

Generic Supporting Statement (September 2019)

Generic Clearance for Medicaid and CHIP State Plan, Waiver, and Program Submissions
(CMS-10398, OMB 0938-1148)

Generic Information Collection # 58 Medicaid Section 1115 Eligibility and Coverage Demonstration Implementation Plan and Monitoring Reports Documents and Templates

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

A. Background

The Centers for Medicare & Medicaid Services (CMS) works in partnership with States to implement the 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 because 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.

Under section 1115(a) of the Social Security Act, the Secretary of Health and Human Services (“Secretary”) may authorize a state to conduct experimental, pilot, or demonstration projects that, in the judgment of the Secretary, promote the objectives of title XIX of the Act. The Secretary (1) may, under section 1115(a)(1), waive provisions in section 1902 of the Act; and/or (2) may, under section 1115(a)(2)(A), authorize federal matching funds for state expenditures that would not otherwise be matchable (i.e., expenditure authority) under section 1903 of the Act. Section 1902 of the Act lists what elements the Medicaid state plan must include, such as provisions relating to eligibility, beneficiary protections, benefits and services and cost sharing. Section 1903, “Payments to States,” describes expenditures that may be “matched” with federal title XIX dollars, allowable sources of non-federal share, and managed care requirements.

On January 11, 2018, CMS released a letter #18-002 to all State Medicaid Directors announcing a new Section 1115 demonstration opportunity designed to assist states in their efforts to improve Medicaid enrollee health and well-being, as well as Medicaid program sustainability, through incentivizing work and community engagement among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability.

In addition, states are accompanying this opportunity with demonstration tests of other policy approaches under Section 1115 authority, such as including premium assistance, waiver of retroactive eligibility, monthly premiums, and imposition of non-eligibility periods for failure to meet certain requirements. Together, these complementary policy approaches are herein called eligibility and coverage demonstrations.

CMS Section 1115 demonstration monitoring and evaluation Special Terms and Conditions, and the letter #18-002, make clear that CMS remains committed to ensuring state accountability for the health and well-being of Medicaid enrollees and that monitoring and evaluation are important for understanding the outcomes and impacts of alternative approaches to Medicaid eligibility and coverage demonstrations. For this purpose, CMS is undertaking efforts to help states monitor the elements of these demonstrations, while giving them the flexibility to adapt to changing conditions in their states. States with approved eligibility and coverage demonstrations are required to develop implementation and monitoring plans, including monitoring metrics, and submit regular monitoring reports describing their implementation progress.

The STCs require States that are testing alternative approaches to eligibility and coverage demonstrations to submit to CMS for approval a draft implementation plan and proposed metrics and a monitoring plan, the STCs further indicate that CMS will work with the state to jointly identify metrics for the monitoring reports, and that such metrics will reflect the major elements of the demonstration. The STCs also require that performance on these monitoring metrics and monitoring reports be reported quarterly and annually.

In accordance with the regulations in 42 C.F.R. 431.420, CMS requires in the STCs for approved eligibility and coverage demonstrations that State reports provide sufficient information to document key challenges, underlying causes of those challenges, and strategies for addressing those challenges, as well as key achievements and the conditions and efforts that lead to those successes.

In accordance with § 431.428, the STCs for these approved demonstrations include that the State will submit information approved by CMS as part of the monitoring framework in accordance with changes in the CMS monitoring systems as they develop and evolve, and that states are required to report in a structured manner that supports federal tracking and analysis. Also in accordance with § 431.428, the STCs provide the timelines for the submission of all post approval deliverables.

To improve the quality and efficiency of the reporting requirements for *Medicaid Section 1115 Eligibility and Coverage* demonstrations, CMS in conjunction with state advisory groups developed an implementation plan and a set of standardized monitoring tools for states to use for their regular reporting, including:

- The Medicaid Section 1115 Eligibility and Coverage Demonstration Implementation Plan (this is one-time submission);
- The Medicaid Section 1115 Eligibility and Coverage Demonstration monitoring protocol (this is one-time submission);
- The Medicaid Section 1115 Eligibility and Coverage Demonstration monitoring report template, and;
- The Medicaid Section 1115 Eligibility and Coverage Demonstration metrics template workbook/metrics.

