

Supporting Statement – Part A
Medicaid Managed Care and Supporting Regulations
CMS-10856, OMB 0938-1453

Note: For logistical reasons, this is a temporary package that will be folded under its proper place (CMS-10108, 0938-0920) when ready.

BACKGROUND

In our May 10, 2024 (89 FR 41002) final rule (CMS-2439-F; RIN 0938–AU99), amendments to § 438.6(c)(2)(ii)(H) requires the following:

“(H)(1) Ensure that providers receiving payment under a State directed payment attest that they do not participate in any hold harmless arrangement for any health care-related tax as specified in § 433.68(f)(3) of this subchapter in which the State or other unit of government imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold the taxpayer harmless for all or any portion of the tax amount, and\

(2) Ensure either that, upon CMS request, such attestations are available, or that the State provides an explanation that is satisfactory to CMS about why specific providers are unable or unwilling to make such attestations.”

The 60-day notice for such requirements published in the Federal Register on May 21, 2024 (89 FR 44685). Comments must be received by July 22, 2024.

This collection of information does not include any reporting instruments.

A. JUSTIFICATION

1. Need and Legal Basis:

- Section 1902(a)(4) of the Social Security Act requires such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan.
- Under section 1915(a) of the Act, States can implement a voluntary managed care program by executing a contract with organizations that the State has procured using a competitive procurement process. To require beneficiaries to enroll in a managed care program to receive services, a State must obtain approval from CMS under two primary authorities:
- Through a State plan amendment (SPA) that meets standards set forth in section 1932(a) of the Act, States can implement a mandatory managed care delivery system.
- We may grant a waiver under section 1915(b) of the Act, permitting a State to require all Medicaid beneficiaries to enroll in a managed care delivery system, including dually eligible beneficiaries, American Indians/Alaska Natives, or children with special health care needs.

- Section 1902(a)(2) of the Act and its implementing regulation in 42 CFR part 433, subpart B require States to share in the cost of medical assistance expenditures and permit other units of State or local government to contribute to the financing of the non-Federal share of medical assistance expenditures. These provisions are intended to safeguard the Federal-State partnership, irrespective of the Medicaid delivery system or authority.
- There are several types of permissible means for financing the non-Federal share of Medicaid expenditures, including, but not limited to: (1) State general funds, typically derived from tax revenue appropriated directly to the Medicaid agency; (2) revenue derived from health care-related taxes when consistent with Federal statutory requirements at section 1903(w) of the Act and implementing regulations at 42 CFR part 433, subpart B; (3) provider-related donations to the State which must be “bona fide” in accordance with section 1903(w) of the Act and implementing regulations at 42 CFR part 433, subpart B; and (4) IGTs from units of State or local government that contribute funding for the non-Federal share of Medicaid expenditures by transferring their own funds to and for the unrestricted use of the Medicaid agency. Regardless of the source or sources of financing used, the State must meet the requirements at section 1902(a)(2) of the Act and § 433.53 that obligate the State to fund at least 40 percent of the non-Federal share of total Medicaid expenditures (both medical assistance and administrative expenditures) with State funds.
- Under section 1903(w)(4) of the Act, all health care-related taxes must be imposed in a manner consistent with applicable Federal statutes and regulations, which prohibit direct or indirect “hold harmless” arrangements.
- Section 1903(w)(1)(A) of the Act specifies that, for purposes of determining the Federal matching funds to be paid to a State, the total amount of the State's Medicaid expenditures must be reduced by the amount of revenue received by the State (or by a unit of local government in the State) from impermissible health care-related taxes, including, as specified in section 1903(w)(1)(A)(iii) of the Act, from a broad-based health care-related tax for which there is in effect a hold harmless provision described in section 1903(w)(4) of the Act.

2. Information Users:

Reporting: Information required to be reported (see Section 12, below) is used by states for program administration as well as reported to CMS for program compliance monitoring and review. There are no templates used for the state reporting to CMS. Some of the information reported by States may be collected from their contracted managed care plans, but this will be at a state’s discretion.

3. Use of Information Technology:

These changes do not establish any information technology requirements. CMS anticipates that states will likely use information technology to gather and organize the attestations collected pursuant to this requirement.

4. Duplication of Similar Information:

The information collection requirements that are set out below under section 12 do not duplicate any other information collections.

5. Small Businesses:

This requirement imposes an attestation requirement on medical providers. To the extent the medical provider is regarded as a small business, we have determined that there is no significant economic impact on a substantial number of small entities for the requirements in section 12 of this Supporting Statement.

6. Less Frequent Collection:

The timing of this requirement will be affected by a state's individual circumstances, and will be at the discretion of states to determine how often they wish to collect attestations, and then how often the state wishes to establish or modify a state directed payment that would require submission of attestations to CMS. As such, CMS cannot establish a less frequent collection.

7. Special Circumstances:

There are no special circumstances that 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/Outside Consultation:

The 60-day notice published in the Federal Register on May 21, 2024 (89 FR 44685). Comments must be received by July 22, 2024.

9. Payment/Gift to Respondent:

There is no payment/gift to respondents.

10. Confidentiality:

The information received by CMS is not confidential and its release would fall under the Freedom of Information Act.

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. Collection of Information Requirements and Associated Burden Estimates:

The regulatory sections that support our collection of information's requirements are set out in 42 CFR part 438 (Managed Care). The requirements and burden follow.

12.1 Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2022 National Occupational Employment and Wage Estimates (http://www.bls.gov/2022/may/current/oes_nat.htm). In this regard, the following table presents BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs, and our adjusted hourly wage.

