waiver expenditures, ensure that the federally-established limit is not exceeded for HCBS waivers, and to allow for the implementation of the Assignment of Rights and Part A and Part B Premium (i.e., accounting for overdue Part A and Part B Premiums under State buy-in agreements)--Billing Offsets.

The structure of the current form CMS-64 has evolved from the previous forms used for reporting (form OA.41 and form CMS-64). Classification, identification and referencing used in the CMS-64 forms has been in place for several years, is readily understood and accepted by the report users, and is supported by strong sentiments in both CMS and the States to maintain the existing format. Beginning in the first quarter of FY 2010 expenditure reporting cycle, CMS redesigned the MBES/CBES system, and have received favorable responses from both CMS and the States.

Sections 4901, 4911, and 4912, of the Balanced Budget Act of 1997 (BBA) established a new Title XXI of the Act and related Medicaid provisions, which provides funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children. In order to make appropriate payments to States pursuant to this new legislation, CMS amended the existing Medicaid Budget and Expenditure System (MBES) and established a new Child Health Budget and Expenditure System (CBES) and established new report forms for States to report budget, expenditure and related statistical information to CMS on a quarterly basis. Reporting of this information by States began after the end of the second quarter of Federal fiscal year 1998 (after the end of June 1998). The MBES/CBES system added a calculation to account for a temporary increase in the federal medical assistance percentage (FMAP) enacted under Section 5001 of the Affordable Care Act (ACA) of 2009. In addition, Sections 2301, 2501, 2703, and 4107 enacted under the ACA, established a Freestanding Birth Center Category of Service (COS), Prescription Drug Rebate COS, Health Homes for Enrollees with Chronic Conditions COS, and Tobacco Cessation for Pregnant Women COS respectively. To account for this legislation, CMS expanded the MBES/CBES through the addition of new COS Line items.

2. Information Users

Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

The form CMS-64 consists of a one-page Certification Sheet and a one-page summary sheet with supporting forms for specific expenditure categories contained on the summary. Medicaid program expenditures reported on the summary sheet are supported by 64.9 forms. Administrative expenditures are supported by 64.10 forms. These forms detail, by category, the current quarter program and administration expenditures. Claims or adjustments for prior periods noted on Lines 7, 8, 10.A. or 10.B. of the summary sheet are supported by forms designated as 64.9; or 64.10P. These forms detail the prior period program and administration expenditures by category, arraying the expenditures by fiscal year. A separate form is prepared to support each fiscal year. Third Party Liability collections reported on Line 9.A. of the summary sheet are detailed on the form CMS-64.9A. Medicaid overpayment adjustments reported on line 10.C. of the summary sheet are detailed on the form CMS-64.9O. Allocation of Disproportionate Share Hospital (DSH) Payment Adjustments is detailed on the form CMS-64.9D. Provider-Related Donations and Health Care related Taxes, Fees and Assessments Received Under Public Law 102-234 are detailed on the form CMS-64.11A. Summary Total of Receipts from Form CMS-64.11A represents the total of all CMS-64.11A detailed on the form CMS-64.11. Medicaid Drug Rebate Schedule is detailed on form CMS-64.9R. There are no forms numbered 64.1 through 64.8.

Prior to the implementation of the updated MBES/CBES system, many payments without a defined category of service (COS) Line item were noted on an informational form I-Form (e.g., inpatient supplemental payments, physician supplemental, and outpatient

supplemental payments), and then claimed on the COS Line titled “Other Care Services”. The redesign provided the MBES/CBES with the capacity to expand, and more efficiently respond to State and/or Federal changes in the program.

Beginning with FFY 2010, the following Line Items were added to the medical assistance 64.9 series of forms:

- Line 1C Inpatient Hospital Services – Supplemental Payments, These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272.
- Line 1D Inpatient Hospital Services – Graduate Medical Education Payments, GME payments include supplemental payments for direct medical education (DME) (i.e. costs of training physicians such as resident and teaching physician salaries/benefits, overhead and other costs directly related to the program) and indirect medical education (IME) costs hospitals incur for operating teaching programs. Report all supplemental payments for DME and IME that are provided for in the State plan.
- Line 3B Nursing Facility Services – Supplemental Payments, These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272.
- Line 4C Intermediate Care Facility Services-Mentally Retarded Supplemental Payments, These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272.
- Line 5B Physician and Surgical Services – Supplemental Payments, These are payments for physician and other practitioner services that are made in addition to the standard fee schedule payment for those services. When combined with regular payments, these supplemental payments are equal to or less than the Federal upper payment limit.