Including that approved states will submit three quarterly and one annual monitoring reports.

In summary, while similar templates for other types of 1115 demonstrations have been approved under other generic packages, such as the SUD Gen IC (specifically, CMS-10398 #53), this July 2019 package is for the following templates and metrics:

- The Medicaid Section 1115 Eligibility and Coverage Demonstration Implementation Plan (this is one-time submission);
- The Medicaid Section 1115 Eligibility and Coverage Demonstration monitoring protocol (this is one-time submission);
- The Medicaid Section 1115 Eligibility and Coverage Demonstration monitoring report template, and;

- The Medicaid Section 1115 Eligibility and Coverage Demonstration metrics template workbook/metrics.

These templates and metrics are also consistent with the requirements of the STCs to which approved states have agreed. In addition, CMS convened a State Advisory Group to review and provide comments on these templates, their content and the metrics, and CMS made adjustments in consideration of those comments.

CMS believes that these documents are noncontroversial and does not anticipate any adverse reaction from interested parties.

B. Description of Information Collection

Respondents (State Medicaid Agencies) will manually populate the necessary data fields in the templates and submit to CMS project officer and monitoring lead electronically via the Performance Metrics Database & Analytics (PMDA). By incorporating these Medicaid Section 1115 Eligibility and Coverage demonstration-monitoring documents into the Medicaid 1115 PMDA workflow, submissions are parsed and validated, notifying the state of any upfront potential problems with their submissions, reducing downstream communication, and subsequent needs for clarification or modifications to the templates and metrics.

Per each demonstration's STCs, states are required to submit to CMS quarterly monitoring reports within 60-days of the end of each quarter, as well as an annual report within 90-days of a demonstration year's completion.

Currently, there are inconsistencies in the manner in which states submit their required monitoring reports, in significant part due to minimal standardization of the collection instrument. This causes time-consuming reviews and does not support efficient or robust monitoring and assessment across the 1115 demonstration portfolio.

To support more efficient, timely and accurate review of states' Medicaid Section 1115 Eligibility and Coverage demonstrations monitoring reports submissions, CMS has standardized the reporting methodology and together with automation of the reporting submission will support:

- Insight into an approved State's approach to implementation of the Community Engagement (i.e. work) requirements included in the Letter #18-009, which crosswalks to the Community Engagement (i.e., work) requirements in the monitoring metrics and reports, providing a clear basis for assessing the state's implementation of such requirements.
- Consistency of monitoring and evaluation of Community Engagement (i.e., work) requirements and other policy approaches that complement Community Engagement (i.e., work) requirements, such as premium assistance, waiver of retroactive eligibility, monthly premiums, and imposition of non-eligibility periods for failure to meet certain requirements.
- Streamlined communication and shorter timeframes for state development and CMS approval of implementation and monitoring plans for eligibility and coverage demonstrations,

- Accuracy in state reporting, and
- Reduction in timeframes for state reporting and CMS review of monitoring metrics and reports
- More robust evaluation in so much as it is informed by a clear implementation plan and monitoring data.
- Improvements in needed mid-course corrections and the identification and diffusion of best practices under eligibility and coverage demonstrations.

To achieve these goals, CMS has developed for the Medicaid Section 1115 Eligibility and Coverage Demonstrations standardized implementation plan, monitoring reporting templates and performance metrics, as follows:

Medicaid Section 1115 Eligibility and Coverage Implementation Plan

The state will submit the Medicaid Section 1115 Eligibility and Coverage Demonstration Implementation Plan to provide information about implementation of the state's Community Engagement (i.e. work requirements) and to respond to each prompt listed in the tables. The information in the implementation plan flow down from the state's Community Engagement Special Terms and Conditions (STC). It creates an implementation framework that crosswalks to the Community Engagement (i.e., work) requirement segments of the Medicaid Section 1115 Eligibility and Coverage Monitoring Protocol Template.