National Occupation Titles and Wage Rates

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
Healthcare Practitioners and Technical Occupations	29-0000	46.52	46.52	93.04
Software and web developers, programmers, and testers	15-1250	60.07	60.07	120.14

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 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.

12.2 Collection of Information Requirements and Associated Burden Estimates:

Subpart A-General Provisions

Subpart A specifies requirements for states and managed care plans including contract requirements and payment.

Section 438.6 Special Contract Provisions Related to Payment

In our May 10, 2024 (89 FR 41002) final rule (CMS-2439-F; RIN 0938–AU99), amendments to § 438.6(c)(2)(ii)(H) will require all States with managed care delivery systems to collect attestations from providers who would receive an SDP attesting that they do not participate in any hold harmless arrangements. The paperwork burdens associated with this requirement include the following for States: developing instructions and communication for providers/plans; recordkeeping; and reporting to CMS when requested. For providers, the burden associated with this requirement relates to reviewing and signing the attestations. Although States will have the flexibility to delegate work of collecting attestations to managed care plans, we cannot predict how many States will elect this option. As such, we are not accounting for that burden separately in these estimates.

States: We estimate that 44 States with MCOs, PIHPs and PAHPs will need to develop an attestation process and prepare attestations and communicate with providers. For each State, we estimate on a one-time basis it will take 200 hours at \$79.50/hr for a business operations specialist to plan the data collection process and develop the attestations and communications providers, and 200 hours at \$120.14/hr for a software and web developers, programmers, and testers to program an ingest and recordkeeping process for the attestations. In total, we estimate a one-time burden of \$1,756,832 and 17,600 hours (44 States x [(200 x \$79.50/hr) + (200 x \$120.14/hr)]), or \$39,928 per State. Taking into account the 50 percent Federal administrative match, we estimate one time cost per State of \$19,964 ([\$15,900 + \$24,028] x 0.5).

On an ongoing basis, we estimate that annually, it will take 200 hours at \$79.50/hr for a business operations specialist to manage the data collection process and 232 hours at \$39.56/hr for an office clerk to input the attestations. On an annual, national basis, we estimate States will submit 55 SDPs across 44 States with MCOs, PIHPs, and PAHPs for which they would need to provide attestations at CMS's request. We estimate at each instance it will take a general and operations manager 2 hours at \$118.14/hr for to prepare the submission and any necessary explanations, or 110 hours annually across all States. In total, we estimate an annual burden of \$1,116,424 and 19,118 hours [(44 States x [(200 x \$79.50) + (232 x \$39.56)]) + (55 SDPs x (2 x \$118.14))], or \$25,373 per State. Taking into account the 50 percent Federal administrative match, we estimate ongoing costs per State of \$12,687 (\$25,373 x 0.5).

Providers: For the purposes of these estimates, we are using a provider estimate of 1,088,050 providers enrolled with MCOs, PIHPs, and PAHPs, based on T-MSIS Analytic Files (also known as TAF) data, that will need to submit an attestation to the State. We are further assuming for the purposes of these estimates that these collections will occur on an annual basis, one per provider, but want to note States may elect different timing or number of attestations per provider that would increase or decrease these estimates. We estimate it will take a healthcare administrator at a provider 6 minutes to review and sign the attestation at \$93.04/hr. In total, we estimate an annual burden of \$10,123,217 and 108,805 hours (1,088,050 providers x (\$93.04/hr x 0.1)).

We have summarized the total burden in Table 1.

12.3 Burden Summary

Table 1: Summary of One time and Ongoing Costs for States and Providers Related to Attestations (§ 438.6(c)(2)(ii)(H)(1) and (2))

(Response Type: R=reporting; RK=recordkeeping; TPD=third-party disclosure)

Requirement	No. Respondents	Total Responses	Response Type	Frequency	Time per Response (hr)	Total Time (hr)	Wage (\$/hr)	Total Cost (\$)	State Share (\$)
§438.6(c)(2)(ii)(H) Attestations - States	44	44	RK	One-time	400	17,600	Varies	1,756,832	878,416
§438.6(c)(2)(ii)(H) Attestations - States	44	44	RK	Annual	435	19,118	Varies	1,116,424	558,212
§438.6(c)(2)(ii)(H) Attestations – Providers	1,088,050	1,088,050	R	Annual	0.1	108,805	Varies	10,123,217	N/A
TOTAL	1,088,094	1,088,138	Varies	Varies	Varies	145,523	Varies	12,996,473	1,436,628

12.4 Collection of Information Instruments and Instruction/Guidance Documents

This collection of information does not include any reporting instruments.

13. Capital Costs (Maintenance of Capital Costs):

There are no capital costs.

14. Cost to Federal Government:

When states submit attestations (and explanations, as applicable) with an SDP proposal, staff will need to review the submission. We expect this will require minimal additional time beyond the regular review process. The approximate amount of staff time utilized will be 30 minutes (0.5 hr) per state submission, for which we estimated previously would be 55 per annum. This will total 28 hours per annum staff time (55 submissions x 0.5 hr). Wage levels would approximate \$94.40/hr (CMS Central Office Staff: 1 FTE (GS-13 Step 1)), costing the government \$5,192 per annum to review this data.

15. Program and Burden Changes:

See section 12 of this Supporting Statement.

16. Publication and Tabulation Dates:

The information submitted to CMS will not be published by CMS. Rather, that information is reviewed as part of the agency's normal oversight activity of State Medicaid managed care

programs. The information collection is undertaken by States. Accordingly, States are responsible for ensuring that information collected is not manipulated and erroneously published.

17. Expiration Date:

The expiration date and PRA Disclosure Statement are displayed.

18. Certification Statement:

There are no exceptions to the certification statement.

B. Collection of Information Employing Statistical Methods

There are no statistical methods.