Application to Use Burden/Hours from Generic PRA Clearance:
Medicaid and CHIP State Plan, Waiver, and Program Submissions
(CMS-10398, OMB 0938-1148)

Information Collection #37 Managed Care Rate Setting Guidance

December 2014

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

A. Background

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

B. Description of Information Collection

States are required to submit an actuarial certification for all Medicaid managed care capitation rates per §438.6(c). This document specifies our requirements for that certification and details what types of descriptions we expect to be included. These elements include descriptions of data used, projected benefit and non-benefit costs, rate range development, risk and contract provisions, and other considerations in all rate setting packages. This document also details expectations for states when they submit rate certification letters for their newly eligible population.

Statute at 1903(m) of the Social Security Act requires rates paid to Medicaid managed care organizations (MCO) to be actuarially sound. Regulations at §438.6(c) requires all capitation rates paid to an MCO, Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plans (PAHP) to be actuarially sound and require each state to submit an actuarial certification for each set of capitation rates developed.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

The total approved burden ceiling of the generic ICR is 86,240 hours, and CMS previously requested to use 58,513 hours, leaving our burden ceiling at 27,727 hours. CMS estimates that each State will complete the collection of data and submission to CMS within 2 hours. There is a potential universe of 42 respondents, so the total burden deducted from the total for this request is 140 hours.

Based upon CMS's experiences with rate setting, we estimate that on average it will take a state 2 hours per certification to organize and describe the data in a way that complies with the guide. 42 states have rates developed for an MCO, PIHP or PAHP and in these states we estimate approximately 70 rate certifications submitted. We estimate that 70 certificates will be submitted on an annual basis for a total annual burden of 140 hours (70 certificates x 2 hours).

E. Timeline

Not applicable. This is an extension (without change) of a currently approved GenIC.

Attachments
The following attachment is provided for this information collection:

- 2015 Managed Care Rate Guidance 09-3-14
- http://www.gpo.gov/fdsys/pkg/FR-2002-06-14/pdf/02-14747.pdf