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 #47 Health Home Core Sets

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

Section 2703 of the Affordable Care Act (Public Law 111-148), entitled "State Option to Provide Health Homes for Enrollees with Chronic Conditions," creates a new opportunity for states to support improved integration of care for individuals with chronic conditions. Through the establishment of section 1945 of the Social Security Act, this provision allows states to elect a new Health Homes service option under the Medicaid state plan. This provision is an important opportunity for states to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness.

To support ongoing assessment of the effectiveness of the Health Home model, CMS has established a core set of health care quality measures (Health Homes Core Set). These recommended Health Home Core Set measures are an integral part of a larger payment and care delivery reform effort that focuses on quality outcomes for beneficiaries. The Health Home Core Set will be used to inform the required independent evaluation for the 2017 report to Congress. The Core Set will also be used to assess quality outcomes and performance, as well as to inform ongoing quality monitoring of the Health Home program. Health Home providers will be expected to report to the state Medicaid program, which will report the data in aggregate to CMS at the State Plan Amendment (SPA) level.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

Burden Ceiling

The total approved burden ceiling of the generic ICR is 154,104 hours, and CMS previously requested to use 69,879 hours, leaving our burden ceiling at 84,225 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)**
Medical and Health Services Manager	11-9111	$52.58	$52.58	$105.16

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 Estimate

Annually, states will submit performance measure data on the eight (8) Health Home Core Set measures and three (3) utilization measures. Data is collected at the Health Home provider level and aggregated up to a health home program level rate for the state depending on how many Health Home programs a state has.

CMS estimates that each State will complete the collection of data and submission to CMS within 40 hours. There is a potential universe of up to 30 respondents.

CMS expects that a Medical and Health Services Manager (11-9111) would need 40 hours to complete the report at an adjusted wage of $105.16/hr. Per response, we estimate a cost of $4,206.40 (40 hr x $105.16/hr).

In aggregate, we estimate 1,200 hours (30 responses x 40 hours) at a cost of $126,192 (1,200 hr x $105.16/hr).

Note: This submission seeks OMB approval until the Medicaid and Chip Program (MACPro) system becomes fully functioning. Once MACPro becomes the sole system of record we will transition this collection to the MACPro PRA package (CMS-10434, OMB 0938-1188). Eventually, the MACPro system will provide access to all State Plans and other program data by all CMS MACPro users according to their user roles. The MACPro system will be used for standardized reporting on these measures by states.

Information Collection Instruments

- Health Home Core Set collection tool screenshots

E. Timeline

n/a