



Medicaid Premiums and Cost Sharing

DRAFT

State Name:

OMB Control Number: 0938-1148

Transmittal Number: NH - 16 - 0002

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting

G2c

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals.

Yes

Population Name (optional):

Eligibility Group(s) Included:

Incomes Greater than TO Incomes Less than or Equal to

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Primary Care Provider to Treat Illness/Injury	3.00	\$	Visit		X
+	Specialty Physician Visit	8.00	\$	Visit		X
+	Inpatient Hospital Services	125.00	\$	Entire Stay		X
+	Mental Health Inpatient Services	125.00	\$	Entire Stay		X
+	Substance Use Disorder Inpatient Services	125.00	\$	Entire Stay		X
+	Mental Health Outpatient Services	3.00	\$	Visit		X
+	Substance Use Disorder Outpatient Services	3.00	\$	Visit		X
+	High cost Imaging (CT/PET Scans, MRI)	35.00	\$	Procedure		X
+	Rehabilitative Speech Therapy	8.00	\$	Visit		X
+	Rehabilitative Occupational Therapy	3.00	\$	Visit		X
+	Rehabilitative Physical Therapy	3.00	\$	Visit		X
+	Generic Drugs	4.00	\$	Prescription		X
+	Preferred and Non-Preferred Brand Drugs	8.00	\$	Prescription		X
+	Specialty Drugs	8.00	\$	Prescription		X
+	Chiropractic Care	3.00	\$	Visit		X
+	Other Medical Professional Office Visit (Nurse, PA)	3.00	\$	Visit		X



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The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL.

No

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.

No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.

No

Remove Population

Population Name (optional):

Eligibility Group(s) Included:

Incomes Greater than TO Incomes Less than or Equal to

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Primary Care Provider Visit to Treat Illness/Injury	3.00	\$	Visit		X
+	Specialty Physician Visit	8.00	\$	Visit		X
+	Inpatient Hospital Services	125.00	\$	Entire Stay		X
+	Mental Health Inpatient Services	125.00	\$	Entire Stay		X
+	Mental Health Outpatient Services	3.00	\$	Visit		X
+	High Cost Imaging (CT/PET Scans, MRI)	35.00	\$	Procedure		X
+	Rehabilitative Speech Therapy	8.00	\$	Visit		X
+	Rehabilitative Occupational Therapy	3.00	\$	Visit		X
+	Rehabilitative Physical Therapy	3.00	\$	Visit		X
+	Preferred Drugs	4.00	\$	Prescription		X
+	Non-Preferred Drugs	8.00	\$	Prescription		X



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	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Other Medical Professional Office Visit (Nurse, PA)	3.00	\$	Visit		X

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Population Name (optional):

Eligibility Group(s) Included:

Incomes Greater than TO Incomes Less than or Equal to

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Primary Care Provider Visit to Treat Illness/Injury	3.00	\$	Visit		X
+	Specialty Physician Visit	8.00	\$	Visit		X
+	Inpatient Hospital Services	125.00	\$	Entire Stay		X
+	Mental Health Inpatient Services	125.00	\$	Entire Stay		X
+	Mental Health Outpatient Services	3.00	\$	Visit		X
+	High Cost Imaging (CT/PET Scans, MRI)	35.00	\$	Procedure		X
+	Rehabilitative Speech Therapy	8.00	\$	Visit		X
+	Rehabilitative Occupational Therapy	3.00	\$	Visit		X
+	Rehabilitative Physical Therapy	3.00	\$	Visit		X



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	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Preferred Drugs	4.00	\$	Prescription		X
+	Non-Preferred Brand Drugs	8.00	\$	Prescription		X
+	Other Medical Professional Office Visit (Nurse, PA)	3.00	\$	Visit		X

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The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Population Name (optional):

Eligibility Group(s) Included:

