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 #8: Payer Initiated Eligibility/Benefit Transaction
December 2014

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

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

CMS collaborated with States and representatives of the health care industry to determine the most efficient way to exchange eligibility and benefit information between the State, or its agent, and the health plans or their agent(s) that are under contract to maintain eligibility records and process claims. Therefore, CMS has created this PIE Transaction tool to strengthen States ability to identify and collect payments from liable third parties. The PIE Transaction was developed to transmit benefit and membership information from the plan to the State (or a designated contractor) in one single, unsolicited transaction. This tool provides the format for sharing eligibility and benefit information between the State, or its agent, and health plans. The PIE Transaction is a cumulative listing to be used as a one-way transaction to identify plan members‟ eligibility for health coverage and their associated benefits. Use of these formats will help to ensure standardization among plans, particularly those that operate in multiple States.

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 101,000 hours, leaving our burden ceiling at 76,140 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

Not applicable. This is an extension (without change) of a currently approved GenIC.

Attachments

The following attachments are provided for this information collection:

Attachment A – Payer Initiated Eligibility/Benefit Transaction
Attachment B – Companion Guide - Business Scenarios
Attachment C – State Medicaid Director Letter#10-011