Medicaid Section 1115 Eligibility and Coverage Monitoring Protocol Template

The state will use the Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protocol template to develop its Monitoring Protocol for Community Engagement and other eligibility and coverage policy approaches such as premium assistance, waiver of retroactive eligibility, monthly premiums, and imposition of non-eligibility periods for failure to meet certain requirements. This protocol specifies that the details of the state's monitoring plans for these policy approaches. It is comprised of two components – qualitative and quantitative (metrics) reporting plans. The metrics component of the Monitoring Protocol are described below under Monitoring Metrics Template.

The Medicaid Section 1115 Eligibility and Coverage Monitoring Protocol template helps the state specify the methods of data collection and timeframes for reporting on the state's progress on required measures and milestones. In addition, the Medicaid Section 1115 Eligibility and Coverage Monitoring Protocol template helps states identify the demonstration baseline and performance targets to be achieved by the end of the demonstration.

Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Report Template

The Monitoring Report Template mirrors the Monitoring Protocol, and like the Protocol, it is comprised of qualitative and quantitative (metrics) performance information that the state reports to CMS on a quarterly and annual basis for each of the eligibility and coverage policy approaches that a state may be testing, including community engagement, premium assistance, waiver of retroactive eligibility, monthly premiums, and imposition of non-eligibility periods for failure to meet certain requirements. Performance values on the metrics in the approved Monitoring Protocol are reported in the Monitoring Metrics Template described below.

Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Metrics Template

The Monitoring Metrics Template is one of the two components of both the Monitoring Protocol and the Monitoring Report Templates described above. It is an Excel file that contains a set of metrics for each of the eligibility and coverage policy approaches that a state may be testing, including Community Engagement (i.e., work) requirements, premium assistance, waiver of retroactive eligibility, monthly premiums, and imposition of non-eligibility periods for failure to meet certain requirements.

For the Monitoring Protocol, the state will review the metrics listed in the ‘Protocol’ tab of the Medicaid Section 1115 Eligibility and Coverage Metrics Workbook and the accompanying metrics technical specifications, and use the template to identify the metrics it plans to report, including any additional state-identified metrics. The state also identifies annual goals and targets, as well as any deviations from CMS technical specifications. The state’s performance on the CMS approved metrics are reported on a quarterly and annual basis under the subsequent ‘Report’ tabs.

C. Deviations from Generic Request

No deviations from the generic PRA request.

D. Burden Hour Deduction

The total approved burden ceiling of the generic ICR is 154,104 hours, and CMS previously requested to use 59,141 hours, leaving our burden ceiling at 94,963 hours.

High-level Assumptions

- Each state submits three quarterly and one annual report per year. Annual reports require somewhat higher level of effort than quarterly reports due to additional metrics reported.
- Each state’s first report will require some additional effort for programming/calculating the metrics; all subsequent reports will require a lower level of effort.
- Estimates are provided by state by year, given that CMS can approve demonstrations for varying lengths of time.
- All templates are completed by a health services manager and/or a computer programmer.

Wage Estimates

To derive average costs, we are using data from the U.S. Bureau of Labor Statistics' May 2018 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 and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr.)	Fringe Benefits and Overhead (\$/hr.)	Adjusted Hourly Wage (\$/hr.)
Computer programmer	15-1131	43.07	43.07	86.14
Health services manager	11-9111	54.68	54.68	109.36

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, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Collection of Information Requirements and Associated Burden Estimates

Currently, there are 7 (seven) states with an approved Medicaid Section 1115 Eligibility and Coverage demonstration for reporting, however, we anticipate this number to expand somewhat, so for the purpose of calculating burden estimates we use the number of ten (10) states.

1. The Medicaid Section 1115 Eligibility and Coverage Implementation Plan

The Implementation Plan consists of a one-time submission for year-one of the demonstration.