- Line 6B Outpatient Hospital Services – Supplemental Payments, These are payments for outpatient hospital services as defined in line 6A that are made in addition to the base fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. The combined standard payment and supplemental payment cannot exceed the Federal upper payment limit.
- Line 7A3 MCO – National Agreement –FMAP Rate, Managed Care Organizations (MCO) – National Agreement: The Affordable Care Act requires manufacturers that participate in the Medicaid Drug Rebate Program to pay rebates for drugs dispensed to individuals enrolled with a Medicaid MCO if the MCO is responsible for coverage of such drugs, effective March 23, 2010. This is a refund from the manufacturer to the State Medical Assistance plan for single source drugs, innovator multiple source drugs, and non-innovator multiple source drugs that are dispensed to Medicaid recipients who are enrolled in a Medicaid MCO. Rebates are to take place quarterly.
- Line 7A4 MCO – State Sidebar Agreement – FMAP Rate,
- Line 7A5 Increased ACA OFFSETT – Fee for Service – 100%, Fee for Service - 100% Section 2501 of the Affordable Care Act increased the amount of rebates that drug manufacturers are required to pay under the Medicaid drug rebate program, with different formulas for single source and innovator multiple source drugs (brand name drugs) and noninnovator multiple source drugs (generic drugs), and drugs that are line extensions of a single source drug or an innovator multiple source drug, effective January 1, 2010. The Affordable Care Act also required that amounts "attributable" to these increased rebates be remitted to the Federal Government.
- Line 7A6 MCO – Increased ACA OFFSETT-MCO – 100% 100% 7A6. Increased ACA OFFSET – MCO: Similar to the increased ACA offset for fee-for-service, for covered outpatient drugs that are dispensed to Medicaid MCO enrollees, the Affordable Care Act also required that amounts "attributable" to the increased rebates be remitted to the Federal Government.
- Line 42 Freestanding Birth Center,
- Line 9B Other Practitioner Services – Supplemental Payments, These are payments for other practitioner services as defined in Line 9A that are made in addition to the standard fee schedule payment for those services. When combined with regular payments, these supplemental payments are equal to or less than the Federal upper payment limit.▪ Line 19B Home and Community-Based Services – State Plan 1915(i) Only Payment, Only the home and community based services elected and defined in the approved State plan may be claimed on this line.
- Line 19C Home & Community-Based Services - St. Plan 1915(j) Only Payments. 42 CFR Part 441 – Self-Directed Personal Assistance Services Program State Plan Option. These are PAS services provided under the self-directed service delivery model authorized by 1915(j) including any approved home and community-based services otherwise available under a 1915(c) waiver.
- Line 23B Personal Care Services – Self Directed Services SDS 1915(i), Self-Directed Personal Assistance Services (PAS) State Plan Option. These are

PAS provided under the self-directed service delivery model authorized by 1915(j) for State plan personal care and related services.

- Line 24B Case Management – State Wide, (See §1915(g)(2) of the Act.).--These are services that assist individuals eligible under the State plan in gaining access to needed medical, social, educational and other services. The agency must permit individuals to freely choose any qualified Medicaid provider when obtaining case management services in accordance with 42 CFR 431.51.
- Line 29 Non-Emergency Medical Transportation, (see 42CFR431.53; 440.170; 440.170(a); 440.170(a)(4))--A ride, or reimbursement for a ride, provided so that a Medicaid beneficiary with no other transportation resources can receive services from a medical provider. (NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room for life-threatening situations.
- Line 30 Physical Therapy, (See 42CFR440.110(a)(1)).--Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under Stae law and provided to a recipient by or under the direction f a qualified physical therapist. It includes any necessary supplies and equipment.
- Line 31 Occupational Therapy, (see 42CFR440.110(b))--Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.
- Line 32 Services for Speech, Hearing and Language, --Services for individuals with speech, hearing, and language disorders (See 42CFR440.110(c)). Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or correction services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment, including hearing aids.
- Line 33 Prosthetic Devices, Dentures, Eyeglasses, (See 42 CFR 440.120) Prosthetic devises means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner to:
  1. Artificially replace a missing portion of the body;
  2. Prevent or correct physical deformity or malfunction;
  3. Support a weak or deformed portion of the body.
- Line 34 Diagnostic Screening & Preventive Services, (see 42CFR440.130)--(a) "Diagnostic services", includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.
- Line 35 Nurse Mid-Wife, See 42 CFR 440.165) "Nurse-midwife services" means services that are furnished within the scope or practice authorized by State law or regulation and, in the case of inpatient or outpatient hospital services or

clinic services, are furnished by or under the direction of a nurse mid-wife to the extent permitted by the facility. Unless required by required by State law or regulations or a facility, are reimbursed without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider. See 42 CFR 441.21 for provisions on independent provider agreements for nurse-midwives.

