Supporting Statement Part A
Dual Eligible Special Needs Plan Contract with the State Medicaid Agency
CMS-10796, OMB 0938-TBD

Background

Our Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs proposed rule (January 12, 2022; 87 FR TBD) (CMS-4192-P, RIN 0938-AU30)) (hereinafter referred to as the January 2022 proposed rule) proposes revisions to regulation related to the dual eligible special needs plan (D-SNP) contract with the State Medicaid agency.

The burden for the creation and submission of the D-SNP contract with the State Medicaid agency is currently approved under by OMB under control numbers 0938-0753 (CMS-R-267) and 0938-0935 (CMS-10237) and is being extracted into this new stand-alone package (CMS-10796; OMB 0938-TBD).

As further explained in sections 12 and 15 of this Supporting Statement, we are also proposing changes to the currently approved burden to account for the proposed rule's changes.

A. Justification

1. Need and Legal Basis

Special needs plans (SNPs) are MA plans created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) that are specifically designed to provide targeted care and limit enrollment to special needs individuals. Under section 1859(b)(6) of the Act, D-SNPs restrict enrollment to individuals entitled to medical assistance under a State plan under title XIX of the Act.

Section 1859(f)(3)(D) of the Act and 42 CFR 422.107 established the requirement for D-SNPs to have contracts with State Medicaid agencies in addition to other contracting requirements that that apply to all MA plans.

Section 50311(b) of the BBA of 2018 amended section 1859 of the Act to add new requirements for D-SNPs, beginning in 2021, including minimum integration standards, coordination of the delivery of Medicare and Medicaid benefits, and unified appeals and grievance procedures for integrated D-SNPs, the last of which we implemented through regulation to apply to certain D-SNPs with exclusively aligned enrollment, termed "applicable integrated plans." These requirements, along with clarifications to existing regulations, were codified in the "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021" final rule

(April 16, 2019; 84 FR 15680) (hereinafter referred to as the April 2019 final rule).[1]

2. Information Users

Medicare Advantage (MA) organizations with D-SNPs and States use the information in the contract to provide benefits, or arrange for the provision of Medicaid benefits, to which an enrollee is entitled. CMS reviews the D-SNP contract with the State Medicaid agency to ensure that it meets the requirements at § 422.107.

3. Improved Information Technology

No data are being collected through this collection of information for analysis; therefore, CMS does not use automated, electronic, mechanical, or other technological collection techniques or other forms of information technology to collect data related to this collection.

4. Duplication of Similar Information

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

There is no significant impact on small businesses.

6. Less Frequent Collection

This information collection requires an MA organization with a D-SNPs to submit the contract with the State Medicaid agency annually or a letter of good standing with a previously executed contract from the State annually. This annual contract submission requirement aligns with the annual contract submission required for all MA-PD contracts. We believe a less frequent collection would not provide CMS with enough information to confirm D-SNPs meet CMS requirements.

7. Special Circumstances

There are no special circumstances to report, and no statistical methods will be employed. More specifically this collection:

- Does not require respondents to report information to the agency more often than quarterly;
- Does not require respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Does not require respondents to submit more than an original and two copies of any document;

[1] See https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

- Does not require respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Is not connected with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Does not require the use of a statistical data classification that has not been reviewed and approved by OMB;
- Does not include a pledge of confidentiality that is not supported by authority established in statue or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Does not require respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register Notice/Outside Consultation

Serving as the 60-day notice, our proposed rule (CMS-4192-P, RIN 0938-AU30) filed for public inspection on January 6, 2022, and will publish in the Federal Register on January 12, 2022 (87 FR TBD). Comments are due on/by March 7, 2022.

9. Payments/Gifts to Respondents

This collection provides zero payments or gifts to respondents.

10. Confidentiality

Consistent with Federal government and CMS policies, CMS will protect the confidentiality of the requested proprietary information. Specifically, only information within a submitted D-SNP contract with the State Medicaid agency (or attachments thereto) that constitutes a trade secret, privileged or confidential information, (as such terms are interpreted under the Freedom of Information Act and applicable case law), and is clearly labeled as such by the applicant, and which includes an explanation of how it meets one of the expectations specified n 45 CFR Part 5, will be protected from release by CMS under 5 U.S.C. 552(b)(4). Information not labeled as trade secret, privileged, confidential or does not include an explanation of why it meets one or more of the Freedom of Information Act exceptions in 45 CFR Part 5 will not be withheld from release under 5 U.S.C. 552(b)(4).

11. Sensitive Questions

No questions of a sensitive nature will be asked.

