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MEMORANDUM January 30, 2017

Subject: **CMS collections of information from states under the Medicaid program**[1]

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This memorandum was prepared to enable distribution to more than one congressional office.

The memorandum contains a list of CMS's collections of information from states under the Medicaid program, from a September 2016 search of the Office of Management and Budget (OMB) Office of Information and Regulatory Affairs (OIRA) Information Collection Review database.[2] This database contains summary information on active collections of information that are covered under the federal Paperwork Reduction Act (PRA). The PRA is described in the archived CRS Report R40636, *Paperwork Reduction Act (PRA): OMB and Agency Responsibilities and Burden Estimates*[3] as follows:

> The PRA generally defines a "collection of information" as the obtaining, causing to be obtained, or disclosure of facts or opinions by or for an agency by 10 or more nonfederal "persons." A "person" is defined in the act as including individuals, partnerships, associations, corporations, groups, and any element of a state or local government. Therefore, if a covered agency wants to collect information from 10 or more of these non-federal entities, or to require 10 or more of these entities to provide information to a third party or to the public (e.g., via a product labeling requirement), that information collection or disclosure requirement is probably covered by the PRA.

The U.S. Department of Health and Human Services (HHS) website has additional PRA guidance for HHS agencies:[4]

> PRA clearance is required when standardized data collection from 10 or more respondents is collected in response to a federally sponsored data collection within a 12 month period…
>
> Q. What is meant by "standardized or identical data"?
>
> A. Whether a question is identical depends on whether each respondent or group of respondents (e.g. focus group) is being asked to provide the same level of information on the same subject.

[1] Sweta Haldar provided research assistance in the preparation of this memorandum.

[2] U.S. Office of Management and Budget, Office of Information and Regulatory Affairs, *Search of Information Collection Review*, http://www.reginfo.gov/public/do/PRASearch.

[3] The authors of this report are no longer at CRS. For questions about its content, please contact Maeve P. Carey, Specialist in Government Organization and Management.

[4] U.S. Department of Health and Human Services, *Frequently Asked Questions About PRA / Information Collection*, http://www.hhs.gov/ocio/policy/collection/infocollectfaq.html.

> Identical questions need not be phrased exactly the same way each time they are asked, nor does each respondents need to be asked the same "set of questions."…
>
> Q. Does the Paperwork Reduction Act apply to collections.... which [are] the result of an Executive Order or Statute?
>
> A. The Paperwork Reduction Act is a law and must be complied with regardless of the origin, mode, or reason for the collection. In accordance with the PRA, OMB approval must be obtained prior to collecting information in any situation where 10 or more respondents are involved and the questions are standardized in nature.

We searched the OMB OIRA Information Collection Review (ICR) database with the following parameters:

- Agency: *Department of Health and Human Services*
- Sub Agency: *Centers for Medicare & Medicaid Services*
- Text: *Medicaid.* This search box is described as searching the "majority of text boxes" in the database.[5]
- ICR Status: *Active* or *Received in OIRA.* This limits the search to currently active information collections, or those that are pending OIRA review. This search excludes temporary, one-time, or expired information collections that are no longer active.
- Affected Public: *State, Local, and Tribal Governments.*[6]

The database search was conducted over several days in September 2016. The same search conducted today would yield different results, due to new, revised, or expired database records.

In the memorandum, a summary list of the database records that met our search criteria can be found beginning on page 4. Following the summary list, for each record we compiled the information directly from the ICR database that is associated with the following fields:[7]

- The **Information Collection** heading lists the database record "Title," as reflected in the ICR database. The headings are also hyperlinked to the database record.[8]
- The **Summary** subheading lists the database record "Abstract" and/or excerpts from "Supporting Statements and Other Documents" as provided in the database.[9]
- The **Statutory or Regulatory Citations** subheading lists citations from the US Code (U.S.C.) and Code of Federal Regulations (C.F.R.), as they are cited in the database

[5] We also searched *Medical Assistance* (an alternative name for Medicaid) and *XIX* (because Medicaid is authorized under Social Security Act Title XIX). These searches did not yield additional records that were not already retrieved from the *Medicaid* search.

[6] If an information collection (IC) applies to both states and territories, it should show up in this search because states would be part of the "Affected Public." But if an information collection applies only to territories, it may not appear in this search, because there are fewer than 10 territories, and the PRA applies only to information collections affecting at least ten respondents.

[7] The descriptions contained herein come directly from the Office of Information and Regulatory Affairs (OIRA) Information Collection Review database. As a result, they may not meet CRS standards for completeness and accuracy and may contain undefined acronyms, incomplete sentences, inconsistencies in capitalization and punctuation and/or unspecified information (e.g., "the Secretary").

[8] Each requirement is hyperlinked to the corresponding record in the Information Collection Review database. To expand a database record, check "All." In the database record, one may also click "View Supporting Statement and Other Documents" and particular information collection (IC) titles for additional information.

[9] Each IC record has its own "Abstract" and "Supporting Statements." For example, although "Supporting Statement Part A" is cited numerous times in this memorandum, the citations are not all referring to the same document but instead are referring to the unique document contained in each record.

record's "Authorizing Statute," and the "Supporting Statement" sections on "Background" and "Need and Legal Basis."

- The **Reporting Frequency** subheading notes the frequency of the information collection, if specified in the database record under "Time Burden (Hours)" or in the "Supporting Statements."
- **Can be submitted electronically?** and **Percentage of Respondents Reporting Electronically** reflects those information collection database fields available through the "View Information Collection (IC) List."
- **Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments** has the collecting agency's time burden estimates for "State, Local, and Tribal Governments," as reflected in the database. The database does not have separate burden estimates specifically for "States."[10]
- **Active or Received in Office of Information and Regulatory Affairs (OIRA)** indicates whether this is a currently active information collection, or an information collection that is pending OIRA review.

Appendix A includes a list of acronyms used in this memorandum.

Note that the search may not be comprehensive. For example, it did not capture the following information:

- It would not have information collections where the questions are not standardized in nature. As noted above, this means the PRA only applies when respondents are "being asked to provide the same level of information on the same subject."[11]
- It would not have information collections that apply to fewer than 10 states. The HHS website notes that "The PRA only applies to collections directed at 10 or more respondents, but with one important exception. Any information requirement in a 'rule of general applicability' is presumed to affect or potentially affect at least 10 respondents, even if the [operating division] expects there to be fewer respondents. A rule should be considered to have general applicability unless you can demonstrate that it would be impossible for there to ever be 10 respondents." [12] For example, the database may not include information collections associated with demonstration programs where the statutory authority for the demonstration limits state participation to less than 10 states.

[10] The time burden estimates may include, for example, the burden of gathering the information, record-keeping, analyzing the information, and making it available to the public, in addition to the burden of reporting the information to CMS.

[11] An example of a state requirement that has been omitted from this memorandum based on this logic relates to state screening of Medicaid providers as a condition of participation in the Medicaid program. Sections 1902(a)(77) and 1902(kk) of the Medicaid statute (title XIX of the Act) require states to comply with the Medicare provider screening processes when determining whether providers and suppliers meet Medicaid program participation requirements, and when imposing temporary enrollment moratoria for those providers who do not meet these requirements. Medicaid provider screening measures may vary according to the provider's categorical risk level (i.e., "limited," "moderate" or "high"), and state Medicaid agencies may rely on the screening results of Medicare contractors, other state Medicaid agencies, or other state CHIP programs. Provider screenings must occur at least every 5 years and may include the verification of an active provider license, on-site visits, and criminal background checks (including fingerprinting), among others. Because each state records the results via its own chosen mechanism and there is no standard, nationwide form that the state is required to submit to CMS to track these results, this requirement has not been included in our list.

[12] U.S. Department of Health and Human Services, *Frequently Asked Questions About PRA / Information Collection*, http://www.hhs.gov/ocio/policy/collection/infocollectfaq.html.

For another example, the database may not include information collections applying only to territories, because there are fewer than ten territories.[13] In a final example, states are required to notify the Secretary of HHS in writing before imposing (or extending an existing) provider moratorium. Such requirements would not be captured because they are triggered on a state-by-state basis.

- It would not have Medicaid-related information collections where CMS is not the sponsoring federal agency. For example, state Medicaid Fraud Control Units file annual reports with the HHS Office of Inspector General.[14] Because these reports are not collected by CMS, this information collection would be excluded by our search.
- It would not have information collections where CMS is violating the PRA by failing to obtain OIRA review and clearance of its information collection(s). We do not know whether any such information collections exist.
- It would not have reporting requirements in statute or regulation that CMS has decided not to implement or enforce. The database only reflects instances where CMS is actually planning or attempting to collect information.
- It excludes information collections under waiver arrangements (e.g., those authorized under Section 1115 of the Social Security Act and/or Section 1915 of the Social Security Act), or other demonstration or grant programs (e.g., those approved under the Centers for Medicare and Medicaid State Innovations or via another Medicaid statutory authority). While the information collections list included in this memorandum includes a generic reporting requirement associated with Section 1115 demonstration waivers, it does not include state-specific reporting requirements as outlined in the waiver Special Terms and Conditions documents. Similarly, while demonstration programs that fit the criteria specified above for inclusion in the OIRA Information Collection Review (ICR) database (e.g., the Medicaid Emergency Psychiatric Services Demonstration) have been included in this memorandum, CRS did not include any additional such programs.

The Medicaid information collections (ICs) that appear in this memorandum include:

1. Annual Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) Participation Report (CMS-416);
2. Medicaid Disproportionate Share Hospital Annual Reporting (CMS-R-266);
3. Quarterly Medicaid and CHIP Budget and Expenditure Reporting for the Medical Assistance Program, Administration and CHIP (CMS-10529);
4. State Medicaid Eligibility Quality Control Sampling Plan;
5. Electronic Health Record Incentive Program-Stage 3 (CMS-10552), Section 495.316 Quarterly Reporting;
6. Medicaid Drug Utilization Review (DUR) Annual Report (CMS-R-153);
7. Medicaid Drug Rebate Program Forms (CMS-368 and CMS-R-144);
8. Income and Eligibility Verification System Reporting and Supporting Regs. (CMS-R-74);
9. Medicaid Statistical Information System (MSIS) and the Transformed - Medicaid Statistical Information System (T-MSIS) (CMS-R-284);

[13] The five territories are American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

[14] OMB, OIRA, Information Collection Review database, "State Medicaid Fraud Control Units Annual Report and Recertification Application," http://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201401-0990-001.

10. Withholding Medicare Payments to Recover Medicaid Overpayments and Supporting Regulations in 42 CFR 447.31 (CMS-R-21);
11. State Plan Under Title XIX of the Social Security Act (Base plan pages, Attachments, Supplements to Attachments) (CMS-179);
12. Medicaid Report on Payables and Receivables;
13. External Quality Review of Medicaid MCOs and Supporting Regulations in 42 CFR 438.360, 438.362, and 438.364 (CMS-R-305);
14. Medicare and Medicaid; Programs For All-Inclusive Care For The Elderly (PACE) Contained in 42 CFR 460.12-460.210;
15. Medicare and Medicaid; Programs For All-Inclusive Care For The Elderly (PACE) Contained in 42 CFR 460.12-460.210 (CMS-R-244);
16. Medicaid Managed Care and Supporting Regulations;
17. Medicaid Managed Care and Supporting Regulations (CMS-10108);
18. 1932 State Plan Amendment Template, State Plan Requirements, and Supporting Regulations in 42 CFR 438.50 (CMS-10120);
19. Monthly State File of Medicaid/Medicare Dual Eligible Enrollees (CMS-10143);
20. Payment Error Rate Measurement in Medicaid & Children's Health Insurance Program (CHIP);
21. Payment Error Rate Measurement - State Medicaid and CHIP Eligibility;
22. PACE State Plan Amendment Pre-print (CMS-10227);
23. Administrative Requirements for Section 6071 of the Deficit Reduction Act of 2005 (CMS-10249);
24. CHIPRA 2009, Dental Provider and Benefit Information Posted on Insure Kids Now! Website (CMS-10291);
25. Recovery Act - Reporting Requirements for States Under FMAP Increase and TMA Provisions (CMS-10295);
26. Recovery Act - Reporting Requirements for States Under FMAP Increase and TMA Provisions (CMS-10295);
27. State Medicaid HIT Plan (SMHP) and Template for Implementation of Section 4201 of ARRA (CMS-10292);
28. Tribal Consultation State Plan Amendment Template (CMS-10293);
29. Methods for Assuring Access to Covered Medicaid Services Under 42 CFR 447.203 and 447.204 (CMS-10391);
30. Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010 (CMS-10410);
31. Generic Clearance for Medicaid and CHIP State Plan, Waiver, and Program Submissions;
32. Medicaid Program; Review and Approval Process for Section 1115 Demonstrations (CMS-10341);
33. Medicaid and CHIP Program (MACPro) (CMS-10434);
34. Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment;
35. Medicaid Incentives for Prevention of Chronic Diseases Evaluation (CMS-10477);
36. Medicaid Emergency Psychiatric Services Demonstration Evaluation;

37. Nationwide Consumer Assessment of Healthcare Providers and Systems (DCAHPS) Survey for Adults in Medicaid (CMS-10493);
38. Improving Quality of Care in Medicaid and CHIP through Increased Access to Preventive Services, State Survey (CMS-10521);
39. Executive Summary Form for Research Identifiable Data (CMS-10522);
40. Medical Necessity and Contract Amendments Under Mental Health Parity (CMS-10556);
41. State Review of Accreditation Status, Medicaid Managed Care Quality Rating System, and Quality Strategy (QS) and Supporting Regulations in 438.310, 438.330, 438.332, 438.334, and 438.340 (CMS-10553);
42. State Plan Preprint for Medicaid Recovery Audit Contractor (RAC) Program (CMS-10343);
43. State Medicaid Eligibility Quality Control Sample Selection Lists and Supporting Regulations;
44. Medicaid Eligibility and Enrollment (EE) Implementation Advanced Planning Document (IAPD) Template (CMS-10536); and
45. HIPAA Administrative Simplification Non-Privacy Enforcement.

