Supporting Statement for the State Children's Health Insurance Program and Supporting Regulations in 42 CFR 431.636, 457.50, 457.60, 457.70,457.340, 457.350, 457.431, 457.440, 457.525, 457.560, 457.570, 457.740, 457.750, 457.810, 457.940, 457.945, 457.965, 457.985, 457.1005, 457.1015, and 457.1180

A. Background

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act by adding a new title XXI. Title XXI provides funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, States must submit a State plan, which must be approved by the Secretary.

B. Justification

1. Need and Legal Basis

The legal authority for this collection is title XXI of the Social Security Act.

a. State Plan

Regulatory basis: 42 CFR 457.50 State Plan
Statutory basis: Sections 2101(a) and (b), 2102(a), 2102(c), 2106, 2107(c), (d) and (e) of title XXI of the Social Security Act.

Section 457.1 states that title XXI of the Social Security Act, enacted in 1997 by the BBA, authorizes Federal grants to States for provision of child health assistance to uninsured, low-income children. The program is jointly financed by the Federal and State governments and administered by the States. Within broad Federal rules, each State decides eligible groups, types and ranges of services, payment levels for benefit coverage, and administrative and operating procedures.

Section 457.30 interprets sections 2101(a) and (b), 2102(a), 2102(c), 2106, 2107(c), (d) and (e) of title XXI of the Social Security Act and sets forth the related State plan requirements for a State child health assistance program. It includes the requirements related to administration of the State program and the process for Federal review of a State plan or plan amendment. This subpart applies to all States that seek to provide health benefits coverage through the State Children's Health Insurance Program (SCHIP). These collection requirements are currently approved by OMB under OMB# 0938-0707, with a

current expiration date of 5/31/2008.

b. Amendments

Regulatory basis: 42 CFR 457.60 Amendments
Statutory basis: Section 2106(b)(1) of title XXI of the Social Security Act.

Section 2106(b)(1) of the Act permits a State to amend its approved State plan in whole or in part at any time through the submittal of a plan amendment. We require in §457.60 that the State plan must be amended whenever necessary to reflect changes in Federal law, regulations, policy interpretations or court decision; changes in State law, organization, policy or operation of the program; and changes in the source of the State share of funding.

c. Program Options

Regulatory basis: 42 CFR 457.70 Program Options
Statutory basis: Section 2101(a) of title XXI of the Social Security Act.

Under section 2101(a) of the Act, a State may obtain health benefits coverage for uninsured, low-income children in one of three ways: (1) a State may provide coverage by expanding its Medicaid program; (2) a State may develop a plan that meets the requirements of section 2103 of the Act; or (3) a State may provide coverage through a combination of a Medicaid expansion program and a separate child health program.

d. Application for and Enrollment in a Separate Child Health Program

Regulatory basis: 42 CFR 457.340 Application for and Enrollment in a Separate Child Health Program
Statutory basis: 2101(a) of title XXI of the Social Security Act

This provision sets forth the application procedures that a State must follow when determining eligibility for targeted low-income children under a separate child health program, including:

- States must inform applicants, in writing or orally as appropriate, of their rights and responsibilities as part of the application process and provide them an opportunity to apply without delay.

- States must provide information about the eligibility requirements, their obligations under the program, and their right to review of enrollment matters.

- States must promptly determine SCHIP eligibility, within a period not to exceed 45 days, except in circumstances that are beyond the State's

control. The State must define the date of application and count calendar days (except days during which the application has been suspended) from the date of application to the day the agency provides notice of its decision to the applicant.

- States must provide written notice of decisions concerning eligibility and inform applicants in writing of a decision on an application or any other action that affects the child's eligibility. In the case of a suspension or termination of eligibility, the State must provide sufficient notice to enable the parent or caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption.

e. Eligibility Screening

Regulatory basis: 42 CFR 457.350 Eligibility Screening and Facilitation of Medicaid Enrollment
Statutory basis: 2102(b)(3)(A) and (B), 2110(b)(1)(C) and 2110(b)(3)(B) of title XXI of the Social Security Act.

The State plan must ensure that individuals applying for SCHIP, but who are eligible for Medicaid or any other form of health care assistance programs, are enrolled in those other programs and not inappropriately enrolled in SCHIP. Section 2102(b)(3)(A) and (B) of the Act require that a State plan include a description of screening procedures used, at intake and any follow up including any periodic redetermination, to ensure that only children who meet the definition of a targeted low-income child receive child health assistance under the plan, and that all children who are eligible for Medicaid are enrolled in that program. In accordance with the statutory provisions, we require at §457.350(a) that a State plan must include a description of these screening procedures.