The Implementation Plan would be developed by a health services manager and a computer programmer:

We estimate it would take a total of 20 hours (per state) to complete one response. This would consist of 8 hours at \$86.14/hr. for a computer programmer to review technical specifications and 12 hours at \$109.36/hr. for a health services manager to: complete the metrics workbook (4 hr.), the narrative portion by reviewing the monitoring report template and budget neutrality materials for attestations (4 hr.), and QA the monitoring protocol (4 hr.).

In aggregate, we estimate a burden of 200 hours (10 states x 20 hr.) at a cost of \$3,035.12 ([8 hr. x \$86.14/hr.] + [12 hr. x \$109.36/hr.]).

2. The Medicaid Section 1115 Eligibility and Coverage Monitoring Protocol

Monitoring protocol consists of a one-time submission for year-one of the demonstration. The protocol would be developed by a health services manager and a computer programmer:

We estimate it would take a total 20 hours (per state) to complete one response. This would consist of 8 hours at \$86.14/hr. for a computer programmer to review technical specifications and 12 hours at \$109.36/hr. for a health services manager to: complete the metrics workbook (4 hr.), complete the narrative portion by reviewing the monitoring report template and budget neutrality materials for attestations (4 hr.), and QA the monitoring protocol (4 hr.).

In aggregate, we estimate a burden of 200 hours (10 states x 20 hr.) at a cost of \$3,035.12 ([8 hr. x \$86.14/hr.] + [12 hr. x \$109.36/hr.]).

3. The Medicaid Section 1115 Eligibility and Coverage Monitoring Report Templates

We aimed to streamline reporting by allowing states to check a box if it has no updates/changes to report. We assumed that for approximately 1/4 of the reports, the average state would elect not to report updates.

For the annual report, we estimate it would take 12 hours at \$109.36/hr. for a health services manager to prepare and submit the report per state per demonstration year. In aggregate, we estimate an annual report burden of 120 hours (1 report x 12 hr. x 10 states) at a cost of \$13,123.20 (120 hr. x \$109.36/hr.).

For each quarterly report, we estimate it would take 8 hours at \$109.36/hr. for a health services manager to prepare and submit each report per state per demonstration year. In aggregate, we estimate a quarterly report burden of 240 hours (3 reports x 8 hr. x 10 states) at a cost of \$26,246.40 (240 hr. x \$109.36/hr.).

Consequently, we estimate a total burden of 360 hours (120 hr. + 240 hr.) at a cost of \$39,369.60 (\$13,123.20 + \$26,246.40).

4. The Medicaid Section 1115 Eligibility and Coverage Monitoring Metrics Template

Outside of the 4 hours burden estimated above for the monitoring protocol portion of the metrics workbook, we assume a computer programmer will calculate the metrics and populate the metrics template. Groups of metrics will be calculated simultaneously, rather than sequentially. Initial calculations require an upfront investment, but recalculations for subsequent reports will require significantly less time.

- Low LOE metrics (for 15 metrics total: 4 annual metrics, 8 quarterly metrics, and 3 health IT metrics):
 - 24 hours for initial report per state for the ***1st year of the demonstration only*** (assume it's annual and includes all metrics)
 - 8 hours for each ***subsequent annual report*** per state
 - 4 hours for each ***subsequent quarterly report*** per state

- Medium LOE metrics (6 metrics total: 4 annual metrics, 2 quarterly metrics):
 - 48 hours for initial report per state for the **1st year of the demonstration only** (assume it's annual and includes all metrics)
 - 20 hours for each **subsequent annual report** per state
 - 4 hours for each **subsequent quarterly report**
- High LOE metrics (5 annual metrics):
 - 56 hours for initial report per state **1st year of the demonstration only** (assume it's annual and includes all metrics)
 - 4 hours for each **subsequent annual report** per state
 - 4 hours for each **subsequent quarterly report** per state.

YEAR 1 164 hours per state for first demonstration year = ([128 hr. per state for initial report including all metrics x 1 report] + [12 hr. per state x 3 subsequent quarterly reports]). In aggregate we estimate a burden of 1,640 (164 hr x 10 states) at a cost of \$141,269.60 (1,640 hr x \$86.14/hr).

