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 #21 FMAP Claiming State Plan Amendment

September 17, 2013

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

CMS is requesting expedited approval of this SPA template in order to make it available to states as early as possible so that states can begin the process of preparing their submission which entails supplying requested data and/or data sources as outlined in the instructions. This SPA template must be approved by CMS before expenditures can be claimed at the increased FMAP rates beginning January 1, 2014 for certain individuals determined eligible under the new adult eligibility group.

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.

B. Description of Information Collection

The provision of the Affordable Care Act (ACA) relating to the availability of increased Federal Medical Assistance Percentage (FMAP) rates will be applicable beginning January 1, 2014. The final rule published in the Federal Register April 2, 2013 (78 FR 19918) http://www.gpo.gov/fdsys/pkg/FR-2013-04-02/pdf/2013-07599.pdf set forth allowable methods for determining which expenditures qualify for increased FMAP rates. The new section of the Medicaid state plan applies only to states that adopt the new adult coverage group described in 42 CFR 435.119. States that wish to claim newly eligible and/or expansion state FMAP for enrollees in the adult group must submit a State Plan Amendment (SPA) to CMS. The SPA is required by 42 CFR 433.206(h), which requires a state that wish to claim expenditures at the increased FMAPs to submit a SPA describing its methodology for determining which expenditures may be claimed at the higher FMAP rates. The final rule published in the Federal Register on April 2, 2013 (78 FR 19918) set forth allowable methods for determining which expenditures qualify for increased FMAP rates.[1]

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 34,676 hours leaving our burden ceiling at 51,564 hours. CMS estimates that each State will complete the collection of data and submission to CMS within 4 hours. There is a

[1] 78 Federal Register 19918-19947, accessible at http://www.gpo.gov/fdsys/pkg/FR-2013-04-02/pdf/2013-07599.pdf

potential universe of 40 respondents, so the total burden deducted from the total for this request is 160 hours.

E. Timeline
CMS hopes to deploy this collection in September 2013.

The following attachment is provided for this information collection:

- Instructions for FMAP Claiming State Plan Amendment
- FMAP Claiming State Plan Amendment Template