Information Collection 1. Annual Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) Participation Report (CMS-416)

Summary

“States are required to submit an annual report on the provision of EPSDT services to CMS pursuant to section 1902(a)(43)(D) of the Social Security Act. These reports provide CMS with data necessary to assess the effectiveness of State EPSDT programs, to determine a state's results in achieving its participation goal, and to respond to inquiries. Respondents are State Medicaid agencies. The data is due April 1 of every year so States need to have the form and instructions as soon as possible in order to report timely.” (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

SSA §1902(a)(43)(D)/42 U.S.C. 1396a(a)(43)(D). P.L. 101-239 sec. 6403 (Name of Law: EPSDT Defined).(Source: Authorizing Statute(s))

“State Medicaid Manual § 2700.4 contains form CMS-416, instructions for completion of the form, and the required PRA disclosure statement.” (Source: Supporting Statement Part A, p. 1)

Reporting Frequency

“Annual”

Can be Submitted Electronically?

“Yes”

Percentage of Respondents Reporting Electronically

“100%”

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

1,834 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

“Active”

Information Collection 2. Medicaid Disproportionate Share Hospital Annual Reporting (CMS-R-266)

Summary

“Section 1923(a)(2)(D) of the Social Security Act requires the States to submit an annual report that identifies each DSH payment under the State's Medicaid program in the preceding fiscal year and the amount of DSH payments paid to that hospital in the same year and such other information as the Secretary [of Health and Human Services (HHS)] determines necessary to ensure the appropriateness of DSH payments. The information supplied will satisfy the requirements under Section 1923(a)(2)(D) of the Act as well.” (Source: Abstract)

“Section 1923(j)(1) of the [Social Security] Act requires States to submit an annual report that includes the following:

- Identification of each [hospital] that received a DSH payment under the State’s Medicaid program in the preceding fiscal year and the amount of DSH payments paid to that hospital in the same year.
- Such other information as the Secretary [of HHS] determines necessary to ensure the appropriateness of DSH payments.” (Source: Supporting Statement Part A, p. 1)

Statutory, Regulatory or CMS Guidance Citations

[Social Security Act] SSA § 1923(a)(2)(D) and 1923(j)(1)/42 U.S.C. 1396r–4(a)(2)(D) and (j)(1). P.L. 108-173, §1001 (Name of Law: Medicare Modernization Act) (Source: Authorizing Statute(s))

Reporting Frequency

“Annual”

Can be Submitted Electronically?

“Yes”

Percentage of Respondents Reporting Electronically

“100%”

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

2,142 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

“Active”

Information Collection 3. Quarterly Medicaid and CHIP Budget and Expenditure Reporting for the Medical Assistance Program, Administration and CHIP (CMS-10529)

Summary

“MBES/CBES is a financial reporting system that produces budget and expenditures for Medical Assistance and Children's Health Insurance Program. All forms (CMS-21, -21B, -37, and -64) are to be filed on a quarterly basis and need to be certified by the States to the CMS.” (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

[Social Security Act] SSA §1903(d)/ 42 U.S.C. 1396b(d). Balanced Budget Act of 1997, P.L. 105-33, §§4901, 4911, 4912.

“On April 1, 2014, the Protecting Access to Medicare Act of 2014 (Public Law 113-93) was enacted. The law included a 2-year ‘Demonstration Program to Improve Community Mental Health Services’ at Section 223 of the Act." This added several reporting lines to the forms. (Source: Justification for a Nonsubstantive Change, p. 1)

Reporting Frequency

“Quarterly”

Can be Submitted Electronically?

“Yes”

Percentage of Respondents Reporting Electronically

“100%”

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

17,920 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

“Active”

Information Collection 4. State Medicaid Eligibility Quality Control Sampling Plan

Summary

"MEQC is operated by the State Title XIX agency to monitor and improve the administration of its Medicaid system. The MEQC system is based on monthly State reviews of Medicaid and Medicaid expansion under title XXI cases by States performing the traditional sampling process identified through statistically reliable statewide samples of cases selected from the eligibility files. These reviews are conducted to determine whether or not the sampled cases meet applicable State title XIX or XXI eligibility requirements when applicable. The reviews are also used to assess beneficiary liability, if any, and to determine the amounts paid to provide Medicaid services for these cases...."

"State title XIX agencies are required to submit sampling plan revisions 60 days prior to the corresponding review period and universe estimates and sampling intervals 2 weeks prior to the first selection of the review period. CMS or its contractors reviews the plans to ensure States are using valid statistical methods for sample selection." (Source: Supporting Statement Part A, pp. 1-2)

Statutory, Regulatory or CMS Guidance Citations

42 USC 1396b/ SSA §1903(u) (Name of Law: Payment to States). 42 CFR 431.814. (Source: Authorizing Statute(s))

"The collection of information is also necessary to implement provisions from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3) with regard to the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs." (Source: Supporting Statement Part A, p. 2)

Supporting regulations are at 42 CFR 431.800 - 431.865 (Source: Supporting Statement Part A, p. 2)

Reporting Frequency

Not specified

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"90%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

480 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 5. Electronic Health Record Incentive Program-Stage 3 (CMS-10552), Section 495.316 Quarterly Reporting

Summary

"Title IV of Division B of the Recovery Act amends titles XVIII and XIX of the Social Security Act (the Act) by establishing incentive payments to eligible professionals (EPs), eligible hospitals and critical access hospitals (CAHs), and Medicare Advantage (MA) organizations participating in the Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified EHR technology." (Source: Supporting Statement Part A, p. 1)

"The Centers for Medicare and Medicaid Services is requesting approval to collect information from eligible professionals (EPs), eligible hospitals and critical access hospitals (CAHs) in order to implement requirements under Stage 3 of the Medicare and Medicaid EHR Incentive Programs." (Source: Abstract)

State-specific requirements are in 42 CFR 495.316, "State monitoring and reporting regarding activities required to receive an incentive payment." In general, States must submit the following to CMS: a State Medicaid Health Information Technology Plan; annual reports on EHR provider adoption, implementation, and upgrade, and aggregated, de-identified meaningful use data; and quarterly reports on "provider-level attestation data for each EP and eligible hospital that attests to demonstrating meaningful use."

Statutory, Regulatory or CMS Guidance Citations

42 CFR 495.316, P.L. 111-5, title IV of Division B and Title XIII of Division A (Name of Law: The American Recovery and Reinvestment Act of 2009) (Source: Authorizing Statute(s), Supporting Statement Part A, p. 5)

"This information collection serves to implement the HITECH Act. To avoid duplicate payments, all EPs are enumerated through their individual National Provider Identifier (NPI), and all eligible hospitals and CAHs are enumerated through their CMS Certification Number (CCN). State Medicaid agencies and CMS use the provider tax identification number and NPI or CCN combination to make payments; validate payment eligibility; and detect and prevent duplicate payments for EPs, eligible hospitals, and CAHs." (Source: Supporting Statement Part A, pp. 1-2)

Reporting Frequency

"Quarterly"

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

4,480 hours for State, Local, and Tribal Governments; separate time burden for private sector.

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Received in OIRA (New collection of information)."

Information Collection 6. Medicaid Drug Utilization Review (DUR) Annual Report (CMS-R-153)

Summary

"Section 4401 of the Omnibus Budget Reconciliation Act of 1990 and section 1927(d) of the Social Security Act requires States to provide for a Medicaid Drug Utilization Review (DUR) program for covered outpatient drugs. The DUR program is required to assure that prescriptions are appropriate, medically necessary and are not likely to result in adverse medical results. Each State DUR program must consist of prospective drug use review, retrospective drug use review, data assessment of drug use against predetermined standards, and ongoing educational outreach activities. In addition, States are required to submit an annual DUR program report that includes a description of the nature and scope of State DUR activities as outlined in the statute and regulations. The Centers for Medicare and Medicaid Services, Center for Medicaid, CHIP and Survey and Certification, is requesting a 3-year approval of the State data collection requirements, the CMS forms CMS-R-153, CMS-R-153a, CMS-R-153b, and CMS-R-153c data collection instruments with instructions and the annual reporting contained in the Medicaid Drug Utilization Review regulation." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

P.L. 101 – 508, sec. 4401 (Name of Law: Reimbursement for prescribed drugs); 42 USC 1396r-8 (Name of Law: Payment for Covered Outpatient Drugs) (Source: Authorizing Statute(s))

"The authority for requiring States to collect data for the DUR program is section 1927(g) of the Social Security Act (the Act) and implementing regulations at 42 CFR 456.700." (Source: Supporting Statement Part A, p. 1)

Reporting Frequency

"Annual"

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

20,808 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 7. Medicaid Drug Rebate Program Forms (CMS-368 and CMS-R-144)

Summary

"Section 1927 of the Social Security Act requires each State Medicaid agency to report quarterly prescription drug utilization information to drug manufacturers and to CMS via form CMS-R-144. As part of this information, the State Medicaid agencies are required to report the total Medicaid rebate amount they claim they are owed by each drug manufacturer for each covered prescription drug product each quarter. In accordance with new reporting requirements established by the Patient Protection and Affordable Care Act, form CMS-R-144 is being revised to include a new column that will enable States to distinguish between fee-for-service and managed care utilization." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

Section 1927 of the Social Security Act; P.L. 111 – 148, sec. 2501(c) (Name of Law: Patient Protection and Affordable Care Act) (Source: Authorizing Statute(s))

Reporting Frequency

"Quarterly" (Source: Abstract)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

12,101 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 8. Income and Eligibility Verification System Reporting and Supporting Regs. (CMS-R-74)

Summary

"This collection is necessary to verify income and eligibility requirements for Medicaid recipients, as required by Section 1137 of the Social Security Act." (Source: Abstract)

"States must submit a State Plan Amendment (SPA) to CMS to document their established income and eligibility verification system and their participation in PARIS" [Public Assistance Reporting Information System].

Additionally, 42 CFR 945(c) requires State Medicaid agencies to furnish income and eligibility information to other agencies in the State, other States, and certain Federal programs. (Source: Supporting Statement A, p. 1)

Statutory, Regulatory or CMS Guidance Citations

"The information collected is used to verify the income and eligibility of Medicaid applicants and recipients, as required by Section 1137 of the Social Security Act. Final regulations to implement Section 1137 of the [Social Security] Act were published February 28, 1986. Subsequent final amendments to the regulations were published on February 27, 1987; March 2, 1989; October 7, 1992; January 31, 1994; January 11, 2001 and March 23, 2012. These regulations provide the standards States use with respect to the verification of applicant and beneficiary eligibility, the requirements related to use of an individual's social security number, as well as release of information..."

"The Qualifying Individual (QI) Program Supplemental Funding Act of 2008 amended Section 1903(r) of the Social Security Act to incorporate the requirement that States include data matching through the Public Assistance Reporting Information System (PARIS) in their Income and Eligibility Verification Systems (IEVS)...."

"Section 1413 of the Affordable Care Act (Pub. L. 111-148 as amended by Pub. L. 111-152) established new requirements for streamlining eligibility and enrollment procedures, including more modern and efficient verification processes. Many of the original provisions implementing section 1137 of the Act were replaced with new requirements to implement these new streamlined processes." (Source: Supporting Statement A, p. 1)

P.L. 110 – 379, sec. 3(a)(3) (Name of Law: QI Program Supplemental Funding Act of 2008) (Source: Authorizing Statute(s))

In addition to submitting a State Plan Amendment, States must also follow 42 CFR 435.945(c).

Reporting Frequency

"Because CMS no longer prescribes the frequency and number of inquiries for applicants, the State has discretion to determine if, and how often, it will query this information outside the application and renewal process. Annual reporting is not mandated, but States are required to furnish data on the elements periodically if requested by the Secretary [of HHS]." (Source: Supporting Statement A, p. 3)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

1,130 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 9. Medicaid Statistical Information System (MSIS) and the Transformed - Medicaid Statistical Information System (T-MSIS) (CMS-R-284)

Summary

“State data are reported by the Federally mandated electronic process, known as MSIS is currently collecting eligibility and claim data in 5 separate files. These data are the basis of actuarial forecasts for Medicaid service utilization and costs; of analysis and cost savings estimates required for legislative initiatives relating to Medicaid and for responding to requests for information from CMS components, the Department, Congress and other customers. The expanded version of MSIS is now referred to as TMSIS will incorporate 3 additional files (Provider, Managed Care Plans, and Third Party Liability).” (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

“MSIS: The Balanced Budget Act of 1997 (Section 4753) mandated that States report their Medicaid data via MSIS. The Act required that all States implement MSIS by January 1, 1999....”