12. Collection of Information Requirements and Associated Burden Estimates

12.1 Wage Estimates

To derive average costs, we used data form the U.S. Bureau of Labor Statistics' May 2020 National Occupation Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents BLS'

mean hourly wage, our estimated cost of fringe benefits and overhead (calculated at 100 percent of salary), and our adjusted wage.

National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operation Specialists, All Other	13-1198	40.53	40.53	81.06
Lawyer	23-1011	71.59	71.59	143.18
Software Developers and Programmers	15-1250	52.86	52.86	105.72

12.2 Proposed Requirements and Associated Burden Estimates

The contract between D-SNP and a State Medicaid agency is a formal written agreement between an MA organization and the State Medicaid agency documenting each entity's roles and responsibilities with regard to dually eligible individuals. The State Medicaid agency and a new D-SNP submit a contract in July prior to the initial year of the D-SNP operation. In future years, the D-SNP can submit the existing contract with a letter of good standing from the State.

The burden associated with this requirement is the time and effort put forth by each MA organization offering a D-SNP and the State Medicaid agency to sign the contract or letter of good standing and for the D-SNP to submit the contract or letter through CMS' Health Plan Management System (HPMS).

(A) Annual State Burden For D-SNP Contract

Section 1903(a)(7) of the Act requires the Federal government to pay a match rate for administrative expenses. Since cost is split between the State Medicaid agency and the Federal government, we split in half the total costs in this section, half of which the States incur and half of which the Federal government incurs, associated with administering the Medicaid program. The Federal government's cost is presented in the Section 14 of this collection.

In our experience, the State[2] drafts the initial contract for the D-SNPs in its market and applies the same contract to all MA organizations with D-SNPs. While each State includes a different level Medicare and Medicaid integration with the D-SNPs in their market, resulting in differing levels of effort to draft a contract, we estimate that on average the initial burden for State staff to draft a contract with D-SNPs is 40 hours at $143.18/hr. This time estimate is based on the collaborative work for the 2021 contract year between States and the CMS Medicare-Medicaid Coordination Office and its contractor, the Integrated Care Resource Center. For 2021, States were required to update contracts with D-SNPs due to changes to the requirements in § 422.107.

With the vast majority of States already having an existing D-SNP contract (45 States, the District of Columbia, and Puerto Rico), we estimate that at most one State develops a new contract with D-SNPs annually resulting in a total burden of $2,864 (40 hr x $143.18/hr x 0.5).

Each State with an existing D-SNP contract signs the contract or a letter of good standing with each MA organization offering a D-SNP annually. We estimate on average it would take State staff 8 hours to review and sign a contract or letter for good standing for the D-SNPs in their market at a cost of $143.18/hr. This time frame takes into consideration that a State may make occasional updates to the contract with D-SNPs. We estimate the aggregate annual State burden to be 376 hours (47 States x 8 hr) at a cost of $26,918 (376 hr x $143.18/hr x 0.5).

(B) Annual MA Organization Burden For D-SNP Contract

As noted previously, each contract with the State Medicaid agency has a different level of Medicare and Medicaid integration with the D-SNPs, resulting in differing levels of effort for a D-SNP to review a contract, therefore our estimates are based on an average experience for D-SNPs. We are uncertain of the difference in the amount of time for a MA organization to review a new D-SNP contract with the State or to review an existing contract or letter of good standing. Based our experience providing technical assistance to plans and reviewing contract submissions, we estimate it would take an MA organization offering a D-SNP 30 hours to review, sign, and submit a new or existing contract with a letter of good standing at a cost of $81.06/hr. This estimate includes completing the D-SNP matrices in Appendix A and submit the matrices and contract to HPMS. We believe this time allows for variation between the level of complexity in a contract and between a new or existing contract.

For the CY 2022 plan year, 307 MA organizations submitted 464 D-SNP contracts with the State Medicaid agency in compliance with the requirement at § 422.107.[3] We used this data to estimate the annual burden for MA organizations at 13,920 hours (464 D-SNP contracts x 30hr/contract) at a cost of $1,128,355 (13,920 hr x $81.06/hr).