- Line 36 Emergency Hospital Services, Emergency hospital services means services that:
  1. Are necessary to prevent the death or serious impairment of the health of the recipient; and 2. Because of the threat to the life or health of the recipient necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet-
  (i) The conditions for participation under Medicare; or
  (ii) The definitions of inpatient or outpatient hospital services under 42 CFR 440.10 and 440.20.
- Line 37 Critical Access Hospitals, (See 42 CFR 440.170) -- Critical access hospital services that are furnished by a provider that meet the requirements for participation in Medicare as a CAH (see subpart F of 42 CFR part 485), and (ii) are of a type that would be paid for by Medicare when furnished to a Medicare beneficiary. Inpatient CAH services do not include nursing facility services furnished by a CAH with a swing-bed approval.
- Line 38 Nurse Practitioner Services, (See 42 CFR 440.166) services that are furnished by a registered professional nurse who meets a State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses. See 42 CFR 440.166 for requirements related to certified pediatric nurse practitioner and certified family nurse practitioner.
- Line 39 School Based Services, (See section 1903(c) of the Act)--These services include medical assistance for covered services (see section 1905(a)) furnished to a child with a disability because such services are included in the child's individualized educational program established pursuant to Part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan.
- Line 40 Rehabilitative Services (non-school-based), (see 42CFR440.130(d))--Rehabilitative services includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, with the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.
- Line 41 Private Duty Nursing (see 42CFR440.80)--Nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided:
  (a) by a registered nurse or a licensed practical nurse;
  (b) under the direction of the recipient's physician ; and

(c) to a recipient in one or more of the following locations at the option of the State:
(1) his or her own home;
(2) a hospital; or
(3) a skilled nursing facility.

- Line 42 Freestanding Birth Centers – A line added to the CMS-37.3 and CMS-64.9 series of forms Form pursuant to Section 2301 of ACA.
- Line 43 Home Health for Enrollees with Chronic Conditions A line added to the CMS-37.3 and CMS-64.9 series of forms Form pursuant to Section 2703 of ACA.
- Line 44 Tobacco Cessation for Pregnant Women A line added to the CMS-37.3 and CMS-64.9 series of forms Form pursuant to Section 4107 of ACA.

Beginning with FFY 2010, the following Line Items were added to the 64.10 administrative cost series of forms:

- Line 3B Skilled Professional Medical Personnel – Other Agency, These are administrative expenses for Skilled Professional Medical Personnel (SPMP) and directly supporting staff of the state (other than the Single State Medicaid Agency) and local public agencies as defined in 42 CFR 432.2. These costs must be supported by a written interagency agreement in accordance with 45 CFR 95.507(b)(6).
- Line 5C Planning for Health Homes for Enrollees with Chronic Conditions, Not Approved under MMIS Procedures: Interagency - Enter in Column (A) the total computable amount of expenditures for the costs related to the design, development, installation, improvement or operation of a mechanized claims processing and information retrieval system of a state-level public agency other than the Single State Agency and not approved under MMIS procedures. These costs must be supported by a written interagency agreement in accordance with 45 CFR 95.507(b)(6).
- Line 16 - TANF Secondary Allocation 75% matching Line 16 is the total computable and federal share (75%) costs for Medicaid administrative TANF activities allowable at the 75% Federal share rate against the secondary allocation. (See Federal Register notice MB-103-NC, May 14, 1997.)
- Line 19 School Based Administration: This line captures the total computable school-based Medicaid administrative costs incurred under the authority of an approved Medicaid Administrative Claiming Plan as required in the Claiming Guide issued by CMS in May 2003. These costs must be supported by a written interagency agreement in accordance with 45 CFR 95.507(b)(6).
- Line 20 Program Integrity/Fraud, Waste, and Abuse Activities - These costs include activities of the Surveillance and Utilization Review Units or other similar units of the State Agency. These costs may also include the costs of special provider audits (does not include routine audits of providers for cost-settlement purposes), data mining, and other administrative and legal costs related to program integrity activities. Any costs incurred by public agencies other than the single State Agency must be supported by an interagency

agreement in accordance with 45 CFR 95.507(b)(6).