“T-MSIS: States have already increased their data submission frequency from quarterly to monthly under the authority determined by the Secretary of Health and Human Services and based on legislative authority given via The Medicaid Data Reporting Requirements found at the Social Security Act § 1903(r)(1)(F) as added by the Balanced Budget Act of 1997, P.L. 105-33 § 4753(a)(1), and amended by the ACA, P.L. 111-148 § 6504, to include data elements the Secretary determines are necessary for program integrity, oversight, and administration.” (Source: Supporting Statement Part A, p. 4)

P.L. 114 – 148, sec. 6504 (Name of Law: ACA); P.L. 105 - 32, sec. 4753 (Name of Law: BBA); P.L. 108 - 173, sec. 103 (Name of Law: MMA); 42 USC 1935 (Name of Law: Medicare Prescription Drugs); 42 USC 1396b(r) (Name of Law: MMIS); and 42 USC 1301 (Name of Law: HIPAA Law) (Source: Authorizing Statute(s))

Reporting Frequency

“Monthly” (Source: Supporting Statement Part A, p. 4)

Can be Submitted Electronically?

“Yes”

Percentage of Respondents Reporting Electronically

“100%”

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

7,880 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

“Active”

Information Collection 10. Withholding Medicare Payments to Recover Medicaid Overpayments and Supporting Regulations in 42 CFR 447.31 (CMS-R-21)

Summary

"Overpayments may occur in either the Medicare and Medicaid program, at times resulting in a situation where an institution or person that provides services owes a repayment to one program while still receiving reimbursement from the other. Certain Medicaid providers which are subject to offsets for the collection of Medicaid overpayments may terminate or substantially reduce their participation in Medicaid, leaving the State Medicaid agency unable to recover the amounts due. These information collection requirements give CMS the authority to recover Medicaid overpayments by offsetting payments due to a provider under the program." (Source: Abstract)

"To effectuate the withholding, the Medicaid State agency must furnish the CMS Regional Office (RO) with certain documentation that identifies the provider and the Medicaid overpayment amount (that is, statement of reason for withholding, amount and type of overpayment, date overpayment was determined, closing date of pertinent cost reports, quarter in which overpayment was reported on quarterly expenditure report, as needed and upon request the names and addresses of provider's officers and owners at time of overpayment, reports of attempted contact with provider concerning overpayment recovery, and a copy of the provider's agreement with CMS). The Medicaid State agency must also furnish documentation to show that the provider was notified of the overpayment and that demand for the overpayment was made. The data being requested is normally already accumulated in one form or another by the States and territories. Additionally, an opportunity to appeal the overpayment determination must have been afforded the provider by the Medicaid State agency. Lastly, Medicaid State agencies must notify CMS when to terminate the withholding." (Source: Supporting Statement A, p. 1)

Statutory, Regulatory or CMS Guidance Citations

"Section 2104 of the Omnibus Reconciliation Act of 1981 (Pub.L. 97-35) provides CMS with the authority to withhold Federal Medicare payments to recover Medicaid overpayments that the Medicaid State agency has been unable to recover."

"Effective June 10, 1985, regulation BPO-20-F was implemented to provide a remedy to this problem. The section of the regulation pertaining to recovery of Medicaid overpayments is codified at 42 CFR 447.31. It contains provisions giving CMS the authority to recover Medicaid overpayments by offsetting payments due to a provider under Medicare." (Source: Supporting Statement A, p. 2)

P.L. 97 – 35, sec. 2104 (Name of Law: Omnibus Reconciliation Act of 1981) (Source: Authorizing Statute(s))

Reporting Frequency

"The information is reported on an as-needed basis. If the information was collected less frequently, CMS would not be able to implement this withholding procedure to recoup the Medicaid overpayment and the need for litigation in these overpayment situations would increase. Litigation is a more costly collection method." (Source: Supporting Statement A, p. 2-3)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

“100%”

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

81 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

“Active”

Information Collection 11. State Plan Under Title XIX of the Social Security Act (Base plan pages, Attachments, Supplements to Attachments) (CMS-179)

Summary

“The Medicaid State base plan pages and attachments are documents utilized by State and territorial agencies which have the responsibility for administering the Medicaid program. The Medicaid State plan is comprised of "pages" and organized by subject matter which include Medicaid eligibility (Section 2), services (Section 3), payment for services (Section 4), and general, financial and personnel administration (Sections 1, 5, 6, 7). When States or territories seek to change selected pages of their State plans, the page(s) are transmitted to the Centers for Medicare & Medicaid Services (CMS) for review and approval by the CMS Central and Regional Offices prior to amending its State plan. Associated with the "CMS-179", a one page cover page that is included in every State plan amendment, the base State plan pages contain approximately 150 documents, and the attachments and supplements contain approximately 500 documents that correspond to implementing regulations in the CFR and statutes in the Social Security Act. The base and plan page documents have the same OMB approval number as the CMS-179. The present revision of the current collection is to revise and update selected pages to comply with Federal laws and regulations.” (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

“Section 1901 of the Social Security Act (42 U.S.C. 1936)”

Reporting Frequency

As needed

Can be Submitted Electronically?

“Yes”

Percentage of Respondents Reporting Electronically

“100%”

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

22,400 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

“Active”

Information Collection 12. Medicaid Report on Payables and Receivables

Summary

“The Chief Financial Officers Act of 1990, as amended by the Government Management and Reform Act of 1994, requires government agencies to produce auditable financial statements. Form CMS-R-199 will collect accounting data from the States on payables and receivables.” (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

“Section 1903(b)(d)(1) of the Social Security Act requires the Secretary [of HHS] to estimate the amount each State should be paid at the beginning of each quarter. This amount is to be based on a report filed by the State. Section 1903(b)(d)(2)(A) of the Social Security Act authorizes the Secretary [of HHS] to pay the amount estimated, reduced or increased to the extent of any overpayment or underpayment for any prior quarter. Section 3515 of CFO Act requires government agencies to produce auditable financial statements in accordance with Office of Management and Budget guidelines on form and content. The Government Management and Reform Act of 1994 requires that all offices, bureaus and associated activities of the 24 CFO Act agencies must be covered in an agency-wide, audited financial statement.” (Source: Supporting Statement Part A, p. 1)

P.L. 101 – 576, sec. 3515 (Name of Law: Chief Financial Officers Act of 1990) (Source: Authorizing Statute(s))

Reporting Frequency

“The information cannot be collected less frequently than once a year, since the law requires annual financial statements.” (Source: Supporting Statement A, p. 2)

Can be Submitted Electronically?

“No”

Percentage of Respondents Reporting Electronically

“0%”

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

392 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Received in OIRA (Reinstatement without change of a previously approved collection)."

Information Collection 13. External Quality Review of Medicaid MCOs and Supporting Regulations in 42 CFR 438.360, 438.362, and 438.364 (CMS-R-305)

Summary

"The results of Medicare reviews, Medicare accreditation surveys, and Medicaid external quality reviews will be used by States in assessing the quality of care provided to Medicaid beneficiaries provided by managed care organizations and to provide information on the quality of the care provided to the general public upon request." (Source: Abstract)

"The law requires that the State agency provide to the EQRO information obtained through methods consistent with the Protocols specified by CMS. This information is generated by an EQRO, other State contractor that is not an MCO or PIHP, or the State, and is used by the EQRO to determine the quality of care furnished by an MCO."

"The regulation extends the availability of the results of EQR to the general public. This allows Medicaid/CHIP enrollees and potential enrollees to make informed choices regarding the selection of their providers. It also allows advocacy organizations, researchers, and other interested parties access to information on the quality of care provided to Medicaid beneficiaries enrolled in Medicaid/CHIP MCOs." (Source: Supporting Statement Part A, p. 2)

Statutory, Regulatory or CMS Guidance Citations

"[SSA] Section 1932(c)(2)(A)(iii) requires that the Secretary have protocols developed to be used in EQRs."

"Section 1932(c)(2)(A)(iv) requires that the results of EQR be made available to participating health care providers, enrollees and potential enrollees of the MCO."

"Section 2103(f) requires managed care providers in the CHIP Program to be subject to the same type of EQR which has been applied to Medicaid managed care providers." (Source: Supporting Statement Part A, p. 2)

P.L. 111 – 3, sec. 403 (Name of Law: CHIPRA of 2009); P.L.. 105 – 33, sec. 4705 (Name of Law: BBA of 1997); 42 USC 1396 (Name of Law: External Independent Review of Managed Care Activities) (Source: Authorizing Statute(s))

Reporting Frequency

Some information is collected annually, biannually or quarterly.

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

451,288 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

“Active”

Information Collection 14. Medicare and Medicaid; Programs For All-Inclusive Care For The Elderly (PACE) Contained in 42 CFR 460.12-460.210

Summary

“PACE organizations must demonstrate their ability to provide quality community-based care for the frail elderly who meet their State's nursing home eligibility standards using capitated payments from Medicare and the State. The model of care includes as core services the provision of adult day health care and multidisciplinary team case management, through which access to and allocation of all health services is controlled. Physician, therapeutic, ancillary, and social support services are provided in the participant's residence or on-site at the adult day health center. PACE programs must provide all Medicare and Medicaid covered services including hospital, nursing home, home health, and other specialized services. Financing of this model is accomplished through prospective capitation of both Medicare and Medicaid payments.” (Source: Abstract)

Per 42 CFR 460.12(a)(2) and 460.30(c), States must develop a State plan amendment. (Source: Supporting Statement Part A, p. 4).

42 CFR 460.152(a)(3) requires that “…the State administering agency must assess the potential participant, including any individual who is not eligible for Medicaid, to ensure that he or she needs the level of care required under the State Medicaid plan for coverage of nursing facility services.” (Source: Supporting Statement Part A, p. 9).

42 CFR 460.160(b) requires that “…at least annually, the State administering agency must reevaluate whether a participant needs the level of care required under the State Medicaid plan for coverage of nursing facility services.” (Source: Supporting Statement Part A, p. 11)

42 CFR 460.164(e) requires that “…before an involuntary disenrollment is effective, the State administering agency must review the documentation and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.” (Source: Supporting Statement Part A, p. 11)

Statutory, Regulatory or CMS Guidance Citations

“Section 4801 of Pub. Law 105-33, the BBA of 1997, authorized coverage of PACE under the Medicare program. It amended title XVIII of the Social Security Act (the Act) by adding section 1894, which addresses Medicare payments to, and coverage of benefits under, PACE. Section 4802 of the BBA authorized the establishment of PACE as a State option under Medicaid. It amended title XIX of the Act by adding section 1934, which directly parallels the provisions of section 1894. Section 4803 of the BBA addresses implementation of PACE under both Medicare and Medicaid, the effective date, timely issuance of regulations, priority and special consideration in processing applications, and transition from PACE demonstration project waiver status.”

"Section 903 of Pub. Law 106-554, the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA) amended section 1894 and 1943 to provide authority for CMS to modify or waive PACE regulatory provisions." (Source: Supporting Statement Part A, pp. 1-2)

P.L. 105 – 33, sec. 4801 (Name of Law: the Balanced Budget Act of 1997); P.L. 106 - 554, sec. 903 (Name of Law: Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000); 42 USC 1395eee (Name of Law: Payments to, and Coverage of Benefits Under Programs for All-Inclusive Care for the Elderly (PACE)); P.L. 108 - 173, sec. 902 (Name of Law: Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)); 42 USC 1396u-4 (Name of Law: Program for All-Inclusive Care for the Elderly (PACE)) (Source: Authorizing Statute(s))

State requirements are laid out in 42 CFR 460.12(a)(2), 460.30(c), 460.152(a)(3), 460.160(b), and 460.164(e). (Source: Supporting Statement Part A, pp. 12-14)

Reporting Frequency

"Annual" (Source: Supporting Statement Part A, p. 11)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

8,175 hours for State, local and tribal governments; separate time burden for non-profits.

