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 #38 Section 1115 Demonstration: Long Term Services and Supports and Other Models for Individuals with Disabilities and Chronic Conditions

(previously approved under OCN 0938-1159 (CMS-10412)

December 2014

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

The 1115 had been formerly approved under OCN 0938-1159 (CMS-10412).

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

Long term care represents a significant share of Medicaid budgets and a substantial opportunity to improve care for beneficiaries while lowering costs. Under federal statute, nursing home services are mandatory and home and community-based services (HCBS) are optional, creating what has traditionally been known as "an institutional bias." Despite the considerable progress States have made in recent decades to maximize opportunities for community living, most States are still striving to "rebalance" their long term service systems. Several States have successfully used 1115 demonstrations as one tool to "tip the institutional bias" within Medicaid by providing HCBS as a prevention measure rather than having to offer HCBS access only as an equivalent to institutional services.

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. States seeking interventions for individuals needing LTSS to lower costs, improve care and improve health can utilize the 1115 demonstration to test and deliver innovative services and approaches to better and more efficiently meet the needs of this population. States frequently seek to achieve better outcomes through improved care coordination, and reduced institutional and preventable hospital utilization for individuals with disabilities, individuals with chronic conditions, and individuals who are aging. Some States have chosen to deliver these services through managed care service delivery models. Section 1115 demonstrations provide a vehicle for innovations in both care delivery and payment methodologies.

The application for a section 1115 Demonstration must be submitted by the single state Medicaid agency. Proposals are subject to the Centers for Medicare & Medicaid Services (CMS), Office of Management and Budget (OMB), and Department of Health and Human Services (HHS) approval, and may be subject to additional requirements such as site visits before implementation. CMS does not have a specific timeframe to approve, deny, or request additional

information on the proposal. Additionally, CMS usually develops terms and conditions that outline the operation of the demonstration project when it is approved.

Projects are generally approved to operate for a five-year period, and states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the Federal government more than it would cost without the waiver.

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 65,813 hours, leaving our burden ceiling at 20,427 hours.

The estimate of time involved for completing the application for the Section 1115 demonstration is 40 hours. In the above scenario, each State could spend 40 hours to produce 0.2 responses per year, resulting in 8 hours per year per respondent (40 hours * 0.2 responses = 8 hours) or 448 total hours (8 hours per year per respondent * 56 respondents).

Each respondent would submit an application that would be approved for 5 years, meaning each respondent could provide two responses per decade. This means each respondent would respond 0.2 times per year (2 responses ÷ 10 years = 0.2 responses per year). This means the potential annual number of responses is 11.2 per year (56 respondents * 0.2 responses = 11.2 responses per year.)

Respondents: 56
Responses: 1/5 years
Responses/year: 11.2 (or 56/5)
Hours: 40 (per response)
TOTAL HOURS 448 (aggregate, per year)

E. Timeline

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

Attachments

The following attachment is provided for this information collection:

- Section 1115 Application Template