Generic Supporting Statement (March 2018)

Generic Clearance for Medicaid and CHIP State Plan, Waiver, and Program Submissions
(CMS-10398, OMB 0938-1148)

Information Collection #55

Limit on Federal Financial Participation for Durable Medical Equipment in Medicaid

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.

In order to implement section 503 of the Consolidated Appropriations Act, 2016 and section 5002 of the 21st Century Cures Act of 2016, where Congress added section 1903(i)(27) to the Social Security Act (the Act), which prohibits federal Medicaid reimbursement to states for certain durable medical equipment (DME) expenditures that are, in the aggregate, in excess of what Medicare would have paid for such items, we formulated a State Medicaid Directors' Letter (SMDL) in order to comply with the statute. The revised SMDL #18-001 contains the policy guidance to states to comply with this statute. The statute took effect January 1, 2018, to begin reporting by the states. In order for states to comply with the statute, CMS requests each state to either change their Medicaid state plan to reflect payment at or below the Medicare rates for the relevant HCPCS codes, or demonstrate that the state is not spending more than Medicare would have paid for the relevant DME items.

We propose the minimal amount of information be collected from states to comply with this statute. CMS will use this information to calculate compliance with the statute using this State Fee Schedule Drop (calculation tool) as part of its Generic PRA package. This calculation tool will be used to calculate compliance with the annually updated DME pricing schedules from Medicare.

This information collection request was initiated under the regular Paperwork Reduction Act process which included the publication of a 60-day Federal Register notice (Nov. 28, 2017; 82 FR 56242) under CMS identification number CMS-10661 and OMB control number 0938-New. After receiving no substantial comments, we moved to fold our request under the generic process, with a minimal 8 hours of estimated burden per entity per year (state or territory). The comments and our responses have been added to this package. Changes subsequent to the publication of the 60-day notice can be found in the attached Crosswalk and track change version of the instructions.

B. Description of Information Collection

- Who are the respondents: the States that participate in the Medicaid Program that choose to show compliance with the statute by demonstrating their current fee schedules pay out at or below what Medicare would pay for the relevant DME items covered in this statute.

- Identify each collection instrument and its format: State Fee Schedule Drop (calculation tool)

- Explain how the respondents access the collection instrument: These documents will be made available on the Medicaid website: https://www.medicaid.gov/medicaid/finance/accountability-guidance/index.html

- Explain how the respondents complete the collection instrument: We will ask the states to either change their Medicaid state plans to reflect payment at or below the Medicare rates for the relevant HCPCS codes and limit on FFP or to demonstrate compliance by filling in their DME fee schedules onto the attached calculation tool with the relevant information- HCPCS code series A, K, & E only, that are relevant to this information collection of durable medical equipment (DME) limit on FFP. The specific HCPCS codes will be updated annually to comply with the statute by the Medicare program and posted on the Medicaid website with other policy guidance at the website listed above. The calculation tool information from the states that choose to show compliance with the statute through the demonstration should also include all relevant modifiers for the codes, descriptors for these codes, Medicaid fee schedule rates, and the claims volume for each unique combination of the codes for each calendar year- all submitted annually. We understand that most states use Medicare's coding system, but some states develop their own coding system, and this needs to be explained as well in their submission. We would also need the definitions of the state modifiers, if not using the Medicare coding modifiers.

- Explain how the respondents submit/report the completed collection instrument: Respondents will attach the completed calculation tool to an e-mail and send it into the dedicated Medicaid DME mailbox (MedicaidDME@cms.hhs.gov).

- Identify whether there are any other documents provided to the respondent. If yes, please include copies with your package:

State Fee Schedule Drop (calculation tool)
State Fee Schedule Drop Instructions (Text document)

- Discuss the use or end result of the reported information: CMS will use this information to calculate compliance with the statute using the State Fee Schedule Drop (calculation tool) we developed that includes the annual DME pricing schedules from Medicare. This calculation tool will help determine compliance with the statute by calculating the allowable expenditures in Medicare and comparing them to the aggregate Medicaid expenditures for the relevant DME items. States will be in compliance with the statute as long as the Medicaid expenditures do not exceed the Medicare expenditures for the same number and type of DME, in the aggregate and there is no draw down of FFP for the excess amount. States over the Medicare expenditure limit that draw down FFP will be informed and may face the limit on federal financial participation (FFP) for DME, which may mean returning any excess FFP.

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 56,004 hours, leaving our burden ceiling at 98,100 hours.

Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2017 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, Table 1 presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

TABLE 1: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Data Entry Keyers	43-9021	15.64	15.64	31.28
Social Science Research Assistants	19-4061	23.57	23.57	47.14

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 other practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method

Burden Estimates

States that choose to demonstrate compliance will fill in their Medicaid specific DME fee schedules onto the attached calculation tool with the relevant information- the HCPCS codes in series A, K, & E only that are relevant to this information collection of durable medical equipment (in 2017 approximately 244 relevant codes). The calculation tool information should also include all relevant modifiers for the codes, descriptors for these codes, Medicaid fee schedule rates, and the claims volume for each unique combination of the codes for each calendar year, all submitted annually. We understand that most states use Medicare's coding

system, but some states develop their own coding system, and this needs to be explained in their submission. We would also need the definitions of the state modifiers, if not using the Medicare coding modifiers. However, not all states will have to complete this calculation tool. States that pay the same as Medicare or some percentage at or lower than 100% of the Medicare fee schedule or its equivalent in the aggregate, will not have to complete this calculation tool to show compliance with this statute, as long as they can show that their rates are at or below the relevant Medicare rates in the aggregate. We do not know how many states will be exempt from these requirements, so we will assume that the burden will fall on all 50 states, the District of Columbia, and potentially all 5 territories, for a total of **56 entities**, hereafter referred to simply as states.

We estimate that each state that is required to complete the calculation tool, will complete the collection of information and submit to us by email in **8 hours** for the initial year, and within **8 hours** for each subsequent reporting year. This includes the requirements for states to submit data in the calculation tool within three months after the end of each calendar year, for the prior calendar year.

The 8 hour estimate takes into account the time to convert the fee schedule into a spreadsheet format that will be submitted to us for analysis in the calculation tool to ensure compliance with the statute and time for a more senior person to review the submission before submitting this to CMS.

Of those 8 hours, we expect a Data Entry Keyer would need no more than 7 hours at $31.28/hr to complete the initial and subsequent years' of data transfer of the relevant fee schedules into the provided calculation tool, complete with codes and descriptors, as previously stated and transfer those to us. A Social Science Research Assistant would need no more than 1 hour at $47.14/hr to review the initial and subsequent year spreadsheets before submitting them to us. The overall burden would therefore be **448 hours** (56 respondents x 8 hr) at a cost of **$14,901.60** (56 respondents x [(7 hr x $33.28/hr) + (1 hr x $47.14/hr)]) or $266.10 per state/territory ($14,901.60/56 respondents).

Information Instruments and Instruction/Guidance Documents

State Fee Schedule Drop (calculation tool)
State Fee Schedule Drop Instructions (Text document)

E. Timeline

CMS needs this State Fee Schedule Drop (calculation tool) approved by July 2018 in order to train states to use it for future reporting.