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 15. Medicare and Medicaid; Programs For All-Inclusive Care For The Elderly (PACE) Contained in 42 CFR 460.12-460.210 (CMS-R-244)

Summary

"PACE organizations must demonstrate their ability to provide quality community-based care for the frail elderly who meet their State's nursing home eligibility standards using capitated payments from Medicare and the State. The model of care includes as core services the provision of adult day health care and multidisciplinary team case management, through which access to and allocation of all health services is controlled. Physician, therapeutic, ancillary, and social support services are provided in the participant's residence or on-site at the adult day health center. PACE programs must provide all Medicare and Medicaid covered services including hospital, nursing home, home health, and other specialized services. Financing of this model is accomplished through prospective capitation of both Medicare and Medicaid payments." (Source: Abstract)

42 CFR 460.12(b) requires that "States must provide assurance indicating that the State considers the entity to be qualified to be a PACE organization and is willing to enter into a PACE program agreement with the entity." (Source: Supporting Statement Part A, p. 4)

42 CFR 460.30(c) provides that "CMS may only sign program agreements with PACE organizations that are located in States with approved State plan amendments electing PACE as an optional benefit under their Medicaid State plan. The burden associated with this requirement is the time and effort for a State to develop its State plan amendment to elect PACE as an optional Medicaid benefit." (Source: Supporting Statement Part A, p. 6)

42 CFR 460.152(a)(3) requires that "…the State administering agency must assess the potential participant, including any individual who is not eligible for Medicaid, to ensure that he or she needs the level of care required under the State Medicaid plan for coverage of nursing facility services. The burden associated with this requirement is the time and effort necessary for each State administering agency to maintain documentation of each potential participant assessment." (Source: Supporting Statement Part A, p. 13)

42 CFR 460.160(b) requires that "…at least annually, the State administering agency must reevaluate whether a participant needs the level of care required under the State Medicaid plan for coverage of nursing facility services." (Source: Supporting Statement Part A, p. 15)

42 CFR 164(e) requires that "…before an involuntary disenrollment is effective, the State administering agency must review the documentation and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment. The burden associated with this requirement is the time and effort for the State administering agency to review and determine that the PACE organization has adequately documented acceptable grounds for disenrollment." (Source: Supporting Statement Part A, p. 15)

Statutory, Regulatory or CMS Guidance Citations

"Collection of this information is mandated by statute under Sections 1894 and 1934 of the Act and at 42 CFR 460." (Source: Supporting Statement Part A, p. 1)

P.L. 105 – 33, sec. 4801 (Name of Law: the Balanced Budget Act of 1997); P.L. 106 - 554, sec. 903 (Name of Law: Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000); 42 USC 1395eee (Name of Law: Payments to, and Coverage of Benefits Under Programs for All-Inclusive Care for the Elderly (PACE)); P.L. 108 - 173, sec. 902 (Name of Law: Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)); 42 USC 1396u-4 (Name of Law: Program for All-Inclusive Care for the Elderly (PACE)) (Source: Authorizing Statute(s))

State requirements are laid out in 42 CFR 460.12(a)(2), 460.30(c), 460.152(a)(3), 460.160(b), 460.164(e) (Source: Supporting Statement Part A, pp. 18-20)"

Reporting Frequency

"Annual" (Source: Supporting Statement Part A, p. 15)

Can be Submitted Electronically?

Yes

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

10,137 hours for State, local and tribal governments; separate time burden for non-profits.

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

“Received in OIRA (Revision of a currently approved collection)”

Information Collection 16. Medicaid Managed Care and Supporting Regulations

Summary

“These information collections requirements implement regulations that allow States greater flexibility to implement mandatory managed care programs, implement new beneficiary protections, and eliminate certain requirements viewed by State agencies as impediments to the growth of managed care programs. Information collected includes information about managed care programs, grievances and appeals, enrollment broker contracts, and managed care organizations capacity to provide health care services.” (Source: Abstract)

“States use the information collected and reported as part of its contracting process with managed care entities, as well as its compliance oversight role. CMS uses the information collected and reported in an oversight role of State Medicaid managed care programs.” (Source: Supporting Statement Part A, p. 3)

Statutory, Regulatory or CMS Guidance Citations

"Medicaid Managed Care and Supporting Regulations Contained in 42 CFR 438.6, 438.8, 438.10, 438.12, 438.50, 438.56, 438.102, 438.202, 438.204, 438.207, 438.208, 438.210, 438.214, 438.230, 438.236, 438.240, 438.242, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.604, 438.608, 438.710, 438.722, 438.724, 438.730, and 438.810.”

Requirements for States are laid out in 42 CFR 438.6, 438.10, 438.50(b), 438.202, 438.722, 438.724, and 438.810. (Source: Supporting Statement Part A, p. 21)

“Only §§438.202 and 438.207 contain requirements concerning reporting to CMS. Most of the other sections do not involve submitting information to any entity; those that do concern submission of information between the State and plans.” (Source: Supporting Statement Part A, p. 3)

Reporting Frequency

Some information is collected annually, biannually or quarterly.

Can be Submitted Electronically?

“Yes”

Percentage of Respondents Reporting Electronically

“1%”

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

1,483,898 hours for State, local and tribal governments; separate time burdens for private sector and individuals.

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 17. Medicaid Managed Care and Supporting Regulations (CMS-10108)

Summary

"These information collections requirements implement regulations that allow States greater flexibility to implement mandatory managed care programs, implement new beneficiary protections, and eliminate certain requirements viewed by State agencies as impediments to the growth of managed care programs. Information collected includes information about managed care programs, grievances and appeals, enrollment broker contracts, and managed care organizations capacity to provide health care services." (Source: Abstract)

"States use the information collected and reported as part of its contracting process with managed care entities, as well as to fulfill its compliance oversight role. CMS uses the information collected and reported in an oversight role of State Medicaid managed care programs." (Source: Supporting Statement Part A, pp. 2-3)

Statutory, Regulatory or CMS Guidance Citations

"Medicaid Managed Care and Supporting Regulations Contained in 42 CFR 438.1, 438.2, 438.3, 438.4, 438.5, 438.6, 438.7, 438.8, 438.9, 438.10, 438.12, 438.14, 438.50, 438.52, 438.54, 438.56, 438.58, 438.60, 438.62, 438.66, 438.68, 438.70, 438.71, 438.74, 438.100, 438.102, 438.104, 438.106, 438.108, 438.110, 438.114, 438.116, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.228, 438.230, 438.236, 438.242, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.600, 438.602, 438.604, 438.606, 438.608, 438.610, 438.700, 438.702, 438.704, 438.706, 438.708, 438.710, 438.722, 438.724, 438.726, 438.730, 438.802, 438.806, 438.808, 438.810, 438.812, 438.816, and 438.818." (Source: Supporting Statement Part A, p. 1)

State reporting requirements are laid out in 42 CFR 438.3, 438.5, 438.7, 438.50, 438.62(b)(1), 438.66(a) and (b), 438.68, 438.70, 438.602, and 438.818(a)(2). (Source: Supporting Statement Part A, pp. 31-32)

Reporting Frequency

Some information is collected annually, biannually or quarterly.

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"95%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

77,806 hours for State, local and tribal governments; separate time burden for private sector.

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Received in OIRA (Revision of a currently approved collection)."

Information Collection 18. 1932 State Plan Amendment Template, State Plan Requirements, and Supporting Regulations in 42 CFR 438.50 (CMS-10120)

Summary

"Section 1932(a)(1)(A) of the Social Security Act (the Act) grants States the authority to enroll Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and primary care case managers (PCCMs)). Under this authority, a State can amend its Medicaid State plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on Statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This template may be used by States to easily modify their State plans if they choose to implement the provisions of 1932(a)(1)(A)." (Source: Supporting Statement A, p. 1)

"The State Medicaid agencies will complete the template. CMS will review the information to determine if the State has met all the requirements under 1932(a)(1)(A) and 42 CFR 438.50. Once the all the requirements are met, the State will be allowed to enroll Medicaid beneficiaries on a mandatory basis into managed care entities without section 1115 or 1915(b) waiver authority." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

"Section 1901 of the [Social Security] Act (42 U.S.C. 1396) requires that States must establish a State plan for medical assistance that are approved by the Secretary [of Health and Human Services] to carry out the purpose of title XIX. The collection of information is defined in section 1932(a)(1)(A) of the [Social Security] Act and in 42 CFR 438.50." (Source: Supporting Statement A, p. 1)

Reporting Frequency

"Once the amendment is approved, there is no need to resubmit unless changes are made to the program. Without this information, CMS cannot grant a State the authority to implement mandatory managed care programs in the absence of waiver authority." (Source: Supporting Statement A, p. 2)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

85 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

“Active”

Information Collection 19. Monthly State File of Medicaid/Medicare Dual Eligible Enrollees (CMS-10143)

Summary

“The monthly file of dual eligible enrollees will be used to determine those duals with drug benefits for the phased down State contribution process required by the Medicare Modernization Act of 2003 (MMA).” (Source: Abstract)

“The monthly data file is provided to CMS by States on dually eligible Medicaid and Medicare beneficiaries, listing the individuals on the Medicaid eligibility file, their Medicare status and other information needed to establish subsidy level, such as income and institutional status. The file will be used to count the exact number of individuals who should be included in the phased-down State contribution calculation that month. CMS will be able to merge the data with other data files and establish Part D enrollment for those individuals on the file. The file may be used by CMS partners to obtain accurate counts of duals on a current basis.” (Source: Supporting Statement Part A, p. 1)

Statutory, Regulatory or CMS Guidance Citations

“The MMA (Section 103) outlines how the phased-down State contribution amounts are computed... Federal regulations, 423.900 through 423.910 detail the implementation of the phase-down State contribution process, the Subpart S regulations implementing title I of the MMA.” (Source: Supporting Statement Part A, p. 2)

SSA sec. 1935(c) (Name of Law: State Phasedown) (Source: Authorizing Statute(s))

Reporting Frequency

“Monthly”

Can be Submitted Electronically?

“Yes”

Percentage of Respondents Reporting Electronically

“100%”

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

6,120 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 20. Payment Error Rate Measurement in Medicaid & Children's Health Insurance Program (CHIP)

Summary

"Payment Error Rate Measurement (PERM) is established to comply with Improper Payment Information Act (IPIA) of 2002. The program measures improper payments in both Medicaid and State Children's Health Insurance Program (SCHIP). Each PERM cycle will measure payment errors in 17 randomly selected States, so that each State will be measured once every three years. PERM measure three components in each program: fee-for-service, managed care, and eligibility. The payment error in the three components will be combined to calculate an annual payment error rate in Medicaid and CHIP." (Source: Abstract)

"CMS needs to collect capitation payment information from the selected States so that the Federal contractor can draw a sample and review the managed care capitation payments. CMS will also collect State managed care contracts, rate schedules and updates to the contracts and rate schedules. This information will be used by the Federal contractor when conducting the managed care claims reviews." (Source: Supporting Statement Part A, pp. 1-2)

Statutory, Regulatory or CMS Guidance Citations

"Sections 1902(a)(6) and 2107(b)(1) of the Social Security Act grants CMS authority to collect information from the States." (Source: Supporting Statement Part A, p. 2)

"The Payment Error Rate Measurement (PERM) program measures improper payments for Medicaid and the State Children's Health Insurance Program (SCHIP). The program was designed to comply with the Improper Payments Information Act (IPIA) of 2002 and the Office of Management and Budget (OMB) guidance. Although OMB guidance requires error rate measurement for SCHIP, 2009 SCHIP legislation temporarily suspended PERM measurement for this program and changed to Children's Health Insurance Program (CHIP) effective April 01, 2009. See Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Public Law 111-3 for more details." (Source: Supporting Statement Part A, p. 1)

P.L. 107 – 300 (Name of Law: Improper Payment Information Act (IPIA) of 2002); SSA sec. 1902 (Source: Authorizing Statute(s))

Reporting Frequency

"Each PERM cycle will measure payment errors in 17 randomly selected States, so that each State will be measured once every three years." (Source: Abstract)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"10%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

28,050 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 21. Payment Error Rate Measurement - State Medicaid and CHIP Eligibility

Summary

"The Improper Payments Information Act (IPIA) of 2002 requires CMS to produce national error rates for Medicaid and SCHIP. To comply with the IPIA, CMS needs the information to be collected in order to provide some Federal overview of State eligibility determinations to ensure correctness and consistency among States and to use the State-specific error rates as the basis for calculating national eligibility error rates for Medicaid and SCHIP." (Source: Abstract)

"We indicated in the proposed rule and the interim final rule that States would be expected to take some part in the eligibility reviews. We determined that States shall:

- Review eligibility in the same year the States are selected for Medicaid or CHIP fee-for-service and managed care reviews;
- Submit a sampling plan;
- Select monthly samples;
- Submit monthly sample lists of those cases randomly selected for review;
- Conduct the eligibility reviews;
- Report summary and detailed findings to CMS; and
- Provide analysis of the findings and proposed actions in a corrective action plan" (Source: Supporting Statement, pp. 2-3)

"The information collected from the States selected for review will be used by CMS to ensure States use a statistically sound sampling methodology, to ensure the States complete reviews on all cases sampled, and will be used by the Federal contractor to calculate State and national Medicaid and CHIP eligibility error rates." (Source: Supporting Statement Part A, p. 5)

Statutory, Regulatory or CMS Guidance Citations

"The collection of information is necessary for CMS to produce national error rates for Medicaid and CHIP as required by Public Law 107-300, the IPIA of 2002.

"The collection of information is also necessary to implement provisions from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3) with regard to the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs." (Source: Supporting Statement Part A, p. 5)

P.L. 107 – 300, sec. 2 (Name of Law: Improper Payment Information Act (IPIA) of 2002) (Source: Authorizing Statute(s))

Reporting Frequency

Not specified

Can be Submitted Electronically?

“Depends on the form”

Percentage of Respondents Reporting Electronically

Ranges from 0 to 10%, depending on the form.

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

946,164 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

“Active”

Information Collection 22. PACE State Plan Amendment Pre-print (CMS-10227)

Summary

“The Balanced Budget Act of 1997 created Section 1934 of the Social Security Act that established the Program for the All-Inclusive Care for the Elderly (PACE). The legislation established the PACE program as a Medicaid State plan option serving the frail and elderly in the home and community. Pursuant to the notice given in 64 FR 66271 (November 24, 199), if a State elects to offer PACE as an optional Medicaid benefit, it must complete a State plan amendment described as Enclosures 3, 4, 5, 6 and 7. The information, collected by CMS on a one-time basis, is used by CMS to affirm that the State elects to offer PACE as an optional State plan service and the specifications of eligibility, payment and enrollment for the program.” (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

“Pursuant to notice given in the Federal Register, 64 FR 66271 (November 24, 1999), if a State elects to offer PACE as an optional Medicaid benefit, it must complete a State plan amendment preprint packet described as “Enclosures #3, 4, 5, 6 and 7.” (Source: Supporting Statement Part A, p. 1)

42 USC 1396 (Name of Law: PACE-State Option) (Source: Authorizing Statute(s))

Reporting Frequency

“One-time basis” (Source: Abstract)

Can be Submitted Electronically?

