

Generic Supporting Statement  
PACE SPA Preprint  
CMS-10398 #83, OMB 0938-1148

This December 2024 iteration proposes to move our non-generic collection of information requirements/burden (CMS-10227, OMB 0938-1027) with change under our generic umbrella (CMS-10398, OMB 0938-1148). If approved, we will formally discontinue OMB control number 0938-1027 (CMS-10227).

The changes consist of:

- Removes outdated “Enclosure” headings from preprint
- Fixes errors in numbering and typos in preprint
- Updates the end date for the mandatory application of spousal impoverishment provisions from 12/31/2019 to 09/30/2027 due to the extension of the ACA provision in section I.A. of the preprint.
- Removes outdated references to CMS “Regional Offices” in section II. of the preprint.
- Adds burden for PACE rate package submissions (as defined below in section D.) which are an existing and ongoing requirement within the preprint, but which have been inadvertently unaccounted for in our currently approved burden estimates since they are separate from the SPA submissions themselves.

## **A. Background**

The Centers for Medicare & Medicaid Services (CMS) work in partnership with States to implement Medicaid and the Children’s Health Insurance Program (CHIP). Together these programs provide health coverage to millions of Americans. Medicaid and CHIP are based in Federal statute, associated regulations and policy guidance, and the approved State plan documents that serve as a contract between CMS and States about how Medicaid and CHIP will be operated in that State. CMS works collaboratively with States in the ongoing management of programs and policies, and CMS continues to develop implementing guidance and templates for States to use to elect new options available as a result of the Affordable Care Act or to comply with new statutory provisions. CMS also continues to work with States through other methods to further the goals of health reform, including program waivers and demonstrations, and other technical assistance initiatives.

The Balanced Budget Act (BBA) of 1997 created section 1934 of the Social Security Act that established the Program for the All-Inclusive Care for the Elderly (PACE). PACE programs coordinate and provide all needed preventive, primary, acute and long-term care services so that older individuals can continue living in the community. PACE is an innovative model designed to enable individuals aged 55 and older who are certified to need nursing home care to live as independently as possible. The legislation authorized the PACE program as a Medicaid state plan option serving the frail and elderly in the home and community. The BBA incorporates the PACE model of care as a benefit of the Medicare program and enables states to provide PACE services to Medicaid beneficiaries as a state option. To provide this Medicaid benefit, states must elect to cover PACE services as a Medicaid state plan option and collaborate with potential

PACE organizations to submit the PACE provider application. Upon completion and approval of a provider application, a three-party program agreement is executed.

The BBA also authorized coverage of PACE under the Medicare program. Section 4802 authorized the establishment of PACE as a state option under Medicaid. Section 4803 addressed 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. Pursuant to our November 24, 1999 (64 FR 66271) interim final rule (HCFA-1903-IFC; RIN 0938-AJ63), if a state elects to offer PACE as an optional Medicaid benefit, it must complete a State Plan Amendment (SPA) preprint packet. A State Medicaid Director Letter (SMDL) was issued Nov 9, 2000, detailing implementation of the BBA, particularly the SPA requirement and preprint. (<https://www.cms.gov/Medicare/Health-Plans/pace/downloads/SMD110900.pdf>)

## **B. Description of Information Collection**

The information, collected by CMS from the state on a one-time basis is needed in order to determine if the state has properly elected to cover PACE services as a Medicaid state plan option. Outside of the one-time requirement, states would need to update their SPA whenever they make changes to their eligibility section or rate setting methodology.

## **C. Deviations from Generic Request**

No deviations are requested.

## **D. Burden Hour Deduction**

### *Wage Estimates*

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2023 National Occupational Employment and Wage Estimates for all salary estimates ([https://www.bls.gov/oes/2023/may/oes\\_nat.htm](https://www.bls.gov/oes/2023/may/oes_nat.htm)). In this regard, the following table presents BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

BLS's wage estimates are updated annually. Current wage figures can be found at [http://www.bls.gov/oes/current/oes\\_nat.htm](http://www.bls.gov/oes/current/oes_nat.htm) and can be used to calculate current cost estimates. May 2023 (see above) is current as of the date of this collection of information request.

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
Actuaries	15-2011	63.70	63.70	127.40
Medical and Health Services Manager	11-9111	64.64	64.64	129.28

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

*Collection of Information Requirements and Associated Burden Estimates*

As of December 2024, there are 180 PACE organizations operating in 34 states including the District of Columbia.<sup>1</sup>

SPA PREPRINT

The burden associated with the requirement that a state have an approved PACE SPA in order for PACE to operate in that state is the time and effort put forth by a state to develop its SPA to elect PACE as an optional Medicaid benefit. CMS estimates that it would take 20 hours at \$129.28/hr for a state medical and health services manager to complete the requirement including time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.