SUBSEQUENT YEARS 68 hours for a computer programmer per state for subsequent years = ([32 hr per state for subsequent annual reports x 1 report] + [12 hr per state x 3 subsequent quarterly reports]). In aggregate we estimate a burden of 680 (68 hr x 10 states) at a cost of \$ 58,575.20 (680 hr x \$86.14/hr).

The Metrics Template becomes the Metric Workbook after States enter respective data and submit it via PMDA. Therefore, we don't expect any additional burden association with the Workbook.

5. PMDA and Instruction Videos

We expect states to submit via PMDA their respective Medicaid Section 1115 Eligibility and Coverage implementation plan, monitoring protocol and quarterly and annual reports (here forward referred to as 'monitoring documents'. The 4th quarter report may be included in the annual report. We expect to maintain the same number of reports. No statistical methods are employed in information collection and in addition, the quarterly and annual reporting data fields are not duplicating any other collections.

We expect the time for each state to complete the submission of the Medicaid Section 1115 Eligibility and Coverage monitoring documents via PMDA to be the same or similar to the time it takes today for states to submit other deliverables and each state may approximately spend 3 to 5 minutes per submission.

Each state/territory with an approved Medicaid Section 1115 Eligibility and Coverage demonstration will be required to complete and submit via PMDA the monitoring documents established by CMS, aimed to support more efficient, timely and accurate review of states' Medicaid Section 1115 Eligibility and Coverage demonstrations monitoring document s submissions. The burden is associated with submitting the Medicaid Section 1115 Eligibility and Coverage monitoring report protocol/templates/ and metrics provided to states/territories by CMS to assist in this effort, as well as the burden related to states viewing as necessary any instructions.

As mentioned above, each demonstration is estimated to need approximately 3 to 5 minutes quarterly/annually at \$109.36/hr. for a Health Services Manager to submit via PMDA the necessary Medicaid Section 1115 Eligibility and Coverage implementation plan and monitoring documents. The burden is subsumed within the preceding estimates along with the time (30 min) to review the “instructions” and watch the respective videos.

Summary of Collection of Information Requirements and Burden Estimates

Requirement	No. Respondents	Total Responses	Time per Response (hours)	Total Annual Time (hours)	Labor cost of Reporting (\$/hr.)	Total Annual Cost (\$)
Eligibility and Coverage Implementation Plan	10	10	20	200	86.14/109.36	3,035.12
Eligibility and Coverage Monitoring Protocol	10	10	20	200	86.14/109.36	3,035.12
Eligibility and Coverage Monitoring Report Template (Annual)	10	10	12	120	109.36	13,123.20
Eligibility and Coverage Monitoring Report Template (Quarterly)	10	30	8	240	109.36	26,246.40
Eligibility and Coverage Monitoring Metrics Template/Work book (Year 1)	10	40	164 (128 hr annual + 12 hr per quarter for 3 quarters)	1,640	86.14	141,269.60
Eligibility and Coverage Monitoring Metrics Template/Work book (Subsequent Years)	10	40	68 (32 hr annual + 12 hr per quarter for 3 quarters)	680	86.14	58,575.20
TOTAL	10	140	Varies	3,080	Varies	245,285

Information Collection Instruments and Instruction/Guidance Documents

- (1) Video: [Overview of the Standardized Monitoring Report Process](#) (8:59 minutes)
- (2) Video: [Populating and Submitting Monitoring Templates](#) (8:24 minutes)
- (3) Video: [Downloading 1115 Monitoring Report Templates](#) (2:59 minutes)

- (4) Medicaid Section 1115 Eligibility and Coverage 1115 Eligibility and Coverage Demonstration Implementation Plan Template
- (5) Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Report
- (6) Section 1115 Eligibility and Coverage Demonstrations Monitoring Metrics Technical Specifications
- (7) Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protocol - Planned metrics
- (8) Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Report Instructions
- (9) Monitoring Metrics for Demonstrations with Community Engagement and Other Eligibility and Coverage Policies
- (10) January 11, 2018 – State Medicaid Directors letter #18-002

E. Timeline

Approval is requested by October 14, 2019.