- Line 21 County / Local Administrative Costs - These costs must be in accordance with cost principles contained in OMB Circular A-87 and must be supported by a written interagency agreement in accordance with 45 CFR 95.507(b)(6).
- Line 22 Interagency Costs (State Level) - Administrative costs of a state-level public agency other than the Single State Agency. These costs must be in accordance with cost principles contained in OMB Circular A-87 and must be supported by a written interagency agreement in accordance with 45 CFR 95.507(b)(6).
- Line 23 Translation and Interpretation – these activities may be allowable as an administrative cost if it is not included and paid for as part of a direct medical service and if it is necessary for the proper and efficient administration of the State plan. However, in order for translation to be claimable as administration, it must be provided either by separate units or separate employees performing solely translation activities and it must facilitate access to Medicaid covered services.
- Line 24A Health Information Technology (HIT): Planning: Cost of In-house Activities Planning Activities for administrative expenses to oversee the Medicaid EHR incentive payments made to eligible providers.
- Line 24B Health Information Technology: Cost of Private Sector Contractors. Planning Activities for administrative expenses to oversee the Medicaid EHR incentive payments made to eligible providers directly attributable to the design, development, and installation of the planning activities related to the administration of the Medicaid EHR incentive payment program.
- Line 24C Health Information Technology: Implementation and Operation - Cost of Private Contractors. Cost of In-house Activities - Implementation Activities for administrative expenses to oversee the Medicaid EHR incentive payments made to eligible providers expenditures directly attributable to the design, development, and installation of the planning activities related to the administration of the Medicaid EHR incentive payment program.
- Line 24D Implementation and Operation: Cost of Private Contractors Health Information Technology Implementation Activities for administrative expenses to oversee the Medicaid EHR incentive payments made to eligible providers directly attributable to the design, development, and installation of the planning activities related to the administration of the Medicaid EHR incentive payment program.
- Line 25 Citizenship Verification Technology (CVT) –CHIPRA: (Section 211 CHIPRA)
- Line 25A CVT Operation –CHIPRA: CVT Development (Section 211 CHIPRA) —There is a 90% FMAP for expenditures for the design, development, or installation of Citizenship Verification technology.
- Line 25B CVT Operation – CHIPRA - (Section 211 CHIPRA)- There is a 75% FMAP for the operation of CVT technology.

The following discussion highlights each section of the form CMS-64 and supporting forms in their order of appearance.

CMS-64 Certification

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program Certification Sheet.

CMS-64 SUMMARY SHEET

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Summary Sheet. The form CMS-64 summary sheet is a one-page summary sheet summarizing the total expenditures reported for the quarter. The remaining forms provide additional detail and support the entries made on the summary sheet.

CMS-64.9BASE

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Expenditures in this Quarter. The form CMS-64.9BASE is comprised of two pages that are used for detailing, by category, current quarter program expenditures by type of service (e.g., clinical services, dental services). The total figures from the form CMS-64.9BASE are transferred to the form CMS-64Summary Sheet, Line 6, columns (a) and (b). This information will be computer generated from the CMS-64.9 and CMS-64.9 Waivers.

CMS-64.9 Waiver

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Expenditures in this Quarter. The form CMS-64.9 Waiver is comprised of two pages that are used for detailing, by category, current quarter program expenditures by type of service (e.g., clinical services, dental services). The total figures from each form CMS-64.9 Waiver are transferred to the form CMS-64.9BASE.

CMS-64.9P

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Prior Period Adjustment. The form CMS-64.9P supports claims or adjustments for prior period (years) which are transferred to the form CMS-64 summary sheet and noted on Lines 7, 8, 10.A., and 10.B., columns (a) and (b). It contains the same service categories as the form CMS-64.9. This two-page form details the program expenditures, by category, arraying the expenditures by fiscal year. A separate form CMS-64.9P is prepared to support each fiscal year and each line entry (Lines 7, 8, 10.A., and 10.B.) on the summary sheet. The prior period waiver-related expenditures are reported on a separate CMS form, CMS-64.9P Waiver. A separate form CMS-64.9P must be filed for each waiver including HCBS waivers.