Since 34 states already elected PACE as an optional benefit, the burden estimate provided here only includes the remaining 18 states. Since we are unable to determine how many of the remaining states will elect this option in any given year; we have divided the burden by 3 (OMB’s typical approval period in years) to obtain an annual estimate of 6 states/year (18 States/3 yr).

In aggregate we estimate an annual burden of 120 hours (6 states x 20 hr/response) at a cost of \$15,514 (120 hr x \$129.28/hr).

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<sup>1</sup> National PACE Association. Retrieved December 6, 2024 from <https://www.npaonline.org/about-npa>

This is likely far above the more realistic burden since we estimate only 2-5 states at most will be submitting a PACE SPA package (consisting at a minimum of the completed CMS-179 transmittal form (OMB 0938-0193), SPA preprint (attached) and, if updating an existing SPA, both redline and clean versions) within the next 3-5 years, however we are estimating on the high end since we have no way of knowing in advance the actual number, and since some states may revise their existing State plan to update their eligibility or rate methodology.

#### Annual Burden for the Completion and Submission of the SPA Preprint

	Respondents	Total Responses	Time per Response (hr)	Total Time (hr)	Labor Rate (\$/hr)	Total Capital/Maintenance Costs (\$)	Total Cost (\$)
Total	18 states	6/yr	20	120	129.28	0	15,514

#### PACE RATE PACKAGE

States must submit their PACE rate package, consisting of proposed rates and supporting documentation, to CMS for review and approval as required in section II. of the attached SPA preprint. This burden is separate from that of the completion of the SPA preprint, however it is included in this collection of information request (GenIC #83) since it is a requirement that states agree to when they submit their SPA. CMS will work with the state during the review process and request any additional information as needed. Once approved, CMS will notify the state in writing of its approval of the rates. The state must then notify the PO(s) in writing to confirm the rates and effective dates.

Because rates are for a period of no less than twelve (12) months, states are required to submit rate packages to CMS no more than once a year. The only exception to this is in cases where a state elects to amend their rate package for a given year due to extenuating circumstances, such as a legislative change that affects the rates paid to all providers throughout the state. Therefore, we anticipate that states would complete the cover sheet, which is Appendix B of the PACE Medicaid Capitation Rate Setting Guide<sup>2</sup>, for their submissions no more than once a year, unless extenuating circumstances permit a mid-year rate adjustment.

The estimated burden associated with the PACE rate package is specific to the development and submission of the PACE rate package inclusive of appropriate supporting documentation to CMS, responses to CMS' question sets based on our review of the package, along with the

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<sup>2</sup> The PACE Medicaid Capitation Rate Setting Guide provides technical assistance to states for their PACE rate setting, and the information to include when submitting rate packages to CMS for review and approval. The guide also includes (as Appendix B) a template cover sheet to be used by states for their rate package submissions as streamlined submission forms which will improve the efficiency of CMS reviews, and which are completed and submitted electronically via email. The PACE Medicaid Capitation Rate Setting Guide, Appendix A (Additional Considerations for Using Medicaid Managed Care Data in the Development of the AWOP), Appendix B (PACE AWOP & Rate Package Submission Cover Sheet), and PACE AWOP and Rate Setting Frequently Asked Questions can be found under OMB control number 0938-1448 (CMS-10398 #84).

notification of the approved rates to the POs once finalized. We estimate that it would take Actuaries (blend of state and contracted) a maximum of 160 hours at \$127.40/hr to complete.

Assuming a year when all 34 states would be submitting rate packages, we estimate an annual burden of 5,440 hours (34 states x 160 hr/response) at a cost of \$693,056 (5,440 hr x \$127.40/hr).

**Annual Burden for PACE Rate Package Requirements**

Regulation Section(s) in Title 42 of the CFR	Respondents	Total Responses	Time per Response (hr)	Total Annual Time (hr)	Labor Rate (\$/hr)	Total Capital/Maintenance Costs (\$)	Total Cost (\$)
§460.182	34 states	34	160	5,440	127.40	0	693,056

*Annual Burden Summary*

	Respondents	Total Responses	Time per Response (hr)	Total Time (hr)	Labor Rate (\$/hr)	Total Capital/Maintenance Costs (\$)	Total Cost (\$)
SPA Preprint	18 states	6	20	120	129.28	0	15,514
PACE Rate Package (§460.182)	34 states	34	160	5,440	127.40	0	693,056
TOTAL	34 states	40	varies	5,560	varies	0	708,570

*Collection of Information Instruments and Instruction/Guidance Documents*

PACE SPA Preprint

**E. Timeline**

The 14-day notice published in the Federal Register on December 13, 2024 (89 FR TBD). Comments must be received by December 27.

CMS hopes to deploy this collection in January 2025.