Incomes Greater than TO Incomes Less than or Equal to

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Primary Care Provider Visit to Treat Illness/Injury	3.00	\$	Visit		X
+	Specialty Physician Visit	8.00	\$	Visit		X
+	Inpatient Hospital Services	125.00	\$	Entire Stay		X
+	Mental Health Inpatient Services	125.00	\$	Entire Stay		X
+	Mental Health Outpatient Services	3.00	\$	Visit		X
+	Imaging (CT/PET Scans, MRI)	35.00	\$	Procedure		X
+	Rehabilitative Speech Therapy	8.00	\$	Visit		X



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	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Rehabilitative Occupational Therapy	3.00	\$	Visit		X
+	Rehabilitative Physical Therapy	3.00	\$	Visit		X
+	Preferred Drugs	4.00	\$	Prescription		X
+	Non-Preferred Drugs	8.00	\$	Prescription		X
+	Other Medical Professional Office Visit (Nurse, PA)	3.00	\$	Visit		X

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Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

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The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.

No

Remove Population

Population Name (optional):

Eligibility Group(s) Included: Parent and Caretaker Relatives Medically Need Who Meet Their Spenddown

Incomes Greater than TO Incomes Less than or Equal to

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Primary Care Provider Visit to Treat Illness/Injury	3.00	\$	Visit		X
+	Specialty Physician	8.00	\$	Visit		X
+	Inpatient Hospital Services	125.00	\$	Entire Stay		X
+	Mental Health Inpatient Services	125.00	\$	Entire Stay		X
+	Mental Health Outpatient Services	3.00	\$	Visit		X



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	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Imaging (CT/PET Scans, MRI)	35.00	\$	Procedure		X
+	Rehabilitative Speech Therapy	8.00	\$	Visit		X
+	Rehabilitative Occupational Therapy	3.00	\$	Visit		X
+	Rehabilitative Physical Therapy	3.00	\$	Visit		X
+	Preferred Drugs	4.00	\$	Prescription		X
+	Non-Preferred Drugs	8.00	\$	Prescription		X
+	Other Medical Professional Office Visit (Nurse, PA)	3.00	\$	Visit		X

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL.

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The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.

No

Remove Population

Population Name (optional):

Eligibility Group(s) Included:

Non-Pregnant Individuals Covered Under Transitional Medical Assistance Who Are Age 18 or Older

Incomes Greater than

100% FPL

TO Incomes Less than or Equal to

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	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Primary Care Provider Visit to Treat Illness/Injury	3.00	\$	Visit		X
+	Specialty Physician Visit	8.00	\$	Visit		X
+	Inpatient Hospital Services	125.00	\$	Entire Stay		X



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	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Mental Health Inpatient Services	125.00	\$	Entire Stay		X
+	Mental Health Outpatient Services	3.00	\$	Visit		X
+	Imaging (CT/PET Scans, MRI)	35.00	\$	Procedure		X
+	Rehabilitative Speech Therapy	8.00	\$	Visit		X
+	Rehabilitative Occupational Therapy	3.00	\$	Visit		X
+	Rehabilitative Physical Therapy	3.00	\$	Visit		X
+	Preferred Drugs	4.00	\$	Prescription		X
+	Non-Preferred Drugs	8.00	\$	Prescription		X
+	Other Medical Professional Office Visit (Nurse, PA)	3.00	\$	Visit		X

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL.

No

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Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.

No

Remove Population

Population Name (optional):

Eligibility Group(s) Included: Individuals Covered Under 42 CFR 435.121 (nonpregnant) Who Are Age 18 or Older

Incomes Greater than TO Incomes Less than or Equal to

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Primary Care Provider Visit to Treat Illness/Injury	3.00	\$	Visit		X



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	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Specialty Physician Visit	8.00	\$	Visit		X
+	Inpatient Hospital Services	125.00	\$	Entire Stay		X
+	Mental Health Inpatient Services	125.00	\$	Entire Stay		X
+	Mental Health Outpatient Services	3.00	\$	Visit		X
+	Imaging (CT/PET Scans, MRI)	35.00	\$	Procedure		X
+	Rehabilitative Speech Therapy	8.00	\$	Visit		X
+	Rehabilitative Occupational Therapy	3.00	\$	Visit		X
+	Rehabilitative Physical Therapy	3.00	\$	Visit		X
+	Preferred Drugs	4.00	\$	Prescription		X
+	Non-Preferred Drugs	8.00	\$	Prescription		X
+	Other Medical Professionals Office Visit	3.00	\$	Visit		X

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL.