CMS-64.9P Waiver

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Prior Period Adjustment. The form CMS-64.9P Waiver supports waiver claims or adjustments for prior period (years) which are transferred to the form CMS-64 summary sheet and

noted on Lines 7, 8, 10.A., and 10.B., columns (a) and (b). It contains the same service categories as the form CMS-64.9. This two-page form details the program expenditures, by category, arraying the expenditures by fiscal year. A separate form CMS-64.9P Waiver is prepared to support each fiscal year and each line entry (Lines 7, 8, 10.A., and 10.B.) on the summary sheet.

CMS-64.9O

The form CMS-64.9O reports the Medicaid overpayments not collected nor adjusted, but refunded because of the expiration of the 60-day time limit for overpayments which occurred on or after October 1, 1985. This is authorized under Section 1903(d)(2) of the Act. Total figures of all CMS-64.9o forms are entered on the form CMS-64 summary sheet on Line 10.C.

CMS-64.9O PERM

The CMS-64.9O PERM reports the Payment Error Rate Measurement (PERM) overpayments not collected nor adjusted, but refunded to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300).

CMS-64.9A

The form CMS-64.9a details TPL collections and cost avoidance information. Total figures from this one page form are entered on the CMS-64 summary sheet on line 9.A., columns (a) and (b).

CMS-64.10 BASE

Expenditures for State and Local Administration for the Medical Assistance Program, Expenditures in this Quarter. The form CMS-64.10 supports administrative expenditures reported on the summary sheet. This one page form details, by category, the current quarter expenditures for administering the Medicaid program. The total figures from the form CMS-64.10 BASE are transferred to the form CMS-64 Summary Sheet, Line 6, columns (c) and (d). This information will be computer generated from the CMS-64.10 and CMS-64.10 Waivers.

CMS-64.10 Waiver

Expenditures for State and Local Administration for the Medical Assistance Program, Expenditures in this Quarter. The form CMS-64.10 supports administrative waiver expenditures reported on the summary sheet. This one page form details, by category, the current quarter expenditures for administering the Medicaid program. The total figures from each form CMS-64.10 Waiver are transferred to the form CMS-64.10BASE.

CMS-64.10P

Expenditures for State and Local Administration for the Medical Assistance Program,

Prior Period Adjustments. The form CMS-64.10P is similar to the form CMS-64.10 except that it addresses non –waiver adjustments to prior period expenditures. The totals from the form CMS-64.10P are transferred to the form CMS-64 summary sheet, Lines 7, or 8. or 10.A., or 10.B., columns (c) and (d). A separate form CMS-64.10P must be completed for each fiscal year.

CMS-64.10P Waiver

Expenditures for State and Local Administration for the Medical Assistance Program, Prior Period Adjustments. The form CMS-64.10P Waiver is similar to the form CMS-64.10 Waiver except that it addresses adjustments to prior period expenditures. The totals from the form CMS-64.10P are transferred to the form CMS-64 summary sheet, Lines 7, or 8. or 10.A., or 10.B., column (c) and (d). A separate form CMS-64.10P Waiver must be completed for each waiver number.

CMS-64.11

Summary Total of Receipts from form CMS-64.11A. The form CMS-64.11 has been created to summarize the information reported on the various CMS-64.11A forms. This is authorized under Section 1903(w) of the Act.

CMS-64.11A

Actual Receipts by Plan Name. The form CMS-64.11A has been created to report the actual receipts by plan names form provider-related donation and health care related taxes, fees and assessments. This is authorized under Section 1903(w) of the Act.

NOTE: There are no forms numbered 64.1 through 64.8 because of form development and redevelopment over the years. There are also no forms detailing items 9.B. through 9.E. of the summary sheet because there is no need for further breakdown of these figures for reimbursement calculations.

CMS-64.9D

Allocation of Disproportionate Share Hospital Payment Adjustments to Applicable FFYs. The form CMS-64.9d has been created to track payments of DSH by Federal Fiscal Year. This one page form details, by Inpatient Hospital Services and Mental Health Facility Services, details the allotment and DSH payments by Federal Fiscal Years. This is authorized under Section 1923(f) of the Act.

CMS-64.9R

The form CMS-64.9R has been created to report the aging of pending Drug Rebate collections for Total Computable. This is authorized under Section1927(c)(1) of the Act.

