

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**

**July 26, 2016**

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

GenIC #37 was first approved by OMB on September 15, 2014 and was extended without change on December 24, 2014. The September 16, 2015, iteration set out the 2016 Managed Care Rate Setting Guide (Guide). This August 2016 iteration sets out the 2017 Guide and revised burden. Changes to the Guide are set out in the attached Crosswalk.

## **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 §438.4. 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.

Section 1903(m) of the Social Security Act requires rates paid to Medicaid managed care organizations (MCOs) to be actuarially sound. Regulations at §438.4 require 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.

*Wage Estimates*

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2015 National Occupational Employment and Wage Estimates for all salary estimates ([http://www.bls.gov/oes/current/oes\\_nat.htm](http://www.bls.gov/oes/current/oes_nat.htm)). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

<b>Occupation Title</b>	<b>Occupation Code</b>	<b>Mean Hourly Wage (\$/hr)</b>	<b>Fringe Benefit (\$/hr)</b>	<b>Adjusted Hourly Wage (\$/hr)</b>
Community and Social Service Occupations	21-0000	22.20	22.20	44.40

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

#### *Burden Estimates*

#### Currently Approved Burden

Currently OMB has approved 140 hours (70 rate certifications x 2 hours/response) for the 2016 Managed Care Rate Setting Guidance.

#### Burden Changes

Based upon CMS's experiences with rate setting, we estimate that on average it will take a state 4 hours per certification (an increase of 2 hours) to organize and describe the data in a way that complies with the 2017 guide.

While 44 states have rates developed for an MCO, PIHP or PAHP we now estimate that approximately 72 rate certifications will be submitted within those states.

In aggregate we estimate 288 hours (72 rate certifications x 4 hr/submission).

#### Revised Burden

As the 2016 and 2017 Rate Guides are largely the same, we do not expect the estimated time to complete each submission to change, however we do expect the number of submissions to increase with additional states implementing managed care. We believe the number of respondents for the 2017 Managed Care Rate Setting Guidance will increase to 44 and the number of certifications will increase to 72.

### *Respondents*

44 states (2017 Guide)  
-42 states (2016 Guide)  
+ 2 states for 2017

### *Responses*

72 rate certifications (2017 Guide)  
-70 rate certifications (2016 Guide)  
+ 2 rate certifications for 2017

### *Hours per Response*

4 hours/response (2017 Guide)  
-2 hours/response (2016 Guide)  
+2 hours/response for 2017

### *Total Hours*

288 hours (2017 Guide)  
-140 hours (2016 Guide)  
+148 hours for 2017

**Note: To avoid double counting, this package does not set out burden which is currently approved.**

### *Information Collection Instruments and Instruction/Guidance Documents*

- 2017 Managed Care Rate Guidance (July 2016)

### **E. Timeline**

States are required to obtain prior approval of contracts and rates per §438.806 which means that the rates need to be approved by CMS before they claim the expenditures on the CMS-64. In order for CMS to have the ability to review and analyze the rate certification and allow sufficient time for questions and answers, states should start submitting their certifications at least 60 days prior to the contract start date. With some contracts starting on January 1, 2017, CMS needs to allow states time to review this guidance and incorporate the elements into its rate certification prior to their submission. States will have already started their rate development for January 1, 2017 contracts and we want to ensure states have ample time to incorporate any additional information required by this guidance before submission.