

Supporting Statement A
Medicaid State Plan Base Plan Pages
CMS-179, OMB 0938-0193

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) works in partnership with States to implement Medicaid, which provides health coverage to millions of Americans. Medicaid is rooted in Federal statute (Title XIX of the Social Security Act), associated regulations and policy guidance, and the approved State plan documents that serve as a contract between CMS and States about how Medicaid will be operated in that State (or Territory). CMS works collaboratively with States (including States and Territories) in the ongoing management of programs and policies.

This 2024 iteration does not propose to revise any of our active collection of information requirements and collection instruments. We have, however, adjusted our cost estimate by using current wage data. Overall, this iteration increases our cost estimate by \$209,216 (see Section 15 for details).

A. JUSTIFICATION

1. Need and Legal Basis

Section 1901 of the Social Security Act (42 U.S.C. 1936) requires States 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 wants 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.

2. Information Users

State Medicaid agencies complete the plan pages and submit them to CMS. CMS reviews the information to determine if the State has met all of the requirements of Title XIX of the Social Security Act provisions the States choose to implement. If the requirements are met, CMS will approve the amendments to the State's Medicaid plan giving the State the authority to implement the flexibilities. If the requirements are not met, CMS will work with the state to modify the submission so that it can move to approval. For a State to receive Medicaid Title XIX funding, there must be an approved Title XIX State plan.

3. Improved Information Technology

The current collection is electronic in the sense that SPAs are normally submitted to CMS via e-mail, generally including either Microsoft Word templates or a scanned version of the paper amendment. CMS is currently developing a structured data system called Medicaid and Chip Program (MACPro) that will become the electronic submission and processing system for this collection and related information. As the new MACPro templates are completed, portions of this collection will be transferred from this collection to the MACPro collection of information (OneMAC) (CMS-10434, OMB 0938-1188). OneMAC is a system that, once completed, will house all of the State Plan pages.

4. Duplication

There is no duplication of similar information.

5. Small Business

State plan amendments are prepared and submitted by states. Consequently, there is no burden on small businesses.

6. Less Frequent Collection

Once any amendment is approved, there is no need to submit additional amendments unless the State initiates a change. This State plan amendment process is rooted in the statutory language found in Title XIX and has been used since the inception of Medicaid in 1965.

7. Special Circumstances

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt

of it;

- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register Notice/Prior Consultation

The 60-day notice published in the Federal Register on June 28, 2024 (89 FR 54002). While comments were due August 27, none were received.

The 30-day notice published on September 3, 2024 (89 FR 71283). Comments must be received by October 3, 2024.

9. Payment/Gift to Respondents

There is no payment or gift to respondents. However, for a State to receive Medicaid Title XIX funding, there must be an approved Title XIX State plan.

10. Confidentiality

The Medicaid State plan is public information. No assurance of confidentiality has been provided to respondents.

11. Sensitive Questions

There are no sensitive questions associated with this collection. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

12. Burden Estimate

Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' (BLS') May 2023 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/2023/may/oes_nat.htm). In this regard, the following table presents

BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

The wage is a comparable position to State employees likely responsible for completing and returning the templates.

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
Business Operations Specialist	13-1000	42.33	42.33	84.66

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 other indirect 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

There will be a total of 56 States and territories as possible respondents for this request, all of whom made the required entry when the election of Medicaid in its State was made. There is no particular methodology or reason why any particular number of States and territories would choose to amend the Title XIX of the Social Security Act funding requirements aforementioned provisions of its Medicaid State plan. The collection is required only if a State determines that a change to its Medicaid program warrants a change in the original response.

If each of the 56 respondents submitted an average of 20 responses per year, this would result in 1,120 responses per year (56 States and territories x 20 responses/yr).

We estimate it would take 20 hours at \$84.66/hr for a business operations specialist to complete and return the templates. In aggregate we estimate an annual burden of 22,400 hours (1,120 responses x 20 hr/response) at a cost of \$1,896,384 (22,400 hr x \$84.66/hr).

Burden Summary

Annual Recordkeeping and Reporting Requirements

Respondents	Responses (per respondent)	Total Responses	Time per Response	Total Annual Time (hr)	Labor Rate (\$/hr)	Total Capital/Maintenance Costs (\$)	Total Annual Cost (\$)
56	20	1,120	20 hr	22,400	84.66	0	1,896,384

Collection of Information Instruments and Instruction/Guidance Documents

The following table lists all collection of information instruments and identifies whether are making any revisions in this 2024 iteration.