Section 2110(b)(1)(C) provides that children who would be eligible for Medicaid if they applied are not eligible for coverage under SCHIP. The statute at 2110 (b)(3)(B) also provides that States have a responsibility to actually enroll children in Medicaid if they are ineligible for the separate child health program because they are Medicaid eligible.

f. Actuarial Report for Benchmark-Equivalent Coverage

Regulatory basis: 42 CFR 457.431 Actuarial Report for Benchmark-Equivalent Coverage
Statutory basis: Section 2103(c)(4) of title XXI of the Social Security Act

In accordance with section 2103(c)(4) of the Act, at §457.431 we require a State, as a condition of approval of benchmark-equivalent coverage, to provide an actuarial report, with an actuarial opinion that the benchmark-equivalent

coverage meets the actuarial requirements of §457.430. The opinion should provide sufficient detail regarding the methodologies used to estimate the value so that CMS's actuaries can review the State's calculations and assumptions for accuracy and completeness.

g. Existing State-Based Comprehensive Coverage

Regulatory basis: 42 CFR 457.440 Existing State-Based Comprehensive Coverage
Statutory basis: Section 2103(d) of title XXI of the Social Security Act

This provision identifies the three existing comprehensive State-based programs (New York, Florida, and Pennsylvania) that were "grandfathered-in" as acceptable coverage programs according to the statute. The provision includes conditions under which States may modify the existing coverage programs for use in developing a SCHIP program.

h. Public Schedule

Regulatory basis: 42 CFR 457.525 Public Schedule
Statutory basis: Section 2103(e)(1)(A) of title XXI of the Social Security Act

Section 2103(e)(1)(A) of the Act requires that the State provide a public schedule of all cost sharing charges including; the current SCHIP cost sharing charges, the beneficiary groups on which cost sharing will be imposed (for example, cost sharing imposed only on children in families with income above 150 percent of the FPL), the cumulative cost sharing maximum allowed under §457.555, and the consequences for a beneficiary who fails to pay a cost sharing charge. The State must also make the public schedule available to beneficiaries at the time of enrollment and when the State revises the cost sharing charges and/or cumulative cost sharing maximum, applicants at the time of application, and the general public. To ensure that providers impose appropriate cost sharing charges at the time services are rendered, the public schedule must be made available to all SCHIP participating providers.

i. Cumulative Cost Sharing Maximum

Regulatory basis: 42 CFR 457.560 Cumulative Cost Sharing Maximum
Statutory basis: Section 2103(e)(3)(B) of title XXI of the Social Security Act

This provision indicates that States must compute cost-sharing amounts in calculating whether the family has met the cumulative cost-sharing maximum.

- All forms of cost sharing may not exceed 5 percent of total family income for a year.
- States must inform the family in writing, and orally if appropriate, of their

cumulative cost-sharing maximum at the time of enrollment as well as at renewal.

j. Disenrollment Protections

Regulatory basis: 42 CFR 457.570 Disenrollment Protections
Statutory basis: Section 2101(a) title XXI of the Social Security Act

This provision describes the procedures States must have in place regarding disenrollment for failure to pay cost sharing.

- States must give enrollees a reasonable opportunity to pay past due cost-sharing amounts prior to disenrollment from SCHIP;
- The disenrollment process must afford the enrollee an opportunity to show that the family's income has declined and take steps to change the child's status in the event that the enrollee qualifies for Medicaid or for a lower level of cost sharing under SCHIP.
- The State must provide the enrollee with an opportunity for an impartial review of the decision to disenroll the child.

k. State Expenditure and Statistical Reports

Regulatory basis: 42 CFR 457.740 State Expenditure and Statistical Reports
Statutory basis: Section 2107(b)(1) of title XXI of the Social Security Act

The recent implementation of SCHIP, results of welfare reform, increased economic stability and reductions in unemployment have affected the scope of health insurance coverage for children. Because each of these factors may confound the coverage level, additional data is needed from States to measure the effectiveness of SCHIP in providing coverage to low-income, uninsured children. Consistent quarterly enrollment data for separate child health programs, Medicaid expansions, and regular Medicaid is necessary for CMS to effectively administer SCHIP, to understand its relative impact on rates of uninsurance among low-income children, and to meet the changing needs of this population.

