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 #18 Alternative Benefit Plans

October 2017

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 provides guidance and templates for States to use for 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

Medicaid, authorized by Title XIX of the Social Security Act, and CHIP, reauthorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) signed into law on February 4, 2009, play an important role in financing health care for almost 75 million people throughout the country. Starting in January 2014 as a result of the Affordable Care Act (Public Law 111-148 – Patient Protection and Affordable Care Act) states choosing to expand their Medicaid programs to the adult group greatly increased the number of individuals eligible for Medicaid. CMS provides a mechanism to ensure timely approval of Medicaid and CHIP State plans, waivers and demonstrations and provide a repository for all Medicaid and CHIP program data that supplies data to populate Healthcare.gov (sec. 1103) as well as other required reports. CMS is in process of moving from a reactive, mostly paper based processing entity to an active, electronic based program manager by automating and streamlining the current systems and processes.

Additionally, 42 CFR 430.12 sets forth the authority for the submittal and collection of State plans and plan amendment information in a format defined by CMS. A State plan for Medicaid consists of preprinted material that covers the basic requirements, and individualized content that reflects the characteristics of the particular State's program. Pursuant to this requirement, CMS has created the MACPro system. This system will eventually be used by CMS and State Medicaid agencies. Overall, MACPro will be used by both State and CMS officials to improve the State application and Federal review processes, improve Federal program management of Medicaid programs and CHIP, and standardize Medicaid program data.

Section 1937 benchmark plans, renamed Alternative Benefit Plans (ABPs), in the final rule, are used for states to gain CMS approval for benefit plans that will be used for the Medicaid adult group, also known as the expansion population. ABPs can also be used by states to implement benefits for other Medicaid eligibility groups. We currently have 31 states, the District of Columbia and 3 territories with one or more approved ABPs for the expansion population. States submit ABP templates through the Medicaid Model Data Lab (MMDL) to implement the ACA requirements for ABPs. ABPs are state plan amendments and follow the same statutory processing time frames as other state plan amendments.

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 29,908 hours, leaving our burden ceiling at 56,332 hours. CMS estimates that each State will complete the collection of data and submission to CMS within 8 hours. There is a potential universe of 56 respondents, so the total burden deducted from the total for this request is 488 hours.

Wage Estimate

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2016 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Community and Social Service Occupations	21-0000	22.69	22.69	45.38

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

In aggregate, we estimate 448 hours (56 responses x 8 hours) at a cost of $20,330.24 (448 hrs x $45.38/hr).

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:

- Mock-up of Interim Form for Alternative Benefit Plans