“No”

Percentage of Respondents Reporting Electronically

"0%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

140 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 23. Administrative Requirements for Section 6071 of the Deficit Reduction Act of 2005 (CMS-10249)

Summary

"The Centers for Medicare & Medicaid Services (CMS) awarded 31 grants to States to participate in the Money Follows the Person Rebalancing Demonstration (MFP) from January 1, 2007 through September 30, 2011. This demonstration, created by section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171), supports State efforts to ""rebalance"" their long-term support systems by offering $1.75 billion over 5 years in competitive grants to States. Specifically, the demonstration will support State efforts to: a) Rebalance their long-term support system so that individuals have a choice of where they live and receive services; b) Transition individuals from institutions who want to live in the community; and c) Promote a strategic approach to implement a system that provides person centered, appropriate, needs based, quality of care and quality of life services and a quality management strategy that ensures the provision of, and improvement of such services in both home and community-based settings and institutions. The demonstration provides enhanced federal medical assistance percentage (FMAP) for 12 months for qualified home and community-based services for each person transitioned from an institution to the community during the demonstration period." (Source: Abstract)

"CMS issued an Operational Protocol Instruction Guide and template for the development of Operational Protocols for the States selected to participate in the MFP Rebalancing Demonstration. The guide provides instruction on the required elements of the State's Operational Protocol which must be submitted and approved before a State may enroll individuals in the State's demonstration program or begin to claim for service dollars."

"The Deficit Reduction Act of 2005 Section 6071(c)(9) requires the States to provide information and assurances that total expenditures under the State Medicaid program for home and community-based long-term care services will not be less for any fiscal year during the MFP demonstration project than for the greater of such expenditures for fiscal year 2005 or any succeeding fiscal year before the first of the year of the MFP demonstration project. Accordingly, States are required to submit Maintenance of Effort (MOE) form and MFP Budget Forms on an annual basis. Additionally, in order to receive enhanced FMAP, States are required to submit the MFP Demonstration Financial Forms on a quarterly basis."

"Section 6071(g) of the Deficit Reduction Act requires a national evaluation of the MFP demonstration project and a final report to the President and Congress. For the national evaluation, States will be required to submit on a quarterly basis a MFP Finders File, which will include eligibility records for all MFP participants, a MFP Program Participation Data file, that includes precise enrollment dates for each MFP participants and information about their qualifying institution and qualifying community residence,

and a MFP Services File, which will include records for each service funded with MFP grant funds. In addition, States will be required administer an MFP Quality of Life Survey to all MFP participants. The survey will be administered immediately before a participant transitions to the community and twice after transitioning to the community (once about 11 months after transition and again about 23 months after transition). States will be required to submit to CMS the MFP Quality of Life data on a quarterly basis. States will also submit semi-annual progress reports to help CMS and the evaluation contractor monitor the progress of program implementation at the grantee level." (Source: Supporting Statement Part A, pp. 1-2)

Statutory, Regulatory or CMS Guidance Citations

"Under section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171) subsection (c), the Secretary [of Health and Human Services] may require States to meet requirements and provide additional information, provisions, and assurances." (Source: Supporting Statement Part A, p. 1)

Reporting Frequency

"The OP will be submitted to CMS no later than 60 days prior to the planned program implementation date or 12 months after the award date, whichever is earlier. Once the OP is approved, there is no need to resubmit (unless changes are made to the program). At the end of each demonstration grant year, States are required to produce the MOE and MFP Budget Forms on an annual basis. Additionally, in order to receive enhanced FMAP, States are required to submit the MFP Demonstration Financial Forms on a quarterly basis. The MFP Finders file, MFP Program Participation Data file, and MFP Services file will also be submitted on a quarterly basis so that results of the program can be assessed on an ongoing basis." (Source: Supporting Statement Part A, p. 4)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

14,200 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 24. CHIPRA 2009, Dental Provider and Benefit Information Posted on Insure Kids Now! Website (CMS-10291)

Summary

"Secretary [of Health and Human Services] shall work with States, pediatric dentists, and other dental providers to include on the Insure Kids Now (IKN) website (http://www.insurekidsnow.gov/) and hotline (1-877-KIDS-NOW), a current and accurate list of all such dentists and providers within each State that

provide dental services to children enrolled in the State plan (or waiver) under Medicaid or the State child health plan (or waiver) under CHIP. Section 501 also requires the Secretary [of Health and Human Services] shall ensure that such a list is updated at least quarterly and includes a description of the dental services provided under Medicaid or CHIP, whether the services are provided through a State plan or a waiver. The Secretary shall also post on the IKN website State specific information on available dental benefits. CMS works closely with the Health Resources Services Administration (HRSA), which administers the IKN website, to implement this provision of CHIPRA. The collection commenced in 2009." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

"Section 501(f)(1) and section 501(f)(2) of CHIPRA 2009 requires the Secretary [of Health and Human Services] to (1) work with States, pediatric dentists, and other dental providers (including providers that are, or are affiliated with, a school of dentistry) to include, not later than 6 months after the date of the enactment of this Act, on the Insure Kids Now website (http://www.insurekidsnow.gov/) and hotline (1–877–KIDS–NOW) (or on any successor websites or hotlines) a current and accurate list of all such dentists and providers within each State that provide dental services to children enrolled in the State plan (or waiver) under Medicaid or the State child health plan (or waiver) under CHIP, and shall ensure that such list is updated at least quarterly; and (2) work with States to include, not later than 6 months after the date of the enactment of this Act, a description of the dental services provided under each State plan (or waiver) under Medicaid and each State child health plan (or waiver) under CHIP on such Insure Kids Now website, and shall ensure that such list is updated at least annually." (Source: Supporting Statement Part A, pp. 1-2)

P.L. 111 – 3, sec. 501 (Name of Law: Children's Health Insurance Program Reauthorization Act of 2009) (Source: Authorizing Statute(s))

Reporting Frequency

"Section 501 specifies the frequency of collection. Specifically, dental provider information must be submitted every three months (quarterly) and dental benefit information is due yearly." (Source: Supporting Statement Part A, p. 3)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

10,838 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 25. Recovery Act - Reporting Requirements for States Under FMAP Increase and TMA Provisions (CMS-10295)

Summary

"The American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5, requires that States submit quarterly reports to the Secretary of Health and Human Services in accordance with section 5001 Temporary Increase of Medicaid Federal Medical Assistance Percentage (FMAP) and section 5004(d) Extension of Transitional Medical Assistance (TMA). The reports under section 5001 are required for the period of October 1, 2008 - September 30, 2011. The reports under section 5004 are required beginning on July 1, 2009 until the federal authority for TMA coverage sunsets (now scheduled to sunset on December 31, 2010). Each State Medicaid agency will submit its quarterly reports to the appropriate Regional Office of the Centers for Medicare & Medicaid Services. The reports will be compiled and summarized for annual reports to Congress." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

"The Secretary of Health and Human Services is required to submit annual reports to Congress with information collected from States in accordance with section 5004(d) of the Recovery Act." (Source: Supporting Statement Part A, p. 1)

P.L. 111 – 5, sec. 5004 (Name of Law: American The Recovery and Reinvestment Act of 2009 (Recovery Act)) (Source: Authorizing Statute(s))

Reporting Frequency

"Quarterly" (Source: Abstract)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

400 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 26. Recovery Act - Reporting Requirements for States Under FMAP Increase and TMA Provisions (CMS-10295)

Summary

"The American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5, requires that States submit quarterly reports to the Secretary of Health and Human Services in accordance with section 5001 Temporary Increase of Medicaid Federal Medical Assistance Percentage (FMAP) and section 5004(d) Extension of Transitional Medical Assistance (TMA). The reports under section 5001 are required for the period of October 1, 2008 - September 30, 2011. The reports under section 5004 are required beginning on July 1, 2009 until the Federal authority for TMA coverage sunsets (now scheduled to sunset on December 31, 2010). Each State Medicaid agency will submit its quarterly reports to the appropriate Regional Office of the Centers for Medicare & Medicaid Services. The reports will be compiled and summarized for annual reports to Congress." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

"The Secretary of Health and Human Services is required to submit annual reports to Congress with information collected from States in accordance with section 5004(d) of the Recovery Act." (Source: Supporting Statement Part A, p. 1)

P.L. 111 – 5, sec. 5004 (Name of Law: American The Recovery and Reinvestment Act of 2009 (Recovery Act)) (Source: Authorizing Statute(s))

Reporting Frequency

"Quarterly" (Source: Abstract)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

400 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Received in OIRA. (Extension without change of a currently approved collection)"

Information Collection 27. State Medicaid HIT Plan (SMHP) and Template for Implementation of Section 4201 of ARRA (CMS-10292)

Summary

"This information collection is being requested in order that States can submit documentation to CMS for review and approval in order that States can implement the Medicaid program and draw down federal financial participation. The American Reinvestment and Recovery Act of 2009 provides States with the flexibility to request funds to develop a health information technology vision and road to get to the ultimate goal of meaningful use of certified EHR technology. We will be sending State Medicaid Directors letters and templates for the SMHP, the PAPD and IAPD to States in an effort to request these changes, if they so choose and to make the process as simple as possible. These documents will be collections of data and therefore, the need for this information request." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

"In order to assess the appropriateness of States' requests for the administrative FFP for expenditures relating to their Medicaid EHR Incentive Program, including health information exchange, CMS must have sufficient information and documentation. The CMS Medicare and Medicaid EHR Incentive Programs final rule, §495.336 and §495.338 and the initial ICR for CMS-10292 include information required from States for Advanced Planning Documents (APDs) for both planning and implementation funding under HITECH. The requirements for the SMHP submission are outlined in §495.332 of the final rule." (Source: Supporting Statement Part A, pp. 1-2)

P.L. 111 – 5, sec. 4201 (Name of Law: American Reinvestment and Recovery Act of 2009) (Source: Authorizing Statute(s))

Reporting Frequency

"States are only required to provide this information if they are specifically seeking FFP for efforts related to the Medicaid EHR Incentive Program, including health information exchange. States that are not seeking FFP for this purpose do not need to submit this additional APD documentation. With the exception of the annual update, once any documents are approved, there is no need to resubmit additional documents, unless the State initiates a change. This process is a longstanding process to implement States Medicaid IT systems and has been used for years. States must submit annual SMHP updates under the final rule." (Source: Supporting Statement Part A, p. 2)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

896 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 28. Tribal Consultation State Plan Amendment Template (CMS-10293)

Summary

"Section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, amends section 1902(a)(73)of the Social Security Act effective July 1, 2009, to require States in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of the Indian Health Service and Urban Indian Organization concerning Medicaid matters having a direct impact on them. The State Medicaid agency for each of these States will complete the template page and submit it for approval as part of a State plan amendment, to document how it meets the requirements for tribal consultation." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

"Effective July 1, 2009, section 5006 of the American Recovery and Reinvestment Act of 2009 (Recovery Act) amended section 1902(a)(73) of the Act to require that certain States utilize a process for the State to seek advice on a regular, ongoing basis from designees of the Indian Health Service (IHS) and Urban Indian Organizations concerning Medicaid and Children's Health Insurance Program (CHIP) matters having a direct effect on them. The consultation process is required for the 37 States in which 1 or more Indian Health Programs or Urban Indian Organizations furnish health care services." (Source: Supporting Statement Part A, p. 1)

SSA Sec. 1902; P.L. 111 – 5, sec. 5006 (Name of Law: Protections for Indians under Medicaid and CHIP) (Source: Authorizing Statute(s))

Reporting Frequency

"Once the amendment is approved, there is no need to resubmit unless changes are made to the method used for tribal consultation. Since the model template outlines the information CMS needs for its review, there should be little need for requests for additional information." (Source: Supporting Statement Part A, p. 2)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"0%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

37 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 29. Methods for Assuring Access to Covered Medicaid Services Under 42 CFR 447.203 and 447.204 (CMS-10391)

Summary

"CMS-2328-FC requires a transparent, data-driven process for States to document that Medicaid beneficiaries have access to services covered under the Medicaid State plan to the extent that services are available to the general population in a geographic area. To meet the requirements of the final rule, States must conduct access review monitoring plans that measure: the extent that enrollee needs are met, the availability of care and qualified providers, service utilization and payment rate comparisons. The reviews will be conducted every three years for: primary care, physician specialists, behavioral health, and pre and postnatal obstetric services (including labor and delivery). As States reduce or restructure provider payment rates or receive significant numbers of complaints from providers and beneficiaries about access to care, additional services must be included in the review plan and monitored for at least 3 years. We are soliciting comments on the services required for ongoing access reviews and the timelines associated with review and monitoring activities. The final rule also requires States have mechanisms for obtaining beneficiary and provider feedback on access to care, such as hotlines, surveys, ombudsman or other equivalent mechanisms and institute corrective action procedures should access issues be discovered through the access review and monitoring processes. Finally, when considering reductions to Medicaid payment rates the final rule requires States to undertake a process that gathers input from stakeholders and relies upon the information analyzed through the data reviews on the proposed reduction or restructuring of Medicaid service payment rates." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