Therefore, section 2107(b)(1) of the Act, as implemented in §457.720 and §457.730, requires that the State plan contain certain assurances regarding the submission of reports to the Secretary. This regulation specifies that a State plan must provide that the SCHIP agency will submit all reports required by the Secretary, follow the Secretary's instructions with regard to the format and content of those reports, and comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. These statutory provisions and regulations serve as our authority for proposing State expenditure and statistical reporting requirements at §457.740.

l. Annual Report

Regulatory basis: 42 CFR 457.750 Annual Report
Statutory basis: Section 2108(a)

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children. This regulation implemented the statutory provision requiring assessment of the program and submission of an annual report at §457.750(a).

m. Premium Assistance Programs: Required Protections Against Substitution

Regulatory basis: 42 CFR 457.810 Premium Assistance for Employer-Sponsored Group Health Plans: Required Protections Against Substitution
Statutory basis: Section 2102(b)(3)(B) and (C), 2105(c)(3)(B) 2102(c)(2) and 2105(d)

This section requires a State that uses title XXI funds to provide premium subsidies under employer-sponsored group health plans to collect information to evaluate the amount of substitution that occurs as a result of the subsidies and the effect of subsidies on access to coverage.

n. Procurement Standards

Regulatory basis: 42 CFR 457.940 Procurement Standards
Statutory basis: Section 2101(a) of title XXI of the Social Security Act

This provision establishes payment limitations for SCHIP services by requiring that States:

- Provide for free and open competition, to the extent possible, in the bidding of contracts for title XXI services; or
- Use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with principles of actuarial soundness.
- States may establish higher rates by justifying that such rates are necessary to ensure sufficient provider participation, provider access, or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services.
- The State must provide CMS upon request, a description of the manner in which the payment rates were developed.

o. Certification for Contracts and Proposals

Regulatory basis: 42 CFR 457.945 Certification for Contracts and Proposals
Statutory basis: Section 2101(a) of title XXI of the Social Security Act

All entities that contract with the State under a separate child health program must certify the integrity of all information specified by the State.

p. Documentation

Regulatory basis: 42 CFR 457.965 Documentation
Statutory basis: Section 2101(a) of title XXI of the Social Security Act

This provision requires States to include in each applicant's record, facts to substantiate eligibility determinations.

q. Integrity of Professional Advice to Enrollees

Regulatory basis: 42 CFR 457.985 Integrity of professional advice to enrollees
Statutory basis: Section 2101(a) of title XXI of the Social Security Act

This provision requires a State to ensure that its contractors comply with Medicare+Choice provisions describing:

- Prohibitions on interference with health care professionals' advice to enrollees and requires that professionals provide information about treatment in an appropriate manner.

It also enforces compliance with limitations on physician incentive plans, and information disclosure requirements related to those physician incentive plans, respectively.

r. Cost-effective Coverage through a Community-Based Health Delivery System

Regulatory basis: 42 CFR 457.1005 Waiver for Cost-effective Coverage through a Community-Based Health Delivery System
Statutory basis: Section 2105(c)(2)(B)

This provision describes the requirements a State must follow to exceed the 10 percent limitation on administrative costs in order to provide child health assistance to targeted low-income children under the state plan through the utilization of cost-effective community-based health care delivery systems.

- Coverage must meet all the requirements of this part, especially the benefits and cost-sharing requirements; and
- The cost of coverage, on an average per child basis, may not exceed the

cost of coverage under the State plan.

s. Cost Effectiveness

Regulatory basis: 42 CFR 457.1015 Cost Effectiveness
Statutory basis: Section 2105(c)(3) of title XXI of the Social Security Act

This provision describes the waiver requirements for demonstrating cost effectiveness in determining whether to provide family coverage in lieu of individual coverage.

- *Cost-effectiveness* means that the State's cost for purchasing family coverage is equal to or less than the State's cost of obtaining coverage for the eligible targeted low-income children involved.
- A State may demonstrate cost-effectiveness by comparing the cost of coverage for the family to the cost of covering the children only on a case-by-case or an aggregate basis.
- Cost-effectiveness must be assessed in the initial request for a waiver and then annually.
- FFP is not available for expenditures in excess of the amounts shown in the annual cost-effectiveness assessment that a State would have paid for coverage only for the children under the State plan.