Attachments: Inclusive of Plan Page Sections and Status

Exhibit	Section(s)	Attachment and Supplements	Title/Subject	2024 Status (New, Revised, Removed, No Changes)
n/a	n/a	n/a	Transmittal and Notice of Approval of State Plan Material	No Changes
A	2.1 through 2.7 (States)	None	State Plan, Section 2, Coverage and Eligibility	No Changes
A1	2.1 through 2.7 (Territories)	None	State Plan, Section 2, Coverage and Eligibility	No Changes
AA	4.19	None	State Plan, Payment for Services	No Changes
AB	4.19(e)	None	State Plan, Timely Claims Payment	No Changes
AC	4.19(f)	None	State Plan, Provider Participation limitations	No Changes
AD	4.19(g)	None	State Plan, Cost Audits	No Changes
AE	4.19(h)	None	State Plan, Documentation of Payment Rates	No Changes
AF	4.19(i)	None	State Plan, Sufficient Medicaid payment to enlist Providers	No Changes
AG	4.19(k)(1)	None	State Plan, Payment to Physicians for Clinical Lab Services	No Changes
D and E	436.110(a)(10)(A)(i) (I) and 1931	Attachment 2.2-A and Supplements 1 – 3	State Plan, Mandatory Coverage	No Changes
DP	4.19(b)	Supplement 1 to Attachment 4.19 B	State Plan, Payment for FQHCS	No Changes
F and Ga, 6, 7, 8, 8a, 8b, 8c, 9b, 10, 11, 12, 13, 14, and 15 (States)	435 Subpart G and F	Attachment 2.6-A and Supplements 1, 2, 3, 4, 5, 5	State Plan, Groups covered and Agency responsible for determination	No Changes
H and J, 11, 12, 14, and 15 (Territories)	436 Subpart G and F	Attachment 2.6-A and Supplements 1, 2, 3, 4, 7, 8a, 8b, 8c, 9b	State Plan, Eligibility Conditions and Requirements	No Changes
N	Title XVIII	Attachment 4.19-B Section 24	State Plan, Methods and	No Changes

Exhibit	Section(s)	Attachment and Supplements	Title/Subject	2024 Status (New, Revised, Removed, No Changes)
			Standards for Other Types of Care	
O	Title XVIII	Attachment 4.19-B Supplement 1	State Plan, Payment of Medicare Part A and B Deductible and Coinsurance	No Changes
P	Section 4.19(c)	4.19(c)	State Plan, Payment to reserve a bed	No Changes
R S T U	Sections 4.31 through 4.34	None	State Plan, Disclosure by Providers and Agents	No Changes
Y	Section 4.19(d)	None	State Plan, Payment for Long Term Care Facilities	No Changes

13. Capital Costs

There are no capital costs associated with this information collection.

14. Costs to Federal Government

To derive average costs, we used data from OPM's 2024 Salary Table for the locality pay area of Washington-Baltimore-Northern Virginia (https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2024/DCB_h.pdf). Our estimate assumes a base hourly wage of \$60.29/hr for a GS-13 step 3. To include the cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), our adjusted hourly wage estimate is \$120.58/hr (\$60.29/hr x 2).

The cost is estimated to be \$405,149 (\$120.58/hr x 1,120 possible yearly amendments x 3 hr per amendment on average).

15. Program/Burden Changes

This 2024 iteration does not propose to revise our active collection of information requirements and collection instruments. We have, however, adjusted our cost estimate by using current wage data (from \$75.32/hr using BLS' 2020 wage data to \$84.66/hr using BLS' 2023 wage data). Overall, this iteration increases our cost estimate by \$209,216 (from \$1,687,168 to \$1,896,384).

With the exception of the Transmittal form, we have changed the electronic file name of each of the remaining exhibits for better tracking. We are not proposing any changes to the content of any of our active exhibits.

16. Publication and Tabulation Dates

Medicaid State plans are public documents generally available on the Internet. However, there are no plans to publish the information specifically for statistical use.

17. Expiration Date

The expiration date is displayed on the SPA templates along with our PRA Disclosure Statement.

18. Certification Statement

There are no exceptions.

B. COLLECTION OF INFORMATION EMPLOYING STATISTICAL METHODS

The use of statistical methods does not apply to this collection of information request.