"The final rule implements section 1902(a)(30)(A) of the act, which requires that States: "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." CMS has requested information from States to document access to care consistent with the statute as part of our State plan amendment review process. This information is particularly relevant when States propose to reduce or restructure provider payments in ways that may harm Medicaid access. We found States' approaches to documenting and monitoring access in Medicaid programs generally lacking and particularly insufficient in reviewing and monitoring data, addressing concerns from beneficiaries and providers and correcting access to care problems when they arise. The final rule describes processes the improve State and CMS oversight of these issues and provides better information for CMS to make informed SPA approval decisions when States propose to reduce provider payments or otherwise restructure payments in ways that may harm access to care." (Source: Supporting Statement Part A, p. 2)

Regulations are laid out at 42 CFR 447.203 and 447.204 (Source: Supporting Statement Part A, p. 1)

Reporting Frequency

"Every three years" (Source: Supporting Statement Part A, pp. 1, 3, 19)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

30,501 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 30. Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010 (CMS-10410)

Summary

"The Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010) are collectively referred to as the Affordable Care Act. The Affordable Care Act expands access to insurance affordability programs through improvements in Medicaid eligibility, enrollment simplification, the establishment of Affordable Insurance Exchanges ("Exchanges"), and coordination between Medicaid, the Children's Health Insurance Program (CHIP), and Exchanges. Relevant to this Statement, the Affordable Care Act promotes a high level of coordination, simplification, and data sharing among State and Federal agencies for the purpose of a seamless and streamlined eligibility system. The Affordable Care Act allows for significant use of Web-based technology to provide information to the public and facilitate application and renewal functions. It creates a "no wrong door" approach to insurance affordability programs so that individuals will not have to apply to multiple programs. Nor will they have to repeat the application process if they initially apply to a program for which they are not ultimately determined eligible. It also provides a simplified process for maintaining coverage through a streamlined renewal process. The provisions of the Affordable Care Act relevant to this statement are effective January 1, 2014. The proposed requirements for the collection and reporting of information and recordkeeping (collectively known as information collections) generally relate to ensuring data sharing and coordination among State and Federal agencies, recordkeeping efforts among State agencies, and the development of Web-based systems and notices in support of the implementation of the Affordable Care Act." (Source: Abstract)

"The State Medicaid and CHIP agencies will provide the information collections. The information collection requirements will assist the public to understand information about health insurance affordability programs and will assist CMS in ensuring the seamless, coordinated, and simplified system of Medicaid and CHIP application, eligibility determination, verification, enrollment, and renewal." (Source: Supporting Statement Part A, p. 2)

Statutory, Regulatory or CMS Guidance Citations

"Sections 1413 and 2201 of the Affordable Care Act provide for a simplified, coordinated, and streamlined system of eligibility for Medicaid, CHIP, and the Exchange. Specifically, section 1413 requires a streamlined system for individuals to apply for, be determined eligible for, and be enrolled in insurance affordability programs-the Exchange, Medicaid, CHIP, and the Basic Health Plan as applicable. Section 2201, which amends section 1943 of the Social Security Act, requires a simplified and coordinated eligibility and enrollment system of Medicaid and CHIP with the Exchange." (Source: Supporting Statement Part A, p. 1)

P.L. 111 – 148, sec. 1413 (Name of Law: Patient Protection and Affordable Care Act); P.L. 111 - 148, sec. 2001 (Name of Law: Patient Protection and Affordable Care Act); P.L. 111 - 148, sec. 1414 (Name of Law: Patient Protection and Affordable Care Act); P.L. 111 - 148, sec. 2002 (Name of Law: Patient Protection and Affordable Care Act); P.L. 111 - 148, sec. 2101 (Name of Law: Patient Protection and Affordable Care Act); P.L. 111 - 148, sec. 2201 (Name of Law: Patient Protection and Affordable Care Act); SSA sec, 1902; SSA sec. 2102; P.L. 111 - 148, sec. 2002 (Name of Law: Patient Protection and Affordable Care Act); P.L. 111 - 148, sec. 1413 (Name of Law: Patient Protection and Affordable Care Act); P.L. 111 - 148, sec. 2001 (Name of Law: Patient Protection and Affordable Care Act) (Source: Authorizing Statute(s))

Requirements relevant to States are laid out in 42 CFR 435.1200, 435.916, 457.343, 457.350. (Source: Supporting Statement Part A, p. 8)

Reporting Frequency

"Many of the information collections, such as interagency agreements, will be submitted once. There is no need to resubmit unless changes are made. Renewal of eligibility occurs once per year, which is less frequent than some States' current practice. The frequency of collection is the minimum required to ensure adequate compliance with Federal statutory requirements." (Source: Supporting Statement Part A, p. 2)

Can be Submitted Electronically?

"No"

Percentage of Respondents Reporting Electronically

0%

However, "all of the information collections, 100 percent, will be available in electronic form." (Source: Supporting Statement Part A, p. 2)

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

12,778,142 hours for State, local and tribal governments; separate time burden for private sector.

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 31. Generic Clearance for Medicaid and CHIP State Plan, Waiver, and Program Submissions (CMS-10398)

Summary

"The Center for Medicaid, CHIP, and Survey & Certification in CMS works in partnership with States to implement Medicaid and the Children's Health Insurance Program (CHIP), and the Social Security Act requires written plans between CMS and the State to implement these programs. The Affordable Care Act enacted comprehensive reform that requires modification of existing programs. In addition to the Medicaid and CHIP State plans, 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 and reporting. This collection will provide streamlined submission forms for States to implement health reform initiatives in Medicaid and CHIP State plans, demonstrations, and waivers, including legislative requirements enacted by the Affordable Care Act." (Source: Abstract)

"State Medicaid and CHIP agencies are responsible for developing submissions to CMS, including State plan amendments and requests for waivers and program demonstrations. States use templates when they are available and submit the forms to CMS to review for consistency with statutory and regulatory requirements (or in the case of waivers and demonstrations whether the proposal is likely to promote the objectives of the Medicaid program). If the requirements are met, CMS approves the State's submission giving the State the authority to implement the flexibilities. For a State to receive Medicaid Title XIX funding, there must be an approved Title XIX State plan."

"The development of streamlined submissions forms enhances the collaboration and partnership between States and CMS by documenting CMS policy for States to use as they are developing program changes. Streamlined forms improve efficiency of administration by creating a common and user-friendly understanding of the information needed by CMS to quickly process requests for State plan amendments, waivers, and demonstration, as well as ongoing reporting." (Source: Supporting Statement Part A, pp. 1-2)

Statutory, Regulatory or CMS Guidance Citations

"Section 1901 of the Social Security Act (42 U.S.C. 1936) requires that States must establish a State plan for medical assistance that is approved by the Secretary to carry out the purpose of Title XIX. CHIP has a corresponding statutory requirement for a State plan outlined in Section 2101to carry out the purpose of Title XXI. 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." (Source: Supporting Statement Part A, p. 1)

SSA sec. 2101; SSA sec. 1915; SSA sec. 1115; SSA sec. 1901 (Source: Authorizing Statute(s))

Reporting Frequency

"Under Medicaid and CHIP State plans, there is no need to resubmit information once it is approved, unless the State elects to change its program. For waiver and demonstration programs, renewals of the programs are required on cycles that vary across statutory authority from 2 –5 years. However, within the approved waiver cycle, States are not asked to resubmit information once it is approved unless the State elects to change its program." (Source: Supporting Statement Part A, p. 2)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

154,104 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 32. Medicaid Program; Review and Approval Process for Section 1115 Demonstrations (CMS-10341)

Summary

"Section 10201(i) of the Affordable Care Act (ACA) added provisions under Section 1115 of the Social Security Act to require the Secretary to publish no later than 180 days after the enactment of this act, regulations that establish application requirements for demonstration projects. Under section 10201(i) of ACA the Secretary must establish a process for public notice and comment at the State level, and at the Federal level after an application for a demonstration project is received by the Secretary. In addition, the Secretary must implement reporting requirements for States, establish a process for the periodic evaluation of demonstration projects and report annually to Congress on the implementation of previously approved demonstration projects. This collection would address the provisions required under Sections 10201(i) of the Affordable Care Act." (Source: Abstract)

"States seeking waiver authority under Section 1115 of the Act are required to meet certain requirements for public notice, the evaluation of demonstration projects, and reports to the Secretary on the implementation of approved demonstrations." (Source: Supporting Statement Part A, p. 1)

Statutory, Regulatory or CMS Guidance Citations

"The information required under this collection is necessary to ensure that State's comply with regulatory and statutory requirements related to the development, implementation and evaluation of demonstration projects allowed under the Statute. States seeking waiver authority under Section 1115 of the Act are required to meet certain requirements for public notice, the evaluation of demonstration projects, and reports to the Secretary on the implementation of approved demonstrations. The legislative authority for these requirements is found in Section 1115 of the Social Security Act, as amended by Section 10201(i) of the Affordable Care Act. This information collection reflects the Affordable Care Act requirements provided in the final rule published on February 27, 2012 (77 FR 11677)." (Source: Supporting Statement Part A, p. 1)

Regulations are at 42 CFR 431.408, 431.412, 431.420, 431.424, and 431.428 (Source: Supporting Statement Part A, p. 1)

Reporting Frequency

Not specified

Can be Submitted Electronically?

"No"

Percentage of Respondents Reporting Electronically

"0%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

13,910 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 33. Medicaid and CHIP Program (MACPro) (CMS-10434)

Summary

"CMS is in the process of evaluating Medicaid systems currently operating, in order to build an enterprise architecture platform and data repository. Ideally, CMS would allow for a single point of entry to access various program and operational data applications. This effort will be implemented in phases over several years. Phase 1 will provide for a Medicaid and CHIP Program data system (MACPro) accessed through a web portal/portlet that will automate the input and retrieval of data from the States related to CHIP eligibility and Alternative Benchmark Plans (ABP). This system will also support an efficient workflow for the review and approval of the CHIP and ABP process. States will access this system and submit program information into structured data templates. CMS staff will review the templates for compliance with Federal statute, regulation and policy, provide feedback to the States and track/monitor the review and approval process. Future project phasing will provide for the design, delivery and implementation of financial management programs and performance and quality metrics. CMS must meet a hard deadline for the implementation of the Affordable Care Act. This system will be operational in phases with the CHIP eligibility and benchmark plans portions/modules to be implemented in January 2013." (Source: Abstract)

"MACPro will be the required means for States to amend Medicaid and CHIP State plans, waivers, and demonstrations...."

"Overall, MACPro will be used by both State and CMS officials to improve the State application and Federal review processes, improve Federal program management of Medicaid programs and CHIP, and standardize Medicaid program data."

"Specifically, it will be used by State agencies to:

- Submit and amend Medicaid State Plans, CHIP State Plans and Information System Advanced Planning Documents (APDs);
- Submit applications and amendments for State waivers, demonstrations, and benchmark and grant programs,
- Submit reporting data.

And MACPro will be used by CMS to:

- Provide for the review and disposition of applications,
- Monitor and track application activity, and
- Analyze performance metrics." Source: (Supporting Statement Part A, pp. 1-2)

Statutory, Regulatory or CMS Guidance Citations

"Medicaid, authorized by Title XIX of the Social Security Act, and CHIP, reauthorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) signed into law on February 4, 2009, play an important role in financing health care for approximately 48 million people throughout the country. As a result of the Affordable Care Act (Public Law 111-148 – Patient Protection and Affordable Care Act) an additional 16 million people became eligible for Medicaid and CHIP. In order to accommodate the influx and implement the statute, CMS must provide a mechanism to ensure timely approval of Medicaid and CHIP State plans, waivers and demonstrations and provide a repository for all Medicaid and CHIP program data that supplies data to populate Healthcare.gov (sec. 1103) as well as other required reports. With these statutory changes in the Medicaid and CHIP programs, CMS will undergo a transformation from a reactive, mostly paper based processing entity to an active, electronic based program manager by automating and streamlining the current systems and processes under CHIP.

"Additionally, 42 CFR 430.12 sets forth the authority for the submittal and collection of State plans and plan amendment information in a format defined by CMS. A State plan for Medicaid consists of preprinted material that covers the basic requirements, and individualized content that reflects the characteristics of the particular State's program. Pursuant to this requirement, CMS has created the MACPro system." (Source: Supporting Statement Part A, pp. 1-2)

Reporting Frequency

"Under Medicaid and CHIP State plans, there is no need to resubmit information once it is approved, unless the State elects to change its program and/or there are changes in Federal Law, regulations, or policy. For waiver and demonstration programs, renewals of the programs are required on cycles that vary across statutory authority from 2 – 5 years. However, within the approved waiver cycle, States are not asked to resubmit information once it is approved unless the State elects to change its program." (Source: Supporting Statement Part A, p. 4)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

2,772 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 34. Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment

Summary

"The Patient Protection and Affordable Care Act expands access to health insurance for individuals and employees of small businesses through the establishment of new Affordable Care Exchanges, including the Small Business Health Options Program. The reporting and data collection in the Exchange rule address Federal requirements that States must meet with respect to the establishment and operation of an Exchange; minimum requirements that health insurance issuers must meet with respect to participation in a State based or Federally-facilitated Exchange; and requirements that employers must meet with respect to participation in the SHOP and compliance with other provisions of the Affordable Care Act. The data collection and reporting requirements in the final rule entitled Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment (Eligibility II Final Rule) address several Exchange provisions including specific provisions including those related to authorized representatives, notices, and verification of eligibility for qualifying coverage in an eligible employer-sponsored plan for Affordable Insurance Exchanges. The submission seeks OMB approval of the information collection requirements associated with 45 CFR parts 155, 156, and 157." (Source: Abstract)

Most of the requirements in this information collection apply to Exchanges, but Exchanges must consult with and coordinate with State Medicaid and CHIP agencies.