The State must report on costs and enrollment related to family coverage in its annual report.

t. Applicant and Enrollee Protections

Regulatory basis: 42 CFR 457.1120-1190 State Plan Requirement: Description of Review Process, Matters Subject to Review, Core Elements of Review, Impartial Review, Time Frames, Continuation of Enrollment, Notice, Application of Review Procedures when States Offer Premium Assistance for Group Health Plans
Statutory basis: Section 2101(a), 2102(a)(7)(B), 2102(b)(2) and 2103 of title XXI of the Social Security Act

Section 2101 of the Act allows the Secretary to provide health assistance in an effective and efficient manner that promotes the best interests of enrollees. Under this authority, we specify that the State must allow enrollees the right to due process in circumstances where their health care services were denied, suspended, terminated or reduced by the State or by its providers. Specifically, States must afford individuals the opportunity for a review process (procedural protections) regarding denial, suspension or termination of eligibility; reduction or denial of services provided for in the State's plan; and disenrollment for failure to pay cost-sharing.

2. Information Users

States must submit title XXI plans and amendments for approval by the Secretary. The plan or amendment must be submitted to CMS. The plan and its subsequent amendments are used by CMS to determine if the State has met the requirements of title XXI.

Information provided in the State plan, State plan amendments, and from the other information CMS is collecting will be used by advocacy groups, beneficiaries, applicants, other Governmental agencies, providers groups, research organizations, health care corporations, health care consultants. States will use the information collected to assess State plan performance, health outcomes and an evaluation of the amount of substitution of private coverage that occurs as a result of the subsidies and the affect of the subsidies on access to coverage.

3. Improved Information Technology

States and non-Federal governmental plans can use their data processing and electronic systems to generate notices to participants and beneficiaries regarding eligibility determinations, public notices and enrollee rights to file grievances and appeals.

States can use their electronic systems to send CMS information regarding: their State plan; plan amendments; actuarial reports for benchmark-equivalent coverage; State expenditure and statistical reports, including the number of children it has covered.

4. Duplication of Similar Information

Title XXI is a program created by the Balanced Budget Act. There is no duplication of this information.

5. Small Businesses

The collection of information does not impact small businesses or other small entities.

6. Less Frequent Collection

Title XXI of the Social Security Act requires that each State submit a child health plan and receive approval by the Secretary in order to be eligible for Federal

funds. Once the plan is approved, it remains in effect until the State requests changes by submitting a plan amendment to CMS for approval. All States and Territories now have approved State plans; however, States will submit amendments for approval when they want to make changes to their plans. The State Plan Amendment Template is currently approved under 0938-0933 with an expiration date of 1/31/2008.

For the rest of the information requested, CMS is requesting the information as outlined in the Statute. The consequence to Federal program or policy activities if the collection is not conducted or is conducted less frequently, will be an inability to monitor the success of the program. There is no method to reduce the frequency that does not result in non-compliance with the requirements. If notices are not generated as required, participants and beneficiaries will not be informed of decisions and events that impact their health benefits coverage. Disclosure of the information requested of States best serves the interests of participants and beneficiaries.

7. Special Circumstances

There are no special circumstances.

8. Federal Register Notice/Outside Consultation

A 60-day Federal Register notice was published on 6/15/2007, attached.

9. Payments/Gifts to Respondents

There are no payments or gifts associated with this information collection requirements.

10. Confidentiality

Section 2108(b)(1) of title XXI requires States to submit to the Secretary an evaluation that includes information on the characteristics of the children and families assisted under the State plan, including age of the children, family income, and the assisted children's access to coverage or coverage by other health insurance prior to the State plan and after eligibility for coverage under the State plan ends. Although States are required to report this information to CMS, on behalf of the Secretary, no personal identifying information will be sent from the State to CMS. Section 2108 of title XXI also required that the Secretary submit to Congress and make available to the public a report based on the information submitted by the States.

11. Sensitive Questions

There are no sensitive questions in the information collection requirements.

12. Burden Estimate (Total Hours & Wages)

§431.636 -- Coordination of Medicaid with the State Children's Health Insurance Program (SCHIP).

Paragraph (b)(3) of this section requires a State Medicaid agency to promptly notify the State agency responsible for determining eligibility under a separate child health program when a child who was screened as potentially eligible for Medicaid is determined ineligible or eligible for Medicaid.

The burden associated with this requirement is the time it takes to prepare a notification and to transmit it. This burden is counted in the burden for §457.350(f) and (g).

Section 457.50 - State Plan

In summary, §457.50 requires a State to submit a child health plan to CMS for approval. The child health plan is a comprehensive written statement submitted by the State describing the purpose, nature, and scope of its Child Health Insurance Program and giving assurance that it will be administered in conformity with the specific requirements of title XXI, title XIX (as appropriate), and the regulations in this chapter. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation in the State program.

The burden associated with this requirement is the time and effort for a State to prepare and submit its child health plan to CMS for approval. These collection requirements are currently approved by OMB under OMB# 0938-0707.

