Supporting Statement part A
Quarterly Medicaid Statement of Expenditures
for the Medical Assistance Program
CMS-64/OCN 0938-0067

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).

A. 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.

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.

Beginning with FFY 2011 to 2013 Qtr. 2, the following Line Items were added to the medical assistance 64.9 series of forms:

- Line 5C Physician & Surgical Services – Evaluation and Management, Section 1202 of the Patient Protection and Affordable Care Act (ACA) requires state Medicaid agencies to increase payments to certain physician specialties for

primary care services provided to Medicaid recipients during calendar years 2013 and 2014. Payments for Evaluation and Management (E/M) procedure codes and immunization services, which are provided by physicians with a specialty designation of family medicine, general practice or pediatric medicine, paid at a rate not less than 100 percent of the Medicare rate for those same procedures and services. Effective 2nd Quarter of 2013.

- Line 5D Physician & Surgical Services – Vaccine codes: Section 1202 of ACA Effective 2nd Quarter of 2013.
- Line 18A1 Medicaid MCO- Evaluation and Management: ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching Rate.
- Line 18A2 Medicaid MCO – Vaccine codes: ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate.
- Line 18A3 Medicaid MCO – Community First Choice: Section 2401 of ACA – Medical Assistance in a home or community setting, which does not include a nursing facility or institution for mental diseases or intermediate care facility for mentally retarded. Effective 1st Quarter of 2013.
- Line 18A4 Medicaid MCO-Preventive Services Grade A OR B. ACIP Vaccine and their Admin.: Section 4106 of ACA, services for diagnostic, screening, preventive and rehabilitative, including any clinical preventive services that are assigned a grade of A or B by the US Preventive Services Task Force. With respect to an adult individual, approved vaccine at additional 1% FMAP rate. CMS Form 37.3 will also be revised. Effective 2nd quarter of 2013
- Line 18B1a MCO PAHP (Prepaid Ambulatory Health Plan) – Evaluation and Management: ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.
- Line 18B1b MCO PAHP – Vaccine codes : ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate
- Line 18B1C MCO PAHP – Community First Choice : Community First Choice: Section 2401 of ACA – Medical Assistance in a home or community setting, which does not include a nursing facility or institution for mental diseases or intermediate care facility for mentally retarded. Effective 1st Quarter of 2013.
- Line 18B1d MCO PAHP Preventive Services Grade A OR B. ACIP Vaccine and their Admin.: Section 4106 of ACA, services for diagnostic, screening, preventive and rehabilitative, including any clinical preventive services that are assigned a grade of A or B by the US Preventive Services Task Force. With respect to an adult individual, approved vaccine at additional 1% FMAP rate. CMS Form 37.3 will also be revised. Effective 2nd quarter of 2013.
- Line 18B2a MCO PIHP (Prepaid Inpatient Hospital Plan) – Evaluation and

Management: ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.

- Line 18B2b MCO PIHP – Vaccine codes: ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate.
- Line 18B2c MCO PIHP – Community First Choice: Community First Choice: Section 2401 of ACA – Medical Assistance in a home or community setting, which does not include a nursing facility or institution for mental diseases or intermediate care facility for mentally retarded. Effective 1st Quarter of 2013.
- Line 18B2d MCO PIHP Preventive Services Grade A OR B. ACIP Vaccine and their Admin.: Section 4106 of ACA, services for diagnostic, screening, preventive and rehabilitative, including any clinical preventive services that are assigned a grade of A or B by the US Preventive Services Task Force. With respect to an adult individual, approved vaccine at additional 1% FMAP rate. CMS Form 37.3 will also be revised. Effective 2nd quarter of 2013.
- Line 19D Home and Community based services State Plan 1915(k) Community First Choice: Section 2401 of ACA – Medical Assistance in a home or community setting, which does not include a nursing facility or institution for mental diseases or intermediate care facility for mentally retarded. Effective 1st Quarter of 2013.
- Line 34A Preventive Services Grade A or B ACIP Vaccine and their Administration: Section 4106 of ACA, services for diagnostic, screening, preventive and rehabilitative, including any clinical preventive services that are assigned a grade of A or B by the US Preventive Services Task Force. With respect to an adult individual, approved vaccine at additional 1% FMAP rate. CMS Form 37.3 will also be revised. Effective 2nd quarter of 2013.

