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 #19 Eligibility and Enrollment Performance Indicators

September 23, 2014

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

Please Note:

- This package revises the generic package that was approved by OMB on September 5, 2013.
- 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. 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 eligibility and enrollment performance indicators for states to complete will provide data for monitoring Medicaid and the Children's Health Insurance Program (CHIP). Data collected on these performance indicators is intended to provide state and federal policymakers, as well as external stakeholders and the public with information about the efficiency and effectiveness of certain aspects of Medicaid and CHIP administrative and business processes. CMS sees state reporting on these performance indicators as vitally important for two reasons: 1) as a way to drive towards more modern approaches to business processes and standards of performance management that are found in the private sector and high-performing public programs; and 2) for monitoring implementation of the Affordable Care Act, beginning in October 2013. Both state and federal officials will seek to evaluate progress in achieving streamlined eligibility and enrollment in Medicaid and CHIP.

We are working with states to ensure that all Medicaid and CHIP beneficiaries – those who will join the program in 2014 and current beneficiaries of the program – receive health care that is efficient and effective. To move towards these goals, CMS articulated the need for monitoring program performance in our Affordable Care Act regulations and guidance. Specifically, CMS signaled our intent to finalize a set of performance indicators in the regulations we issued on the eligibility and enrollment systems 90/10 rule, the Medicaid and CHIP eligibility rule, and in IT Guidance 2.0 where we outlined the 7 Standards and Conditions for IT systems. In addition to this regulatory basis, the performance indicators included in this

template build from a similar set of indicators that we included in the Request for Information (RFI) that CMS released in January 2013 where we sought public comment. Since the issuance of the RFI, CMS has refined these performance indicators based on the public comments and follow-up meetings with states, a crosswalk with CCIIO's metrics, and further internal review within CMS. As CMS indicated in the RFI, we are developing these performance indicators in phases with this first phase focusing on eligibility and enrollment.

CMS plans to ask states to voluntarily report data for these performance indicators. We recognize that given the timeframes, states may not be able to report the data exactly as we have specified. As a result, we have included a section in the reporting template that allows states to explain any limitations that they may have in the data that they are reporting to us. In order for CMS to receive data for monitoring of the Affordable Care Act implementation beginning in October, CMS needs to release this reporting template expeditiously so that states have time to review the definitions and begin pulling reports for the requested information.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

This package revises the package that was approved by OMB on September 5, 2013.

In addition to the burden changes and adjustments, the instrument has been revised to reflect monthly reporting.

The total approved burden ceiling of the generic ICR is 86,240 hours, and CMS previously requested to use 55,613 hours, leaving our burden ceiling at 30,627 hours.

Original Burden (approved September 5, 2013)

Previously, CMS estimated that each State would complete the collection of data and submission to CMS within 40 hours and there would be a potential universe of 56 respondents. That led to a total aggregate burden of 2,240 hours.

Proposed Burden

CMS is no longer requesting the collection of the information from the territories leaving our potential universe at 51 respondents. We request monthly responses from each respondent and have reduced the response time to 20 hr/response.

The revised burden is 12,240 hours (51 states x 20 hr/submission x 12 submissions/yr).

Adjusted Burden

Proposed Burden	12,240 hr
Original Burden	-2,240 hr
ADJUSTMENT	10,000 hr

E. Timeline

The following attachment is provided for this information collection:

- Data Crosswalk
- Monthly Report Form