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

Generic Information Collection #52
Delivery System and Provider Payment Initiatives Under Medicaid Managed Care Products

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

Note: This 2020 collection of information request clarifies the information CMS needs to ensure compliance with the requirements that are set out under 42 CFR 438.6(c). It intends to capture information regularly collected as part of the review process more consistently by incorporating it into the attached preprint form. These edits are meant to accomplish the following goals: 1) increase and enhance oversight of state directed payments, 2) update the preprint in response to work with states and 3) reduce administrative burden for states by capturing information in this revised preprint form currently collected through questions and responses conducted through the review process currently.

As demonstrated in the attached Crosswalk and described below under *Information Collection Instruments and Instruction/Guidance Documents,* Section 438.6(c) Preprint, we have added new questions, revised certain questions, removed references to attachments, and deleted two questions.

In line with our proposed changes to the preprint form, we also propose to revise our per response time estimate from 1 hour to 1.5 hours per response.

Based on the number of actual responses received we are also adjusting the number of responses per respondent from 6 to 3. The adjustment changes our estimated number of annual responses by minus 132 responses (264 responses [44 respondents x 6 responses/respondent] - 132 responses [44 respondents x 3 responses/respondent].

As a result, we have decreased our currently approved burden estimates by 66 hours (from 264 to 198 hr) and $3,204 (from $12,815 to $9,611).

No changes are being made to the two example preprints: Appendix K example and COVID-19 example.

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

We require states to submit a §438.6(c) preprint for state directed expenditures under an MCO, PIHP, or PAHP contract for delivery system and provider payment initiatives in Medicaid

managed care. The preprint will be used to meet the prior approval requirement under §438.6(c)(2)(i). The preprint specifies our requirements for prior approval, including the requirements under §438.6(c)(2)(i)(A) through (F), and the requirements under §438.6(c)(2)(ii)(A) through (D). These requirements specify that states must obtain written approval prior to implementation of the state directed payment arrangement.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

The total approved burden ceiling of the generic ICR is 154,104 hours, and CMS previously requested to use 116,020 hours, leaving our burden ceiling at 38,084 hours.

Wage Estimate

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2019 National Occupational Employment and Wage Estimates for all salary estimates (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 and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Community and Social Service Occupations	21-0000	24.27	24.27	48.54

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, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Burden Estimates

We estimate that it would take a state Community and Social Service employee 1.5 hours at $48.54/hr to complete one preprint. There is a potential universe of 44 respondents and, based on our experience, they submit approximately 3 responses each for a total of 132 responses (44 states x 3 responses/state). In aggregate, we estimate a burden of 198 hours (132 responses x 1.5 hr/response) at a cost of $9,611 (198 hr x $48.54/hr).

Although our currently approved time estimates have decreased by 66 hours (see Note on page 1), this August 2020 information collection request proposes to add 5 hours of burden to account

for the limitations of the submission system which does not allow submissions having zero or negative burden hours.

Outside of system limitations issue, the 5-hour burden estimate is also appropriate to avoid double counting of burden that is currently approved.

Information Collection Instruments and Instruction/Guidance Documents

- Section 438.6(c) Preprint (Revised)

Under §438.6(c)(2)(i), states must obtain written approval prior to implementation of the state-directed payment arrangement. The preprint will be used to meet the prior approval requirement. This clarifies the information CMS needs to ensure compliance with 42 CFR 438.6(c) and is intended to capture information regularly collected as part of the review process more consistently by incorporating it into the preprint form itself.

These edits are meant to accomplish the following goals: 1) increase and enhance oversight of state directed payments, 2) update the preprint in response to work with states and 3) reduce administrative burden for states by capturing information in this revised preprint form currently collected through questions and responses conducted through the review process currently.

As depicted in the attached Crosswalk, this version adds several new questions, including questions:

- to identify the managed care programs affected, (currently this is asked about during review; this change would capture this as part of the preprint form)
- to indicate if the preprint submission is a renewal, amendment or initial submission,
- to identify other authorities for the underlying services (e.g. state plan or 1115)
- to collect additional details on payment arrangements that are currently collected during the review process
- to clarify when states can seek a multi-year approval (only for VBP models as opposed fee schedules)
- to collect additional details on the rate certifications affected and how the payment will be incorporated into the rate certification (currently this is asked about during review; this change would capture this as part of the preprint form)
- to collect additional details on the effect on total reimbursement between the state directed payment, any underlying base rates paid by the plan and any pass-through payments (currently this is asked about during review; this change would capture this as part of the preprint form)
- to collect additional details on the source of the non-federal share of the financing for the state-directed payment (currently this is asked about during review; this change would capture this as part of the preprint form)

This version also revises several questions to clarify the information CMS needs to complete reviews and ensure compliance with the regulatory requirements.

The revisions also try to capture information more consistently across states by moving away from open text fields to more checkboxes and drop-downs.

We are also removing references to attachments to respond to some questions in order to ensure information is captured in the preprint.

This version also deletes two questions that caused confusion and did not yield information necessary to the review.

- SMDL: Additional Guidance on State Directed Payments for Medicaid Managed Care Plans

CMS has reviewed and approved more than 400 state directed payment arrangements since this part of the regulation took effect beginning with contract rating periods on or after July 1, 2017. Based on our reviews, CMS believes additional guidance is needed to:

  - Clarify existing policy and alleviate burden faced by states by proactively addressing common questions that arise during the preprint review;
  - Enhance program integrity in the use of state directed payments; and
  - Remind states of the quality-related requirements that must be met to secure CMS approval.

In May 2020, CMS published guidance specifically on the use of state directed payments in response to the COVID-19 public health emergency; this State Medicaid Director Letter (SMDL) provides additional guidance on the broader policy regarding state directed payments. In this State Medicaid Director Letter, CMS clarifies what is considered a state directed payment and reiterates and provides additional clarification on the federal requirements for state directed payments.

- Section 438.6(c) Preprint Appendix K EXAMPLE (No changes)

The example will be used by states seeking approval to implement state directed payments under §438.6(c) to contractually require managed care plans to make retainer payments to providers where the authorized service is covered under the contract. In order for states to seek approval under §438.6(c), the retainer payments must be authorized as part of the 1915(c) HCBS waiver, section 1115 demonstration waiver, or other CMS authority. Once the retainer payments are authorized under one of these authorities, a state directed payment preprint must be submitted to effectuate these retainer payments under a state's contract with its managed care plans. In order to facilitate CMS' expedited review and approval of these payments, CMS is making a prepopulated template available to states for minimum fee schedule requirements tied to approved retainer payments.

- Section 438.6(c) Preprint COVID19 EXAMPLE (No changes)

The example will be used by states seeking approval to implement state directed payments under §438.6(c) to contractually require managed care plans to make specific payments to providers to help mitigate the impacts of the public health emergency. In order to help states comply with the regulatory requirements under §438.6(c) and to create a framework for states that can help facilitate CMS' review and approval process, our guidance provides guiding principles related to state directed payments developed in response to COVID-19. The regulations at §438.6(c)(2) also require that states have written approval from CMS prior to implementation of the state directed payments. CMS currently utilizes a preprint to implement the prior approval process that states must complete and submit to CMS for approval of the state directed payments. For states seeking to implement state directed payments to respond to this public health emergency, we are publishing a prepopulated version of the preprint to facilitate a more streamlined submission and review process.

E. Timeline

n/a