CMS-64 Narrative

States will use this form to explain any unusual expenditure, entries on lines 4 and 5 of the summary sheet, CMP, etc.

CMS-64.21

Quarterly Medical Assistance Expenditure by Children's Health Insurance Program Expenditure Categories. States use this form to report current quarter non-waiver expenditures for children who are determined presumptively eligible under Section 1920A of the Act.

CMS-64.21P

Quarterly Medical Assistance Expenditures by Children's Health Insurance Program expenditure categories. States use this form to report prior period non-waiver expenditures for children who are determined presumptively eligible under Section 1920A of the Act.

CMS-64.21 Waiver

Quarterly Medical Assistance Expenditure by Children's Health Insurance Program Expenditure Categories. States use this form to report current quarter waiver expenditures for children who are determined presumptively eligible under Section 1920A of the Act.

CMS-64.21P Waiver

Quarterly Medical Assistance Expenditures by Children's Health Insurance Program expenditure categories. States use this form to report prior period waiver expenditures for children who are determined presumptively eligible under Section 1920A of the Act.

CMS-64.21U

Quarterly Medical Assistance Expenditure Categories by Children's Health Insurance Program Expenditure Categories. States use this form to report current quarter non-waiver expenditures described under Section 1905(u)(2) and 1905(u)(3) of the Act.

CMS-64.21U Waiver

Quarterly Medical Assistance Expenditure Categories by Children's Health Insurance Program Expenditure Categories. States use this form to report current quarter waiver expenditures described under section 1905(u)(2) and 1905(u)(3) of the Act.

CMS-64.21UP

Quarterly Medical Assistance Expenditures by Children's Health Insurance Program Expenditure Categories, Prior Period Expenditures. States use this form to report prior period non-waiver expenditures described under Section 1905(u)(2) and (3) of the Act.

CMS-64.21UP Waiver

Quarterly Medical Assistance Expenditures by Children's Health Insurance Program Expenditure Categories, Prior Period Expenditures. States use this form to report prior

period waiver expenditures described under Section 1905(u)(2) and (3) of the Act.

CMS-64.9F

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Summary Sheet. The form CMS-64.9F is a one-page summary sheet summarizing the total expenditures reported for the quarter, by line and by categories of funding.

CMS Informational (I-Forms)

An explanation of the I-Forms is provided following all of the form descriptions.

CMS-64.9T

Medical Assistance Expenditures by Type of Service for the Medical Assistance Program, Expenditures in This Quarter. The form CMS-64.9T supports claims or adjustments for current year which are transferred to the form CMS-64 summary sheet and noted on Lines 6, columns (a) and (b). It contains the same service categories as the form CMS-64.9. This two-page form details the program expenditures, by category, arraying the expenditures by Medicaid and CHIP. These expenditures are non-waiver expenditures. The total figures from the form CMS-64.9 are transferred to the form CMS-64.9BASE.

CMS-64.9TP

Medical Assistance Expenditures by Type of Service for the Medical Assistance Program, Prior Period Adjustment. The form CMS-64.9Tp supports claims or adjustments for prior period (years) which are transferred to the form CMS-64 summary sheet and noted on Lines 7, 8, 10.A., and 10.B., columns (a) and (b). It contains the same service categories as the form CMS-64.9. This two-page form details the program expenditures, by category, arraying the expenditures by fiscal year. A separate form CMS-64.9Tp is prepared to support each fiscal year and each line entry (Lines 7, 8, 10.A., and 10.B.) on the summary sheet. The prior period waiver-related expenditures are reported on a separate CMS form, CMS-64.9Tp Waiver.

CMS-64.9TP Waiver

Medical Assistance Expenditures by Type of Service for the Medical Assistance Program, Prior Period Adjustment. The form CMS-64.9Tp Waiver supports waiver claims or adjustments for prior period (years) which are transferred to the form CMS-64 summary sheet and noted on Lines 7, 8, 10.A., and 10.B., columns (a) and (b). It contains the same service categories as the form CMS-64.9. This two-page form details the program expenditures, by category, arraying the expenditures by fiscal year. A separate form CMS-64.9TP Waiver is prepared to support each fiscal year and each line entry (Lines 7, 8, 10.A., and 10.B.) on the summary sheet.