Beginning with FFY 2011 to 2013 Qt2, the following Line Items were added to the 64.10 administrative cost series of forms:

- Line 24E HIT Incentive Payments-Eligible Professionals: ARRA, Sec. 13301for Grants, Loan and demonstration Programs, subtitle B – Incentive for the use of Health Information Technology
- Line 24F HIT Incentive Payments-Eligible Hospitals: ARRA, Sec. 13301for Grants, Loan and demonstration Programs, subtitle B – Incentive for the use of Health Information Technology
- Line 26 Planning for Health Homes for enrollees with Chronic conditions
- Line 27 Recovery Audit Contractors State Administration: Recovery Audit Contractors State Administration - Section 1902(a)(42)(B)(ii)(IV)(aa) of the Act provides that amounts spent by a State to carry out the administration of the program are to be reimbursed at the 50 percent administrative claiming rate.
- Line 28A Design Development/Installation of Medicaid Eligibility Determination System – Cost of In house activities : Design Development/Installation of Medicaid Eligibility Determination System – Cost of In-house Activities Plus Other State Agencies And Institutions.--Enter in Column (a) the total computable

amount of expenditures directly attributable to the design, development, installation, or enhancement of the Medicaid Eligibility Determination System.

- Line 28B Design Development/Installation of Medicaid Eligibility Determination System – Cost of Private Sec. Contractors: Design Development/Installation of Medicaid Eligibility Determination System – Cost of Private Sector Contractors --Enter in Column (a) the total computable amount of expenditures for the costs of private sector contractors directly attributable to the design, development, installation, or enhancement of the Design Development/Installation of the Medicaid Eligibility Determination System. The MBES will automatically enter in Columns (b) and (d) 90 percent of the amount reported in Column (a).
- Line 28C Operation of an approved Medicaid Eligibility Determination System-Cost of In-house activities: Operation of an Approved Medicaid Eligibility Determination System – Cost of In-house Activities Plus Other State Agencies And Institutions. --Enter in Column (a) the total computable amount of expenditures directly attributable to the operation of the Medicaid Eligibility Determination System. The MBES will automatically enter in Columns (b) and (d) 75 percent of the amount reported in Column (a).
- Line 28D Operation of an approved Medicaid Eligibility Determination System-Cost of Private Sec. Contractors: Operation of an Approved Medicaid Eligibility Determination System. – Cost of Private Sector Contractors. --Enter in Column (a) the total computable amount of expenditures for the costs of private sector contractors directly attributable to the design, development, installation, improvement, or operation of a Medicaid Eligibility Determination System not approved under Medicaid Eligibility Determination System procedures. The MBES will automatically enter in Columns (b) and (d) 75 percent of the amount reported in Column (a).

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).

64.9O RAC:
Over-payment Recovery Screen, Recovery Audit Contractor, Implementation Date 1/28/2011. Manual entry for Federal Share. Now this screen also shows ARRA expenditures. This pre-fills Line 10E of the CMS 64 Summary. *Section 6411 of ACA.*

64.S9 RAC:
Over-payment Recovery Summary Screen, A separate RAC collection Report. RAC contactor fee is deducted from RAC collection. This Net collection pre-fills Line 9E of the 64 Summary. Implementation date 1/28/2011. Now this screen also shows ARRA expenditures. Law: *Section 6411 of ACA*

CMS 64.9OFWA: Deficit Reduction Act (DRA) 6034 Fraud, Waste and Abuse Overpayment Form: This report shows Fraud, Waste & Abuse Amounts Overpayments - Federal Credit Due. It is run for a Quarter or Year and by Line Number.

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 64.9C1
Recoveries from Fraud, Waste & Abuse amount of line 9C1 of 64 Summary. Tot. Computable, Federal Share, ARRA (Col. A, B & C are enterable. These columns pre-fill 64 Summary.

CMS 64.9C2:
Recoveries from OIG compliant of False Claim Act, Line 9C2 of 64 Summary. The form allows for multiple recovery periods. It pre-fills 64 Summary.

CMS 64.9E series:
Low income population: (ACA Section 2202) -viii Group & Transition State adult group and State eligibility for Family Planning Services.

CMS 64.9PE.
Presumed Eligibility forms: (ACA Section 2202) These Forms are there for both MAP and Waivers.

CMS 64.9 Waiver DSH Diversion: Based on 1115 Waiver to demonstrate Neutrality. This report shows MAP DSH Diversion Waiver Total Computable, Federal Share, and State Share by state. It is run for a Quarter or Year and by Line Number.

CMS 64.9P Waiver DSH Diversion: This report shows MAP DSH Diversion Waiver Total Computable, Federal Share, and State Share for Prior Period Adjustments. It is run for a Quarter or Year and by Line Number.

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 Psychiatric residential treatment facilities (PRTF) and money follows the person (MFP) 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 to the guidelines in 5 CFR 1320.6.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice published on March 15, 2013 (78 FR 16507). One comment letter (support) was received and our response has been added to this package.

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 changes (see Crosswalk). We do not anticipate any additional burden to states by adding the new mandated ACA categories of services. These are program lines added to MBES that will allow states to claim for services. Without the additional ACA lines added to the CMS-64 form, states are unable to claim the expenditures and receive their payments.

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.

B. COLLECTION OF INFORMATION EMPLOYING STATISTICAL METHODS

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