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 #33 Opportunity for Families of Disabled Children to Purchase Medicaid Coverage for Such Children - DRA 6062

November 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 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

The Balanced Budget Act of 1997 created the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. Title XXI enables States to initiate and expand health insurance coverage for uninsured children. In order to be eligible for payment under this legislation, each State submitted an initial Title XXI plan for approval by the Secretary that details how the State intends to use the funds. States may also amend their plans at any time by submitting an amendment for approval by the Secretary. All 56 States and Territories have submitted and received approval for State plans and numerous amendments to their plans. States will continue to amend their plans as necessary to reflect changes to their programs.

Under the law, a State plan or an amendment is considered approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. The plan encompasses all of the child health assistance being provided using Title XXI funding. It is important to note that once a Title XXI plan is approved, the State is obligated to continue operating their program in the same manner as described in that plan until the plan is amended in accordance with the rules governing the program.

The Deficit Reduction Act (DRA) provides States with numerous flexibilities in operating their State Medicaid Programs. Section 6062 of the DRA (Opportunity for families of Disabled Children to Purchase Medicaid Coverage for Such Children) allows States the opportunity to provide Medicaid benefits to disabled children who would otherwise be ineligible because of family income that is above the State's highest Medicaid eligibility standards for children. It specifically allows families with disabled children to "buy-in" to Medicaid, and prevents them from having to stay impoverished, become impoverished, place their children in out-of-home placements, or simply give up custody of their child in order to access needed health care for their disabled children.

Under the DRA, States must submit a State Plan Amendment (SPA) to CMS to effectuate this change to their Medicaid programs. CMS has provided the associated SPA template for use by States to modify their Medicaid State Plans, if they choose to implement this provision.

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 50,479 hours, leaving our burden ceiling at 35,761 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)
General and Operations Manager	11-1021	58.70	58.70	117.40

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.

Burden Estimates

CMS estimates that each State will complete the collection of data and submission to CMS within 80 hours. There is a potential universe of 40 respondents, so the total burden deducted from the total for this request is 3,200 hours (40 responses x 80 hours) at a cost of $375,680 (3,200 hrs x $117.40/hr).

Attachments

The following attachment is provided for this information collection:

- FOA Preprint

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