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[2] We use the term "State" to refer to a State, territorial, or District of Columbia Medicaid agency

[3] Please see "Integration Status for Contract Year 2022 D-SNPs (XLSX)", retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs

(C) Additional Burden for the Notification Requirement at § 422.107(d)

Effective on January 1, 2021, a D-SNP that is not a fully integrated or highly integrated dual eligible special needs plan (FIDE SNP or HIDE SNP) must have in its contract the requirement to notify the State, or the State's designated entity, of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals, identified by the State Medicaid agency. No new data would be collected. But for the information burden associated with this requirement, subject to the PRA, we estimate the time and effort for the following two components:

I. State Medicaid Agencies to update one-time their systems
II. Plans to update one-time their systems

We note that 47 State, territory, and District of Columbia Medicaid agencies and the non-FIDE SNP or HIDE SNP D-SNPs within their markets have already made the one-time update to systems to comply with this requirement. We describe the burden estimates for any State that newly offers D-SNPs in its market.

I: State Medicaid Agencies to update one-time their systems

To address differences among the States in available infrastructure, population sizes, and mix of enrollees, this rule provides broad flexibility to identify the groups for which the State Medicaid agency wishes to be notified and how the notification should take place. These flexibilities include: (1) consideration of certain groups who experience hospital and SNF admissions; (2) protocols and timeframes for the notification; (3) data sharing and automated or manual notifications; and (4) use of a stratified approach over several years starting at a small scale and increasing to a larger scale. The final rule also allows States to determine whether to receive notifications directly from D-SNPs or to require that D-SNPs notify a State designee such as a Medicaid managed care organization, section 1915(c) waiver case management entity, area agency on aging, or some other organization.

Some States, using a rich infrastructure and a well-developed automated system, may fulfill this notification requirement with minimal burden, while States with less developed or no infrastructure or automated systems may incur greater burden. Furthermore, the burden, especially to those States starting on a small scale, may differ significantly from year to year. Because of the flexibilities provided in the rule, we expect that a State newly allowing D-SNPs in its market will choose strategies that are within their budget and best fit their existing or already-planned capabilities. We expect any State choosing to receive notification itself of such admissions to claim Federal financial participation under Medicaid for that administrative activity.

We estimate that, on average, this work could be accomplished in a month with one software developer/programmer to build an automated system and one business operations specialist to define requirements. We estimate a one-time burden of 320 hours (1 State x 40 hr/week x 4 weeks x 2 FTEs). Since half of the cost will be offset by 50 percent Federal financial

participation for Medicaid administrative activities, we estimate an adjusted cost of $14,942 [((2,080 hr x $105.72/hr) + (2,080 hr x $81.06/hr)) x 0.50].

Because of the possible wide variability in States' approaches in implementing this requirement, we solicited comment in the proposed rule titled "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, PACE, Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021" (CMS-4185-P, RIN 0938-AT59). We requested suggestions for modeling State approaches and costs related to this provision. Given the uncertainty involved in estimating State behavior, we estimated a minimum of zero burden on plans in subsequent years and a maximum burden that is the estimated first-year cost. We received no comments and finalized our time estimates without change.

II: Plans to update one-time their systems

We have noted previously the broad flexibility in notification options for States. We also note that MA organizations are already required to have systems that are sufficient to organize, implement, control, and evaluate financial and marketing activities, the furnishing of services, the quality improvement program, and the administrative and management aspects of their organization (§ 422.503(b)(4)(ii)). Independent of the State Medicaid agency's selection of high-risk populations, protocols, and notification schedules, an MA organization's most likely method of sharing this notification will be through the use of an automated system that could identify enrollees with criteria stipulated by the States and issue electronic alerts to specified entities. We believe that this work has only minimal one-time cost, as detailed immediately below. Therefore, we estimate it could be accomplished in a month with one software developer/programmer to update systems and one business operations specialist to define requirements.

The burden will be at the contract, not the plan, level for a subset of D-SNP contracts that are not FIDE SNPs or HIDE SNPs and to which the notification requirements are applicable. Existing D-SNPs met the notification requirement starting in January 1, 2021; therefore, going forward we estimate this burden for new non-FIDE SNP or HIDE SNP D-SNP contracts. Using CY 2022 data, we estimate there are 30 new D-SNP contracts a year with 58 percent (or 17 contracts) being non-FIDE SNP or HIDE SNP D-SNP contracts. Accordingly, we estimate a one-time burden of 5,440 hours (17 contracts x 40 hr x 4 weeks x 2 FTEs) or 320 hours per D-SNP contract, at a cost of $508,042 [(2,720 hr x $105.72/hr) + (2,720 hr x $81.06/hr)].

(D) Additional Burden for Applicable Integrated Plans (§§ 422.107(c)(9) and 422.561)

When a D-SNP qualifies as an applicable integrated plan as defined at § 422.561, the D-SNP is required to follow integrated organization determination and grievance procedures under §§ 422.629 – 422.634 and include these requirements in the D-SNP contract with the State Medicaid agency (§ 422.107(c)). We estimate a one-time burden for each new applicable integrated plan to update its policies, procedures, and the D-SNP contract with the State Medicaid agency to reflect the new integrated organization determination and grievance

procedures. We anticipate this task would take a business operation specialist 8 hours at $81.06/hr.

