

Application to Use Burden/Hours from Generic PRA Clearance:
Medicaid and CHIP State Plan, Waiver, and Program Submissions
(CMS-10398, OMB 0938-1148)

Information Collection #15 Medicaid State Plan Eligibility

May 24, 2013

Center for Medicaid and CHIP Services (CMCS)
Centers for Medicare & Medicaid Services (CMS)

CMS requests expedited approval of this collection instrument for release upon OMB approval.

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. When modifications or enhancements to the program are prescribed by Congress through legislation, each State's programs must be amended to comply.

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.

B. Description of Information Collection

Section 1901 of the Social Security Act (42 U.S.C. 1936) requires States to establish a State plan for medical assistance that is approved by the Secretary to carry out the purpose of Title XIX. The State plan is a comprehensive document (approximately 700 pages) comprised of semi-structured templates developed by CMS and completed by State Medicaid agencies. 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.

When a State wants to change their Medicaid eligibility, the State Medicaid agency is responsible for developing an amendment submission for CMS approval, also called a State plan amendment or SPA. The State completes the templates relevant to the program change it seeks and submits the SPA to CMS for approval. The SPA submission includes the relevant eligibility pages the State wishes to update or revise. A State may amend one or more of the plan pages at a time. The Medicaid Eligibility Form (attached), presented for clearance, is used to capture data and information for the Medicaid State Plan Eligibility changes. The Medicaid eligibility is a required Form for completing a Medicaid Eligibility action.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

The total approved burden ceiling of the generic ICR is 86,240 hours, and CMS previously requested to use 23,748 hours, leaving our burden ceiling at 62,492 hours. CMS estimates that each State will complete the collection of data and submission to CMS within 20 hours. There is a potential universe of 56 respondents, so the total burden deducted from the total for this request is 1,120 hours.

E. Timeline

CMS hopes to deploy this collection in July 2013.

The following attachments are provided for this information collection: Medicaid State Plan Eligibility forms

- Tab A1-A3 - Medicaid Administration: State Plan Administration/ Designation and Authority
- Tab S10 - Medicaid Eligibility: MAGI-Based Income Methodologies
- Tab S14 - Medicaid Eligibility: AFDC Income Standards
- Tab S21 - Medicaid Eligibility: Presumptive Eligibility by Hospitals
- Tab S25 - Medicaid Eligibility: Mandatory Coverage Parents and Other Caretaker Relatives
- Tab S28 - Medicaid Eligibility: Mandatory Coverage Pregnant Women
- Tab S30 - Medicaid Eligibility: Mandatory Coverage Infants and Children under Age 19
- Tab S32 - Medicaid Eligibility: Mandatory Coverage Adult Group
- Tab S33 - Medicaid Eligibility: Mandatory Coverage Former Foster Care Children
- Tab S50 - Medicaid Eligibility: Options for Coverage Individuals above 133% FPL
- Tab S51 - Medicaid Eligibility: Options for Coverage Optional Coverage of Parents and Other Caretaker Relatives
- Tab S52 - Medicaid Eligibility: Options for Coverage Reasonable Classification of Individuals under Age 21
- Tab S53 - Medicaid Eligibility: Options for Coverage Children with Non IV-E Adoption Assistance
- Tab S54 - Medicaid Eligibility: Options for Coverage Optional Targeted Low Income Children
- Tab S55 - Medicaid Eligibility: Options for Coverage Individuals with Tuberculosis
- Tab S57 - Medicaid Eligibility: Options for Coverage Independent Foster Care Adolescents
- Tab S59 - Medicaid Eligibility: Options for Coverage Individuals Eligible for Family Planning Services
- Tab S88 - Medicaid Eligibility: Non-Financial Eligibility State Residency

- Tab S89 – Medicaid Eligibility: Non-Financial Eligibility Citizenship and Non-Citizen Eligibility
- Tab S94 – Medicaid Eligibility: General Eligibility Requirements Eligibility Process