Statutory, Regulatory or CMS Guidance Citations

"Sections 1311(b) and 1321(b) of the Affordable Care Act provide that each State has the opportunity to establish an Exchange that (1) facilitates the purchase of insurance coverage by qualified individuals through QHPs; (2) assists qualified employers in the enrollment of their employees in QHPs; and (3) meets other standards specified in the Affordable Care Act. Section 1311(k) of the Affordable Care Act specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary. Section 1311(d) of the Affordable Care Act describes the minimum functions of an Exchange, including the certification of QHPs." (Source: Supporting Statement Part A, pp. 2-3)

"45 CFR parts 155, 156, and 157" (Source: Supporting Statement, p. 50)

Reporting Frequency

"Due to the required flow of information between multiple parties and flow of funds for payments supporting health insurance coverage purchased through the Exchange, it is necessary to collect information according to the indicated frequencies. If the information is collected less frequently, the result would be less accurate, untimely or unavailable eligibility, enrollment or payment information for Exchanges, insurers, employers and individuals. This would lead to delayed payments to insurers; late charges to or payments by employers and enrollees; inaccurate or inappropriate advance payments of the premium tax credit and cost sharing reductions; the release of misleading information regarding health care coverage to potential enrollees; and an overall stress on the organizational structure of the Exchanges and decrease in benefit to individuals and employers." (Source: Supporting Statement Part A, p. 5)

Can be Submitted Electronically?

“Yes”

Percentage of Respondents Reporting Electronically

“100%”

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

12,845,827 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

“Active”

Information Collection 35. Medicaid Incentives for Prevention of Chronic Diseases Evaluation (CMS-10477)

Summary

“Section 4108(a)(1) of the 2010 Affordable Care Act (ACA) established the Medicaid Incentive for Prevention of Chronic Disease program (MIPCD). This national demonstration awarded 10 grants to States to implement programs that provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. Programs address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or in the case of a diabetic, improving the management of the condition. Programs are comprehensive, widely available, easily accessible, and based on relevant evidence-based research and resources. Under Section 4108 (d) of the Affordable Care Act, Health and Human Services Secretary through the Centers for Medicare and Medicaid Services (CMS) awarded a contract to Research Triangle Institute to conduct an independent assessment of these 10 State demonstration Grantees. This assessment will focus on evaluating: (A) the effect of the initiatives on the use of health care services by Medicaid beneficiaries participating in the program; (B) the extent to which special populations (adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program; (C) the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and (D) the administrative costs incurred by State agencies that are responsible for administration of the program. To address these topics we will be conducting Site Visits, Stakeholder Interviews, Focus Groups, Beneficiary Survey and Administrative Cost Forms.” (Source: Abstract)

“The Administrative Costs Forms will collect data from 10 MIPCD demonstration States on administrative costs incurred by their MIPCD program per program year... After the initial submission, RTI will contact the States annually by email... at the end of the MIPCD program year to request that the States fill out the annual MIPCD Administrative Costs Form for the previous programmatic year... Years 4 and 5.” (Source: Supporting Statement Part A, p. 9)

Statutory, Regulatory or CMS Guidance Citations

“Section 4108(a)(1) of the 2010 Affordable Care Act (ACA)”

Reporting Frequency

Annually over the course of the evaluation. (Source: Supporting Statement Part A, p. 9)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

400 for State, local and tribal governments; separate time burden for private sector.

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 36. Medicaid Emergency Psychiatric Services Demonstration Evaluation

Summary

"Inpatient care provided to adults in institutions for mental disease (IMDs) are excluded from Federal Medicaid matching funds. The Affordable Care Act (ACA) authorized the Medicaid Emergency Psychiatric Demonstration (MEPD) to provide Medicaid payment for inpatient services provided by private IMDs to adults with emergency psychiatric conditions. Twelve states and 27 IMDs are participating in the MEPD. The ACA mandates an evaluation of the MEPD that includes assessment of (A) access to inpatient mental health services under the Medicaid program; average lengths of inpatients stays; and emergency room (ER) visits; (B) discharge planning by participating IMDs; (C) the impact of the MEPD on the costs of the full range of mental health services (including inpatient, emergency, and ambulatory care); and (D) the percentage of consumers with Medicaid coverage who are admitted to IMDs as a result of the MEPD as compared to those admitted to the IMDs through other means. The evaluation must include a recommendation regarding whether the MEPD should be continued after December 31, 2013, and expanded on a national basis. The evaluation involves a mixed-methods approach. Quantitative data from administrative records provided by participating States, IMDs, and referring ERs will address ACA areas A, C, and D. Qualitative data will assess discharge planning processes and, to ensure compliance with demonstration requirements, processes used to determine the existence of an emergency psychiatric condition, need for inpatient admission, and stabilization. Qualitative data will be collected through document reviews, telephone interviews with State project directors and beneficiaries, and site visits that include medical record reviews and interviews with staff of participating IMDs and associated general hospitals and ERs." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

"Section 2707 of the Patient Protection and Affordable Care Act (ACA) of 2011 (P.L. 111-148...) directs the Secretary of Health and Human Services to conduct and evaluate a demonstration project to determine the impact of providing payment under Medicaid for inpatient services provided by private IMDs to

individuals with emergency psychiatric conditions between the ages of 21 and 64." (Source: Supporting Statement Part A, p. 2)

Reporting Frequency

"Qualitative data will be collected through site visits and interviews twice during the evaluation, in spring 2014 through summer 2014 and spring 2015 through summer 2015." (Source: Supporting Statement Part A, p. 2)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"0%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

588 for state, local and tribal governments; separate time burdens for private sector and individuals.

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 37. Nationwide Consumer Assessment of Healthcare Providers and Systems (DCAHPS) Survey for Adults in Medicaid (CMS-10493)

Summary

"In 2014, the CMS Centers for Medicare and Medicaid Services (CMCS) plans to conduct a nationwide survey of adults covered by Medicaid using the Consumer Assessment Healthcare Providers and Systems (CAHPS) survey. The survey is to understand Medicaid enrollees' experiences with care, satisfaction with care, and access to care. Collection is critical to the mission of CMS and will sample beneficiaries from four population groups consisting of disabled individuals, non-disabled individuals enrolled in managed care; non-disabled individuals with FFS provider; and individuals dully eligible for Medicare and Medicaid." (Source: Abstract)

"CMCS and NORC [National Opinion Research Center] will work with each State to determine the best approach for extracting the information from State databases for sampling. Each State will be asked to extract Medicaid beneficiary data from the State's MMIS or other beneficiary database. In some cases, the States may wish to provide a download of all MMIS [Medicaid Management Information System] records for the period of time requested. For other States, the best approach may be for State staff to perform the data processing, including selecting the sample based on specifications furnished by CMCS and NORC." (Source: Supporting Statement Part A, p. 5)

Statutory, Regulatory or CMS Guidance Citations

"Section 2701 of ACA required the Secretary of Health and Human Services to identify an initial core set of health care quality measures for adults enrolled in Medicaid for voluntary reporting by States. One of the measures identified by a multi-stakeholder process, the adult CAHPS survey, will be useful for obtaining information on the experiences of care of adults covered by Medicaid." (Source: Supporting Statement Part A, pp. 1-2)

Reporting Frequency

N/A. This PRA package requests approval for conducting a single nationwide adult Medicaid CAHPS survey in 2014.

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

2,244 hours for State, Local, and Tribal governments; separate time burdens for individuals and households.

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 38. Improving Quality of Care in Medicaid and CHIP through Increased Access to Preventive Services, State Survey (CMS-10521)

Summary

"In 2014, CMS plans to conduct a survey of State Medicaid directors that focuses on State coverage of preventive services. The survey is to establish a baseline of covered preventive services by States, to better understand whether incentives impact State coverage of preventive services and to identify which methods of outreach and education are most beneficial to recipients. The collection is critical to the mission of CMS." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

"This survey will give CMS information on preventive services provided by States, including those covered under Section 4106 of the ACA, in order to inform future CMS guidance and technical assistance related to prevention." (Source: Supporting Statement Part A, p. 1)

P.L. 111 – 148, sec. 4106 (Name of Law: Patient Protection and Affordable Care Act/HealthCare and Education Reconciliation Act of 2010); P.L. 111 – 152, sec. 1302(b) (Name of Law: Patient Protection

and Affordable Care Act/HealthCare and Education Reconciliation Act of 2010) (Source: Authorizing Statute(s))

Reporting Frequency

N/A. This PRA package requests approval to conduct a single survey of State Medicaid Directors.

Can be Submitted Electronically?

“Yes”

Percentage of Respondents Reporting Electronically

“100%”

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

128 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

“Active”

Information Collection 39. Executive Summary Form for Research Identifiable Data (CMS-10522)

Summary

“The CMS is responsible for administering the Medicare, Medicaid and State Children's Health Insurance Programs. We collect data to support the Agency's mission and operations. These data include information about Medicare beneficiaries, Medicare claims, Medicare providers, and Medicaid eligibility and claims. We disclose the identifiable data consistent with the routine uses identified in the Privacy Act Systems of Records notices that are published in the Federal Register and the limitations on uses and disclosures that are set out in the HIPAA Privacy Rule. All requests for identifiable data are received and reviewed by the Division of Privacy Operations & Compliance (DPOC) in the Office of E-Health Standards and Services. The DPOC staff and the CMS Privacy Officer review the requests to determine if there is legal authorization for disclosure of the data. If legal authorization exists, the request is reviewed to ensure that the minimal data necessary is requested and approved for the project. Requests for identifiable data for research purposes must be submitted to and approved by the CMS Privacy Board. To assist the CMS Privacy Board with its review of research data requests, OIPDA has developed the Executive Summary (ES) forms. The ES collects all the information that the CMS Privacy Board needs to review and make a determination on whether the request meets the requirements for release of identifiable data for research purposes. We currently have three versions of the ES Form and an ES Supplement for Requestors of the National Death Index (NDI) Causes of Death Variables. Each meets the need for a different type of requestor.” (Source: Abstract)

The Executive Summary Form for Research Identifiable Data is used by States to request CMS data for research purposes.

Statutory, Regulatory or CMS Guidance Citations

"All requests for identifiable data for research purposes must be reviewed and approved by the CMS Privacy Board, as documented in the Privacy Act and HIPAA. The CMS Privacy Board receives over 325 requests a year. The ES allows for a uniform format for the collection and review of the material needed to determine if a request meets the requirements for research disclosure under the Privacy Act and HIPAA. Previously, requestors submitted the information in their own format and it made it difficult and time consuming to review each request and determine if it met all the requirements." (Source: Supporting Statement Part A, p. 2)

Reporting Frequency

"CMS must have an ES for each research request for identifiable data. Without the ES, the request cannot be reviewed by the CMS Privacy Board." (Source: Supporting Statement Part A, p. 3)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

60 for State, Local and Tribal governments; separate time burden for private sector.

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 40. Medical Necessity and Contract Amendments Under Mental Health Parity (CMS-10556)

Summary

"The final rule amends the Medicaid and CHIP regulations to implement the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). MHPAEA is a Federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. The final rule applies mental health parity requirements to Medicaid Managed Care Organizations (MCOs), Section 1937 Alternative Benefit Plans (ABPs), and the CHIP. The final rule also contains provisions related to the disclosure of information related to the reason for denial of reimbursement or payment for MH/SUD benefits. The text only clarifies the expectations for disclosing information concerning the denial of reimbursement or payment for MH/SUD benefits. It does not impose any new or revised third-party disclosure requirements." (Source: Abstract)

"In §438.6(n), States are required to include contract provisions in all applicable MCO, PIHP, and PAHP contracts to comply with part 438, subpart K..."

"In any instance where the full scope of medical/surgical and MH/SUD services are not provided through the MCO, §438.920 specifies that the State must review the MH/SUD and medical/surgical benefits provided through the MCO, PIHP, PAHP, and fee-for service (FFS) coverage to ensure that the full scope of services available to all enrollees of the MCO complies with the requirements in this subpart K. The State is also expected to review the parity analysis provided by an MCO that is responsible for delivering all MH/SUD Medicaid services. The State must provide documentation of compliance with the requirements under this subpart to the general public and post this information on the State's Medicaid website. The 36 states that have an MCO model would be responsible for developing or reviewing the benefits offered by MCOs, PIHPs, PAHPs and FFS to ensure the benefits offered to enrollees of the MCO comply with requirements in this subpart." (Source: Supporting Statement Part A, pp. 8-9)

"State Plan Amendments: Information submitted to CMS regarding compliance of separate CHIP programs with MHPAEA requirements will allow CMS to determine that States are fulfilling the requirements of the final rule."

