

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 # 16 Federally-Facilitated Marketplace (FFM) Integration Data
Collection Tool**

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. States and the Centers for Medicare & Medicaid Services (CMS) share responsibility for operating Medicaid programs consistent with title XIX of the Social Security Act and its implementing regulations. Together, the federal and state governments share accountability for the integrity of the total investment of dollars in the Medicaid program and the extent to which that investment produces value for beneficiaries and taxpayers.

B. Description of Information Collection

The Federally-Facilitated Marketplace (FFM) Integration Data Collection Tool was developed to collect critical state specific information needed from Medicaid and CHIP agencies in order to complete programming of the FFM eligibility system. The data is needed so the eligibility system can determine or assess Medicaid and CHIP eligibility. Data to be collected includes Medicaid and CHIP income eligibility levels for children, parents, pregnant women and adults, as well as which of the state-specific eligibility criteria have been elected by each state. Examples of these options include how cash support is counted, use of reasonably predictable changes in income and how full-time students are counted in the household. In addition, the tool will also collect state Medicaid and CHIP agency names, hotlines, web site information and other resources for the FFM to tailor information to applicants when applying for health affordability programs through the FFM, and it will allow the FFM to pre-populate state specific information to consumers when delivering notices.

In order to begin testing the FFM system in August 2013, programming must be done in July. We need to release the Medicaid eligibility SPA templates so that states can begin the process of submitting the SPAs. The critical pieces of information for the FFM programming purposes are the newly converted income standards for each state's eligibility groups based on MAGI. CMS is assisting states with these conversions, which will be reflected officially in the "MAGI conversion plans" that are required by statute. While the SPAs will be the mechanism for memorializing those new income standards, we are comfortable programming the FFM based on states' MAGI conversion plans. Because of the shortness of time, we cannot wait for all states' SPAs to be adjudicated. If we were to postpone programming the FFM until all SPAs have been approved, CMS would face a significant risk that we would not make our testing deadline and ultimately have a functioning system in place on October 1st.

With regard to the process for updating states' program information in the FFM, there will be a change management process that will involve quarterly (or possibly more frequent) updates to ensure timeliness and accuracy.

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 25,988 hours, leaving our burden ceiling at 60,252 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:

- Federally Facilitated Exchange and State Based Rules Integration Plan
 - Customer Service Information
 - Medicaid
 - CHIP