CMS-64.9T Waiver

Medical Assistance Expenditures by Type of Service for the Medical Assistance

Program, Expenditures in This Quarter. The form CMS-64.9T Waiver is composed of two-page form details the program expenditures, by category, arraying the expenditures by Medicaid and CHIP. The total figures from each form CMS-64.9 Waiver are transferred to the form CMS-64.9BASE.

CMS-21T Tracking

Application of 20% Medicaid Allowance for FY 1998 Thru 2001 Allotment States Used in the Calculation of 20% Limit. System uses this form to verify that the CHIP amount does not exceed the limits assigned by the law.

CMS forms

The aforementioned new category of service Line items, do not result in an increase in burden as this information was originally reported on the COS Line titled "Other".

I Forms

Beginning 1st quarter FY 2002 CMS-64 expenditure reporting cycle, CMS added informational forms (I-forms) to the expenditure package. These forms were established as an outgrowth of the many ongoing requests from Congressional, Office of Management and Budget, Departmental, and other interest groups for special expenditure information that is not separately reported or identified on the expenditure reports. These expenditures are contained within other overall expenditure categories or line items. In response to these requests, on a regular basis we have had to conduct special state surveys in order to obtain the specified expenditure information. The use of these I-forms mitigates and/or eliminates the need for the special surveys or ad-hoc requests. The new COS Lines added into the MBES/CBES redesign and migration significantly reduce the need for the I-Forms. The use of the I-forms are now primarily limited to prior period adjustments or the few programs whose expenditures do not get factored into the calculations of Line 11 of the CMS-64 Summary Sheet (e.g., psychiatric residential treatment facilities (PRTF) and money follows the person (MFP)). Although it is infrequent, when Administrative costs do not fit into a defined Line item, those costs would get claimed on the "Other Financial Participation" Line.

The I-forms do not apply to the Territories and they will not need to address them.

CMS-64.9I

States use this form to report current quarter service expenditure issues such as supplemental payment expenditures for certain providers and school-based services expenditures.

CMS-64.9PI

States use this form to report prior quarter service expenditure issues such as supplemental payment expenditures for certain providers and school-based services

expenditures.

CMS-64.10I

States use this form to report current quarter administrative expenditure issues such as supplemental payment expenditures for certain providers and school-based services expenditures.

CMS-64.10PI

States use this form to report current quarter administrative expenditure issues such as supplemental payment expenditures for certain providers and school-based services expenditures.

3. Improved Information Technology

CMS has developed an automated Medicaid expenditure system for use within CMS using electronic transfer between States and CMS for processing all State Medicaid expenditure data. During the planning phase of the MBES/CBES redesign, CMS saw the need to reorganize and create a System's team to assist with the development, migration and maintenance of the MBES/CBES system. A part of the team's purpose is to be an effective liaison between CMS and the contractor. The system's team consults with the contractor regularly to ensure that the system is functioning according to the system's business rules, and to provide guidance to the State and CMS personnel should they have questions or identify glitches. As a result of this process, the MBES/CBES system continually evolves to meet the needs of MBES/CBES users and stay true to the MBES/CBES system's purpose.

The redesigned MBES has many advantages over the old system. For instance, the MBES system's user-interface is more intuitive than the previous version. The new System's layout utilizes state of the art technology providing a screen or form that has the appearance and functionality of other Web-Based systems frequently used by the public in everyday situations (e.g., banking, license renewal etc.). The System is more user-friendly permitting users to change their own email, reset their password and customize the screen's color and contrast. In addition, the Header columns are now fixed which assists in streamlining a particular task by reducing the time that a user had to scroll up and down to view the headers. As a result of additional COS Line items and enhanced graphics, the loading time has increased for many of the larger forms. To help continually enhance the system's performance, a "quick entry" solution was implemented for the largest forms, and it is CMS' intent to apply this function more frequently to the larger forms.

Prior to the redesign, many COS Lines were claimed on the Line titled "Other". This Line was used when a particular expenditure did not have a corresponding COS Line item. When used, States are required to complete a narrative that describes and accounts for all of the claimed expenditures. The MBES/CBES redesign, however, added more COS Line items (e.g., Inpatient Hospital Supplemental Payments, Outpatient hospital

supplemental payments etc.) reducing the need for this Line. The additional COS Lines assists the States as well as CMS by means simplifying the identification, reporting and analysis of these expenditures. Moreover, the new platform has significantly less down time, and the new platform helps to optimize the overall performance of the MBES/CBES system.