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If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.

No

Remove Population

Add Population



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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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State Name:

OMB Control Number: 0938-1148

Transmittal Number: NH - 16 - 0002

Expiration date: 10/31/2014

Cost Sharing Limitations

G3

42 CFR 447.56
1916
1916A

The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
 - 133% FPL; and
 - If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- Disabled or blind individuals under age 18 eligible for the following eligibility groups:
 - SSI Beneficiaries (42 CFR 435.120).
 - Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
 - Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- An individual receiving hospice care, as defined in section 1905(o) of the Act.
- Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).



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Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over.

No

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs.

Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specifically identified in the state plan as not being related to pregnancy.
- Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
 - The state accepts self-attestation
 - The state runs periodic claims reviews
 - The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
 - The Eligibility and Enrollment and MMIS systems flag exempt recipients
 - Other procedure

Additional description of procedures used is provided below (optional):

The state will rely on the following question in the single streamlined application: "Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian Health Program, or through a referral from one of these programs?" Any individual who answers "yes" will be exempt from cost-sharing.

- To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):



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- The MMIS system flags recipients who are exempt
- The Eligibility and Enrollment System flags recipients who are exempt
- The Medicaid card indicates if beneficiary is exempt
- The Eligibility Verification System notifies providers when a beneficiary is exempt
- Other procedure

Additional description of procedures used is provided below (optional):

Payments to Providers

- The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid.

Yes

- The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

- Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

The percentage of family income used for the aggregate limit is:

5%

4%

3%

2%

1%

Other: %

The state calculates family income for the purpose of the aggregate limit on the following basis:

Quarterly

Monthly



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The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation.

Yes

Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

Managed care organization(s) track each family's incurred cost sharing, as follows:

As claims are submitted for dates of services within the family's current quarterly cap period, the MCO applies the incurred cost sharing for that service to the family's aggregate limit. The MCO reports monthly to DHHS about the incurred cost sharing the member has utilized. DHHS aggregates the cost sharing incurred for the member from FFS and PBM and notifies the eligibility and enrollment system, New Heights, that the copay requirement must be suppressed until the beginning of the next quarter.

Other process:

As claims are submitted to Qualified Health Plans for dates of services within the individual's current quarterly cap period, the QHP applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing, the QHP's online portal notifies the individual and providers that the individual has reached their aggregate limit for the current quarterly cap period, and are no longer subject to cost sharing.

Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

For non-NHHPP adults subject to copay, the eligibility and enrollment system will remove the signifier of copay from the member files. That will be passed to MMIS which will in turn pass it along to the PBM and the MCOs to suppress copayment for the remainder of the quarter. Providers will continue to check MMIS for eligibility and will see that there is no copay for that member during the remainder of the quarter.
For NHHPP adults in the Premium Assistance Program, the Qualified Health Plans will notify members and providers through online member portals where they are in their incurral of copayments and will display when the member has reached his or her quarterly cap.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period.

No

Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The beneficiaries may bring receipts to the Medicaid agency to demonstrate that they have paid cost-sharing in excess of the aggregate limit for the quarter. The Medicaid agency will review the receipts and reimburse beneficiaries for any amount above the aggregate limit.

Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

At any time, enrollees may notify the Medicaid agency of a change in income or other circumstances that might change



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their aggregate cost-sharing limit. Once a beneficiary notifies the Medicaid agency of such change, the Medicaid agency will review the updated information and change the aggregate limits, if necessary.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5).

No

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