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

Generic Information Collection #75
ARP 1135 State Plan Amendment

January 2022

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.

Section 1901 of the Social Security Act (42 U.S.C. 1936) requires all 50 states and 6 territories to establish a State plan for medical assistance that is approved by the Secretary to carry out the purpose of Title XIX. The State plan is a comprehensive document (approximately 700 pages) comprised of semi-structured templates developed by CMS and completed by State Medicaid agencies. The State plan functions as a contract between the State and Federal government, describing how the State will implement its program in accordance with Federal laws and regulations in order to secure Federal funding.

When a State or territory wants or needs to change its Medicaid program, the State Medicaid agency is responsible for developing an amendment submission for CMS approval, also called a State plan amendment or SPA. The State completes the templates relevant to the program change it seeks and submits the SPA to CMS for approval. The SPA submission includes a CMS-179 transmittal form and the relevant SPA templates the State wishes to update or revise. A State may amend one or more of the plan pages at a time. The templates are semi-structured forms that correspond to the statutory and regulatory Medicaid requirements. The data structure CMS provides in the forms allows States to develop SPAs more efficiently by including only relevant information. The plan pages are organized by subject matters which include Medicaid eligibility, services, payment for services, and general and personnel administration.

When CMS receives the SPA, it has 90 calendar days to approve or disapprove the SPA, or formally request additional information. If CMS does not act within 90 calendar days, the SPA is deemed approved. If CMS formally requests additional information, the review clock stops until the State submits a formal response. When the State formally responds, a second 90-day review clock begins, and CMS must either approve or disapprove the SPA within 90 calendar days. For a State to receive Medicaid Title XIX funding, there must be an approved Title XIX State plan.

B. Description of Information Collection

Section 9811 of the American Rescue Plan (ARP) established new mandatory benefits at 1905(a)(4)(E) for COVID-19 vaccine and vaccine administration and 1905(a)(4)(F) for COVID-19 testing and treatment for both Medicaid and CHIP. The effective date time period for these mandatory benefits is March 11, 2021, ending on the last day of the first calendar quarter that

begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act). Given that regular state plan rules do not allow for effective dates prior to the first day of the quarter in which the state plan amendment (SPA) was submitted, we are allowing states to use Section 1135 SPA process waiver authority to allow states to meet the required timeframes of these provisions. The SPAs will implement mandatory Medicaid coverage and reimbursement for COVID-19 vaccine and vaccine administration and COVID-19 testing and treatment are considered part of the Agency's emergency response to COVID. CMS has issued guidance for each of these provisions, a toolkit for vaccines and vaccine administration and State Health Official letters for testing and treatment[1].

In large part, states have already been providing these services throughout the course of the pandemic and these SPAs will reflect what states have been doing. CMS is primarily using an attestation approach for states to affirm that they are in compliance with the requirements of the provisions mentioned above.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

Wage Estimates

To derive average costs, we are using data from the U.S. Bureau of Labor Statistics' May 2020 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 BLS' mean hourly wage, our estimated cost of fringe benefits and overhead (calculated at 100 percent of salary), and our adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operations Specialist	13-1000	37.66	37.66	75.32

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.

[1] Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration and Cost Sharing under Medicaid, CHIP, and Basic Health Program (May 5, 2021), SHO #21-003 - Medicaid Reimbursement Testing (https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-003.pdf), and SHO #21-006: Mandatory Medicaid and CHIP Coverage of COVID-19-Related Treatment under the American Rescue Plan Act of 2021 (https://www.medicaid.gov/federal-policy-guidance/downloads/sho102221.pdf).

Collection of Information Requirements and Associated Burden Estimates

There will be a total of 56 States and territories as respondents for this request, all of whom made the required entry when the election of Medicaid in its State was made. Therefore, each of the respondents will submit a one-time response resulting in 56 responses the first year and at state option thereafter. We are not setting out burden for such subsequent updates since we have no reliable way of knowing when or how many times a state will update their plan.

States are expected to submit all three preprints and the waiver, as necessary. We are not be able to predict how many states will pursue the waiver request.

We estimate it would take up to 3 hours at $75.32/hr for a business operations specialist to review and complete the preprint/waiver pages. In aggregate, we estimate a one-time burden of 168 hours (56 responses x 3 hr/response) at a cost of $12,654 (168 hr x $75.32/hr) or $226 per State or territory ($12,654/56).

Information Collection Instruments and Instruction/Guidance Documents

As indicated, States and territories must complete coverage requirements for Medicaid beneficiaries to receive coverage of COVID-19 vaccine administration, testing and treatment. These attachments will be submitted using a 179 form and added to the Medicaid state plan to authorize coverage. We are locating these SPAs at section 7.7 of the state plan as this is where CMS's COVID related SPAs are located. The 1135 waiver requests will be saved within CMS operational state files. Approval of these waivers will be included in the approval letter for the related state plan amendments. New attachments to the state plan and the 1135 waiver templates are as follows:

Preprint Attachment 7.7A: Vaccine and Vaccine Administration (New)
Preprint Attachment 7.7B: COVID-19 Testing (New)
Preprint Attachment 7.7C: COVID-19 Treatment (New)
Template for Medicaid Section 1135 Waiver of SPA Submission Requirements (New)

E. Timeline

Our 14-day notice published in the Federal Register on January 7, 2022 (87 FR 980). Comments were due on/by January 21. No comments were received.

These are new mandatory benefits established in Section 9811 of the ARP. States will need to submit these SPAs one time to effectuate the mandatory coverage prior to the end of the public health emergency and it is not yet clear when that date will be. The effective date time period for these provisions is March 11, 2021 ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Act. States will have the option to amend these SPAs while they are in effect. The SPAs will automatically sunset at the end of the time period that they are in effect and that language is included on the SPA preprint.