Although there are new COS Lines, they do not result in an increase in burden as this information was originally reported on the 64.9I, 64.10I, 64.9PI, and 64.10PI Informational Forms (I-Forms). In addition, the Line items added in accordance with ACA do not result in an increase in burden because the updated MBES/CBES system's intuitive, efficient nature, and reduced down time offsets any increase in time for data entry.

4. Duplication/Similar Information

The information covered by this request does not duplicate any data being collected. While the form CMS-37, Medicaid Program Budget Report, is used to collect expenditure data, it is used only to report estimated data on a quarterly basis for budgetary purposes. The form CMS-64 is the only means used by CMS to collect actual expenditure data on a quarterly basis.

5. Small Business

This information collection does not significantly impact small businesses.

6. Less Frequent Collection

Failure to collect the data on a quarterly basis may result in Federal funds not being returned promptly and properly to the Federal Government. States could misspend large sums of Federal funds undetected with no immediate mechanism of recovery. Conversely, there are instances where States are due Federal funds and delays in reimbursing States could cause financial hardships on a State and adversely impact the operation of the Medicaid program.

7. Special Circumstances

This request conforms with the guidelines in 5 CFR 1320.6.

8. Federal Register Notice/Outside Consultation

A 60-day Federal Register notice published on December 10, 2010 (75 FR 76988). One comment letter was received.

9. Payment/Gifts To Respondents

There were no payments/gifts to respondents.

10. Confidentiality

The form CMS-64 does not collect information on individuals and is not subject to the Privacy Act.

11. Sensitive Questions

There are no questions of a sensitive nature associated with this report.

12. Burden Estimate

Respondents are 56 State or territorial Medicaid agencies. Each respondent will make four quarterly submissions to CMS with an estimated average staff hour requirement of 81 hours per submission and an average cost per submission of $38*/hour. The Federal government shares in 50% of the State cost. Since reports are submitted electronically, there are negligible printing and distribution costs to the respondent. Therefore, the total annual respondents cost is as follows:

Estimate of Burden Hours

Number of Submissions	224 (56/qtr x 4 qtrs)
Preparation Hours per Submission	x 81
Total Annual Preparation Hours	**18,144 hr**

Estimate of Cost

Total Annual Preparation Hours	18,144 hr
Average Staff Costs per Hour	x $38.00/hr
Total Respondents Cost (Rounded)	$ 689,472
Less 50% Federal Match	- 344,736
Respondents Share of Cost	**$ 344,736**

** Bureau of Labor Statistics - State and Local Government Workers Total Hourly Compensation (12/2007) – rounded to the nearest dollar.*

13. Capital Cost

There is no capital cost.

14. Cost to the Federal Government

Federal Costs

The total Federal cost consists of central office review, regional office review, printing and distribution and the Federal share of State reporting costs. It is estimated to be

$2,061,212, computed as follows:

Central Office Costs

Both analyst and clerical costs are included in the review of the form CMS-64. Analysts' costs are based on reviewing 224 submissions per year (56 submissions times 4 quarters per year). Each review takes approximately 6 hours to complete for the form CMS-64. Analyst costs are based on an average of $45 per hour totaling $60,480. Clerical costs are based on the same number of submissions and half the review time at an average of $19 per hour totaling $12,768.

Printing and Distribution Costs

Printing and distribution costs are estimated to be $7,100. This has been confirmed with CMS's Printing and Distribution Branch.

Regional Office Costs

Regional office costs are calculated as follows: 2,080 total hours per person year, multiplied by 90 full time financial management employees totals 187,200 hours. It is estimated that 23 percent of total staff time is spent on analysis of the form CMS-64 at a cost of $38 per hour (GS-12/5) totaling $1,636,128 (187,200 x 23% x 38).

Federal Share of State Reporting Costs

The total Federal share is half of the total State reporting costs and is estimated to be $344,736.00 and is computed as follows:

18,144	total reporting hours
x $ 38.00	cost per hour
$ 689,472	total reporting costs
Divided by 50%	Federal Share
$344,736.00	

15. Changes in Program/Burden

Due to the migration to the new MBES/CBES platform and the enactment of ACA there were minimal Program/Burden Changes.

16. Publication and Tabulation Data

The results of this information collection are not planned for publication for statistical use nor does this information collection employ statistical research methodologies.

17. Expiration Date

CMS would like to display the expiration date.

18. Certification Statement

There are no exceptions to the certification statement.