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 #11 MAGI-Based Eligibility Verification Plan

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

Regulations at 42 CFR 435.945(j) and 457.380(j), require states to develop, and update as modified, a verification plan describing the verification policies and procedures adopted by the agency in accordance with §§435.940-435.965, and 457.380. The attached verification plan template is for states to describe their verification policies and procedures for individuals whose eligibility is based on Modified Adjusted Gross Income (MAGI). States may use one template for both Medicaid and separate CHIP programs if the verification policies and procedures are the same. If they are different, the State should submit two separate verification plans.

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 15,700 hours, leaving our burden ceiling at 70,540 hours. CMS estimates that each State will complete the collection of data and submission to CMS within 40 hours. There is a potential universe of 56 respondents, so the total burden deducted from the total for this request is 2,240 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 – Verification Plan Template