Between CY 2021, the first-year applicable integrated plans were required to follow the procedures under §§ 422.629 – 422.634 and CY 2022, the number of applicable integrated plans increased by 12. We also believe, if finalized, our proposed changes to the definition of applicable integrated plan in the January 2022 proposed rule will increase the number of applicable integrated plans by 13 in 2023. We are using the estimate of an additional 13 D-SNPs per will because we have no way of knowing how many plans will become D-SNPs in future years.

In aggregate, we estimate an annual burden of 104 hours (13 D-SNPs x 8 hr) at a cost of $8,430 (104 hr x $81.06/hr).

(E) Additional Opportunities for Integration through State Medicaid Agency Contracts (§ 422.107(e))

For States that opt to require the contract requirements at proposed § 422.107(e), States and plans would be required to modify the existing State Medicaid agency contract. These modifications would document the D-SNP's responsibility to only enroll dually eligible individuals who receive coverage of Medicaid benefits from the D-SNP, integrate member materials, and request that CMS establish an MA contract limited to D-SNPs within the State.

(1) State Burden

For each State Medicaid agency, it would take a total of 24 hours at $143.18/hr for State staff to update the State Medicaid agency's contract with the D-SNPs in its market to address the changes in this proposed rule. This estimate includes the cost to negotiate with the D-SNPs on contract changes and engage with CMS to ensure contract changes meet the proposed requirements at §422.107(e).

Based on our experience, we expect that each State Medicaid agency will establish uniform contracting requirements for all D-SNPs operating in their market. We are uncertain of the exact number of States that would opt to require these proposed contract changes over the course of the first 3 years after the effective date (contract years 2025 to 2027). Based on our previous work with States as part of the capitated FAI demonstration and implementing the D-SNP integrations requirements established by the BBA of 2018, we estimate as few as five and as many as 20 States may opt to make these changes in their contracts with D-SNPs and their administration of their programs. Based on the number of States currently collaborating with CMS on Medicare and Medicaid integration and the States likely to transition from MMP-based to D-SNP-based integrated care approaches, we believe there will be 12 States that implement this rule in the first 3 years. We further expect these 12 States to implement this one-time change during the first year it is effective.

As stated previously, Section 1903(a)(7) of the Act requires the Federal government to pay half the States' administrative costs. Therefore, for purposes of this estimate we interpret that the States will incur half the costs for updating the D-SNP contract with the State Medicaid Agency,

the Federal government paying for the other half of the cost. Thus, the cost to each State would be $1,718 per State (1 State x 24 hr x $143.18/hr x .05). The aggregate burden to 12 States would be 288 hours (12 States x 24 hr/State) at an aggregate one-time cost of $20,618 (288 hr x $143.18/hr). After this first-year one-time requirement is satisfied, and given the uncertainty involved in estimating State behavior, we are estimating zero burden in subsequent years on States.

(2) MA Organization Burden

For the initial year, we expect each affected D-SNP would take 8 hours at $143.18/hr for a lawyer to update the contract with the State Medicaid agency to reflect the revised and new provisions proposed in this rule at § 422.107(e). Based on our assumptions of States likely to opt to require the proposed contract changes, we estimate between 40 to 80 MA organizations would be impacted in the first three years. Since we are uncertain of which extreme to use, we use the average, 60 MA organizations per year. We further expect the updates to be done in the first year these regulations are effective. In aggregate we estimate a one-time burden of 480 hours (60 MA organizations x 8 hr) at a cost of $68,726 (480 hr x $143.18/hr).

12.3 Burden Summary

Table 1: Summary of Annual Burden Estimates

Section in Title 42 of the CFR	Number of respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Hourly Labor Cost($/hr)	Total Cost First Year ($)	Total Cost Subsequent years ($)
§422.107	1	1	40	40	143.18	2,864*	2,864*
§422.107	47	47	8	376	143.18	26,918*	26,918*
§422.107(d)	1	1	160	160	105.72	8,458*	8,458*
§422.107(d)	1	1	160	160	81.06	6,485*	6,485*
§422.107(e)	12	12	24	144	143.18	20,618*	-
Subtotal (States)	*48*	*48*	*Varies*	*880*	*Varies*	*65,343*	*44,725*
§422.107	464	464	30	13,920	81.06	1,128,355	1,128,355
§422.107(d)	17	17	160	2,720	105.72	287,558	287,558
§422.107(d)	17	17	160	2,720	81.06	220,483	220,483
§§422.107(c)(9) & 422.561	13	13	8	104	81.06	8,430	8,430
§422.107(e)	60	60	8	480	143.18	68,726	-
Subtotal (Private Sector)	*464*	*464*	*Varies*	*19,944*	*Varies*	*1,713,552*	*1,644,826*
TOTAL	**512**	**512**	**Varies**	**20,824**	**Varies**	**1,778,895**	**1,689,551**