"Contract Requirements: States use the information collected and reported as part of its contracting process with managed care entities, as well as its compliance oversight role. CMS uses the information collected and reported in an oversight role of State Medicaid managed care programs." (Source: Supporting Statement Part A, p. 2)

Statutory, Regulatory or CMS Guidance Citations

"Under section 1932(b)(8) of the Social Security Act, Medicaid managed care organizations (MCOs) are required to comply with the requirements of subpart 2 of part A of title XXVII of the PHS Act, to the same extent that those requirements apply to a health insurance issuer that offers group health insurance. Subpart 2 includes mental health parity requirements added by MHPAEA at section 2726 of the PHS Act (as renumbered; formerly section 2705 of the PHS Act). Under section 1937(b)(6) of the Act, Medicaid Alternative Benefit Plans (ABPs) that are not offered by an MCO and that provide both medical and surgical benefits and mental health and substance use disorder benefits are required to ensure that financial requirements and treatment limitations for such benefits comply with the mental health parity requirements of the PHS Act (referencing section 2705(a) of the PHS Act, which is now renumbered 2726(a) of the PHS Act), in the same manner as such requirements apply to a group health plan. The section 1937 provision applies only to ABPs that are not offered by MCOs; ABPs offered by MCOs are already required to comply with these requirements under section 1932(b)(8) of the Act. Section 2103(c)(6) of the Act requires that State CHIP plans that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that financial requirements and treatment limitations for such benefits comply with mental health parity requirements of the PHS Act (referencing section 2705(a) of the PHS Act, now renumbered as section 2726(a) of the PHS Act) to the same extent as such requirements apply to a group health plan. In addition, section 2103(f)(2) of the Act requires that CHIP benchmark or benchmark equivalent plans comply with all of the requirements of subpart 2 of part A of the title XXVII of the PHS Act, which includes the mental health parity requirements of the PHS Act, insofar as such requirements apply to health insurance issuers that offer group health insurance coverage." (Source: Supporting Statement Part A, p. 2)

P.L. 111 – 148, sec. 2001(c) (Name of Law: Patient Protection and Affordable Care Act of 2010); P.L. 111 - 3, sec. 502 (Name of Law: Children's Health Insurance Program Reauthorization Act of 2009); P.L. 110 - 343, sec. 512(b) (Name of Law: Mental Health Parity and Addiction Equity Act of 2008) (Source: Authorizing Statute(s))

State requirements are laid out in 42 CFR 438.6(n) and 438.920 (Source: Supporting Statement Part A, p. 10)

Reporting Frequency

"The frequency of disclosure of information regarding medical necessity depends on the number of enrollees who request such information, and is not at the discretion of CMS." (Source: Supporting Statement Part A, p. 4)

Can be Submitted Electronically?

"No"

Percentage of Respondents Reporting Electronically

"0%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

589 for State, local and tribal governments; separate time burdens for private sector and individuals.

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 41. State Review of Accreditation Status, Medicaid Managed Care Quality Rating System, and Quality Strategy (QS) and Supporting Regulations in 438.310, 438.330, 438.332, 438.334, and 438.340 (CMS-10553)

Summary

"The May 6, 2016, final rule (RIN 0938-AS25, CMS-2390-F) contains new and revised quality and quality strategy requirements that apply to States that contract with MCOs, PIHPs, PAHPs and certain PCCM entities to deliver Medicaid services. The burden for elements previously captured in the CMS-10108 package (0938-0920), related to quality strategy and quality assessment and performance improvement (QAPI) programs have been moved into this PRA package, as the final rule has re-codified non-EQR portions of the quality regulations from Section 438 Subpart D into Subpart E. This PRA package now includes the Medicaid Quality Assessment and Performance Improvement Programs, State Review of Accreditation Status, Medicaid Managed Care Quality Rating System, and Quality Strategy (QS)." (Source: Abstract)

State reporting requirements include:

"To elect the option under §438.334(c) to use an alternative MMC [Medicaid managed care] QRS [quality rating system] a State will submit a request to CMS and must receive written CMS approval."

"The final rule would establish that States must at least annually post a quality rating for each MCO, PIHP and PAHP for Medicaid managed care enrollees to use in making informed choices about their managed care plan."

"States will post current quality strategies (QS), which include all of the elements required in §438.340(b) on their websites. CMS will maintain a list of hyperlinks to current State QS on Medicaid.gov. States will be required to review and revise their QS at least once every three years; this process will include an

effectiveness evaluation of the QS, the results of which must be published on the State's website. States must make the strategy available for public comment before submitting the strategy to CMS for review CMS will review QS submitted to the agency by States as a part of its normal oversight activities for the Medicaid program." (Source: Supporting Statement Part A, pp. 11, 14, 21)

Statutory, Regulatory or CMS Guidance Citations

"Social Security Act:

- Section 1932(c)(1) requires States to develop and implement quality assessment and improvement strategies for their managed care arrangements.
- Section 1902(a)(4) requires such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan.
- Section 1902(a)(6) requires that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports.
- Section 1902(a)(19) requires such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients."

Supporting regulations are at 42 CFR §§438.310, 438.330, 438.332, 438.334, and 438.340 (Source: Supporting Statement Part A, p. 1)

P.L. 105 – 33, sec. 4705 (Name of Law: BBA of 1997) (Source: Authorizing Statute(s))

Reporting Frequency

"The final rule would establish that the managed care quality strategy should be reviewed and revised at least once every three years.

"The final rule would establish that States must at least annually post a quality rating for each MCO, PIHP and PAHP for Medicaid managed care enrollees to use in making informed choices about their managed care plan." (Source: Supporting Statement Part A, p. 2)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

37,418 hours for State, Local and Tribal governments; separate time burden for private sector.

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Received in OIRA (New collection)"

Information Collection 42. State Plan Preprint for Medicaid Recovery Audit Contractor (RAC) Program (CMS-10343)

Summary

"To provide a mechanism for States to attest that they will establish a Medicaid RAC program and to allow them to amend the State Plan Amendment to reflect how they will tailor the Medicaid RAC's activities to the uniqueness of the Medicaid program in their State, as well as identify and propose targeted areas or susceptibility regarding improper payments." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

P.L. 111 – 48, sec. 6411 (Name of Law: Expansion of Medicaid RAC to States) (Source: Authorizing Statute(s))

Reporting Frequency

"Once the amendment is approved, there is no need to resubmit unless changes are made to the program. This State Plan process is a longstanding process to implement State's Medicaid programs and has been used for years." (Source: Supporting Statement Part A, p. 2)

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

56 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 43. State Medicaid Eligibility Quality Control Sample Selection Lists and Supporting Regulations

Summary

"State Title XIX agencies are required to submit sample selection lists at the beginning of each month. The Regional Office staff review the lists to ensure States are sampling an adequate number of cases." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

42 USC 1396b (Name of Law: Payment to States). 42 CFR 431.800 through 431.865. (Source: Authorizing Statute(s), Supporting Statement Part A, p. 1)

"The authority for collecting this information is Section 1903(u) of the Social Security Act. The specific requirement for submitting sample selection lists is described in regulations at 42 CFR 431.814(h). Regional Office staff review the sample selection lists to determine that States are sampling a sufficient number of cases for review.

"The collection of information is also necessary to implement provisions from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3) with regard to the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs." (Source: Supporting Statement Part A, p. 2)

Reporting Frequency

NA

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"90%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

960 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 44. Medicaid Eligibility and Enrollment (EE) Implementation Advanced Planning Document (IAPD) Template (CMS-10536)

Summary

"The Social Security Act and CMS-2346-F provide 90% Federal financial participation (FFP) to States for the design, development and implementation of Medicaid eligibility determination systems, and 75% FFP for the operation and maintenance of those systems. To receive enhanced FFP for these systems, States must provide further detail on how the proposed system will address the standards and conditions identified in 42 CFR § 433.112(b). In order to justify a request for enhanced FFP to support Medicaid eligibility determination system costs, States must provide sufficient information and documentation in an APD to CMS for review in accordance with 45 CFR § 95.610. The proposed Implementation Advanced Planning Document (IAPD) Template will provide States with an outline of the information necessary to approve an enhanced FFP request." (Source: Abstract)

Statutory, Regulatory or CMS Guidance Citations

SSA sec. 1903 (Name of Law: FFP for Medicaid Eligibility and Enrollment Systems) (Source: Authorizing Statute(s))

"CMS regulations concerning mechanized claims processing and information retrieval systems, including Medicaid eligibility determination systems, are at 42 CFR § 433, subpart C. A state that chooses to develop, enhance, or replace its required system or subsystems must first submit for approval an APD. The general Health and Human Services (HHS) requirements for approval of APDs are at 45 CFR § 95, subpart F and 42 CFR § 457.230." (Source: Supporting Statement Part A, p. 2)

Reporting Frequency

NA

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"100%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

2,688 hours

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

Information Collection 45. HIPAA Administrative Simplification Non-Privacy Enforcement

Summary

"The purpose of this information collection request is to reinstate and to update the complaint form to capture complaint information voluntarily submitted to the Centers for Medicare and Medicaid Services (CMS), National Standards Group by the public regarding the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification (A.S.) regulations with the exception of the Privacy and Security Rules." (Source: Absract)

Statutory, Regulatory or CMS Guidance Citations

P.L. 104 – 191, sec. 1300d (Name of Law: Health Insurance Portability and Accountability Act) (Source: Authorizing Statute(s))

Reporting Frequency

NA

Can be Submitted Electronically?

"Yes"

Percentage of Respondents Reporting Electronically

"90%"

Annual Information Collection Time Burden (Hours) for State, Local, and Tribal Governments

0 for State, Local, and Tribal governments; separate time burden for individuals and households.[15]

Active or Received in Office of Information and Regulatory Affairs (OIRA)?

"Active"

[15] This record appears in the database search because an earlier version of this information collection listed a time burden of 166 hours for "State, Local, and Tribal Governments." This revised information collection removed that burden from State, Local, and Tribal Governments, making their new time burden zero.

Appendix. Acronyms Used

ABP = Alternative Benefit Plan or Alternative Benchmark Plan

ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended)

APD = Advanced Planning Document

AS= Administrative Simplification

BBA = Balanced Budget Act of 1997 (P.L. 105–33)

BIPA = Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (P.L. 106-554)

CAH = Critical Access Hospital

CAHPS = Consumer Assessment Healthcare Providers and Systems

CBES = State Children's Health Insurance Program Budget and Expenditure System

CFR = Code of Federal Regulations.

CHIP = State Children's Health Insurance Program

CHIPRA = Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3)

CCN = CMS Certification Number

CMCS = Center for Medicaid and CHIP Services

CMS = Centers for Medicare & Medicaid Services

DPOC = Division of Privacy Operations & Compliance (within CMS)

DSH = Disproportionate Share Hospital

DUR = Drug Utilization Review

EE= Eligibility and Enrollment

EHR = Electronic Health Record

EP = Eligible Professional

EPSDT = Early and Periodic Screening, Diagnostic and Treatment

EQR = External Quality Review

EQRO = External Quality Review Organization

ER = Emergency Room

ES = Executive Summary

FFP = Federal Financial Participation

FFS = Fee-For-Service

FMAP = Federal Medical Assistance Percentage

FR = Federal Register

HIPAA = Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

HITECH Act = Health Information Technology for Economic and Clinical Health Act (P.L. 111-5)

HRSA = Health Resources Services Administration

IAPD = Implementation Advance Planning Document

IC = Information Collection

ICR database = Information Collection Review database

IEVS = Income and Eligibility Verification Systems

IKN = Insure Kids Now

IMD = Institution for Mental Disease

IPERIA = Improper Payments Elimination and Recovery Improvement Act of 2012 (P.L.112–248)

IPIA = Improper Payments Information Act of 2002 (P.L. 111-204)

MBES = Medicaid Budget and Expenditure System

MCO = Managed Care Organizations

MEPD = Medicaid Emergency Psychiatric Demonstration

MEQC = Medicaid Eligibility Quality Control

MFP = Money Follows the Person

MHPAEA = Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343)

MH/SUD = Mental Health / Substance Use Disorder

MIPCD = Medicaid Incentive for Prevention of Chronic Disease

MMA = Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173)

MMC = Medicaid Managed Care

MMIS = Medicaid Management Information System

MOE = Maintenance of Effort

MSIS = Medicaid Statistical Information System

NDI = National Death Index

NORC = National Opinion Research Center

NPI = National Provider Identifier

OIPDA = Office of Information Products and Data Analytics

OP = Operational Protocol

OMB = Office of Management and Budget

PACE = Program of All-Inclusive Care for the Elderly

PAHP = Prepaid Ambulatory Health Plans

PAPD = Planning Advance Planning Document

PARIS = Public Assistance Reporting Information System

PCCM = Primary Care Case Management

PERM = Payment Error Rate Measurement

PHS Act = Public Health Service Act

PIHP = Prepaid Inpatient Health Plan

P.L. = Public Law

PRA = Paperwork Reduction Act

QAPI = Quality Assessment and Performance Improvement

QI = Qualifying Individual

QRS = Quality Rating System

QS = Quality Strategy

RAC= Recovery Audit Contractor

RO = Regional Office

SHOP = Small Business Health Options Program

SMHP = State Medicaid HIT Plan

SPA = State Plan Amendment

SSA = Social Security Act

TMA = Transitional Medical Assistance

TMSIS or T-MSIS = Transformed Medicaid Statistical Information System

USC = US Code