*For State burdens, reflects 50 percent reduction to Federal Matching program.

12.4 Collection of Information Instruments and Instruction/Guidance Documents

D-SNPs complete and upload the following documents into HPMS with the completed and signed contract with the State Medicaid Agency. These matrices serve as a checklist for D-SNPs to ensure the required elements are included in the contract with the State Medicaid agency. The matrices also aid Federal reviewers to identify the locations of the required elements are in the contract.

Appendix A "D-SNP State Medicaid Agency Contract Matrix"

Appendix B "Special Needs Plan (SNP) Contract Status Review Matrix".

13. Capital Costs

There are no capital costs.

14. Cost to the Federal Government

Section 1903(a)(7) of the Act requires the Federal government pay a match rate for administrative expenses. Since cost is split between the State Medicaid agency and the Federal government, we split in half the total costs for States to update and sign the contract with D-SNPs, half of which the States incur and half of which the Federal government incurs, associated with administering the Medicaid program. The Federal government's cost for the D-SNP contract with the State Medicaid Agency is presented in the Table 2: Federal Government Match Rate for Administrative Expenses Associated with the D-SNP contract with the State Medicaid Agency.

Table 2: Federal Government Match Rate for Administrative Expenses Associated with the D-SNP contract with the State Medicaid Agency

Section in Title 42 of the CFR	Total Federal Cost First Year ($)	Total Federal Cost Subsequent years ($)
§422.107	2,864	2,864
§422.107	26,918	26,918
§422.107(d)	8,458	8,458
§422.107(d)	6,485	6,485
§422.107(e)	20,618	-
TOTAL	**65,343**	**-**

15. Program/Burden Changes

This information collection request is new but incorporates the burden for the creation and submission of the D-SNP contract with the State Medicaid agency is currently approved under OMB 0938-0753 (CMS-R-267) and OMB 0938-0935 (CMS-10237). This request updates the burden for existing estimates based on the most recent data on Medicare Advantage plans.

Additionally, we made added burden estimates for State Medicaid agencies based on experience working with States and D-SNPs to draft contracts since we made the original burden estimates. Table 3 below describes burden changes from the current estimates in OMB 0938-0753 (CMS-R-267) and OMB 0938-0935 (CMS-10237).

Table 3: Updates to Burden Estimates in OMB 0938-0753 (CMS-R-267) and OMB 0938-0935 (CMS-10237)

Section in Title 42 of the CFR	Number of respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Hourly Labor Cost($/hr)	Total Cost First Year ($)	Total Cost Subsequent years ($)
§422.107	1	1	40	40	143.18	2,864*	2,864*
§422.107	47	47	8	376	143.18	26,918*	26,918*
Total	**48**	**48**	***Varies***	**416**	**143.18**	**29,782**	**29,782**

*For State burdens, reflects 50 percent reduction to Federal Matching program.

This information collection request also incorporates burden for the proposed provisions of the January 2022 proposed rule that impact the D-SNP contract with the State Medicaid agency. Table 4 below describes burden changes from the January 2022 proposed rule.

Table 4: Updates to Burden Estimates based on the January 2022 proposed rule.

Section in Title 42 of the CFR	Number of respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Hourly Labor Cost($/hr)	Total Cost First Year ($)	Total Cost Subsequent years ($)
§422.107(e)	12	12	24	144	143.18	20,618	-
§422.107(c)(9) & 422.561	13	13	8	104	81.06	8,430	8,430
§422.107(e)	60	60	8	480	143.18	68,726	-
TOTAL	**85**	**85**	**40**	**728**	***Varies***	**97,774**	**8,430**

16. Publication/Tabulation Dates

CMS does not intend to publish data related this collection of information.

17. Expiration Date

CMS will display the expiration date and OMB approval number on the CMS website.

18. Certification Statement

No exception to any section of OMB Form 83-I is requested.

B. Collections of Information Employing Statistical Methods

This collection does not employ statistical methods.