Although States may submit the information in any manner to demonstrate that they have met the requirements set forth in title XXI of the Social Security Act, CMS in cooperation with the States has developed a model application template and instructions to reduce the burden associated with these information collection requirements to a minimal level. The estimate of burden includes time for reviewing instructions, gathering information and completing the model template. States currently submit amendments when needing to make changes to their programs. They alter only those portions of the model application template that are affected by the change. Because all States already have approved plans, this was a one-time effort and is not counted again in this re-certification statement.

Section 457.60 -- Amendments

In summary, §457.60 requires a State to submit to CMS for approval an amendment to its approved State plan, whenever necessary, to reflect any changes in: 1) Federal law, regulations, policy interpretations, or court decisions, 2) State law, organization, policy or operation of the program, or 3) the source of the State share of funding.

The burden associated with this requirement is the time and effort for a State, using the State Plan Amendment template provided by CMS (OMB# 0938-0933), to prepare and submit to CMS for approval, any necessary amendments to its State plan. Based upon CMS's previous experiences with State plan amendments we estimate that on average, it will take a State 80 hours to complete and submit an amendment. We estimate that 40 amendments will be submitted on an annual basis for a total burden of 3,200 hours.

Record Keeping and Reporting Burden
40 amendments X 80 hours = 3,200 hours.

$23.63 per hour X 3,200 hours per year = $75,616

$75,616 X 30 percent (State share) = $22,685.

Section 457.70 -- Program options

In summary, §457.70 requires a State that elects to obtain health benefits coverage through its Medicaid plan to submit an amendment to the State's Medicaid State plan as appropriate, demonstrating that it meets the requirements in subparts A, and G of part 457 and the applicable Medicaid regulations.

The burden associated with this requirement is the time and effort for a State to prepare and submit to CMS for approval the necessary amendment to its Medicaid State plan. Based upon CMS's previous experiences with State Plan amendments we estimate that on average, it will take a State 2 hours to complete and submit an amendment for CMS approval. We estimate that 19 States/Territories submitted an amendment for a total one-time burden of 38 hours. This one-time burden is not included in the burden in this re-certification.

Section 457.340 -- Application for and enrollment in a separate child health program

In summary, §457.340(b) requires a State with a separate child health program (37 states have separate programs) to inform applicants, at the time of application, in writing and orally if appropriate, about the eligibility requirements

and their rights under the program.

The burden associated with this requirement in §457.340 is the time it takes a State to prepare the notice and materials and to give them out. Preparation of the notice was a one-time burden and is not included in the burden for this re-certification. The burden associated with furnishing the notices to applicants is the time and effort for a State to inform each applicant in writing and orally if appropriate, about the eligibility requirements and their rights and obligations under the program. We estimate the average burden upon the State to disseminate a standard notice to the family is estimated to be 3 minutes. During FFY 2003 there were 5,849,938 million enrollees in SCHIP. Of those enrollees, 4,354,689 enrollees were in the 37 states with separate child health programs. We estimate that on average, each state received 118,000 applications (4,354,689 ÷ 37 = 118,000). We estimate that on average, each State will be required to provide one notice to each of the 118,000 applicants, on an annual basis, for a total annual burden of 5,900 hours per State. Therefore, the total estimated burden for this requirement is calculated to be 218,300 hours annually.

In summary, §457.340(c) requires a State to send each applicant a written notice of the agency's decision on the application and, if eligibility is denied or terminated in accordance with §457.1170(b)(that is, the specific reason or reasons for the action and an explanation of the right to request a hearing within a reasonable time).

The burden associated with the requirements of §457.340(c) is the time it takes a State to prepare the notice and materials and to give them out. Preparation of the notice template was a one-time burden and is not included in the burden for this re-certification. The burden associated with furnishing the notices to applicants is the time and effort for a State to prepare and provide written notice to each applicant of the agency's decision on the application, and if eligibility is denied or terminated, the specific reason or reasons for the action and an explanation of the right to request a hearing within a reasonable time. We estimate that on average, it will take each State 3 minutes to prepare each notice and that each State will be required to provide one notice to each of the 118,000 applicants, on an annual basis, for a total annual burden of 5,900 hours, per State. Therefore, the total estimated burden for this requirement is calculated to be 218,300 hours annually.

In summary, we estimate that each state will be required to provide a total of two notices to each of the 118,000 applicants for a total burden of 436,600 hours annually.

Record Keeping and Reporting Burden
37 entities (States/Territories) X 2 notices X 5,900 hours = 436,600 hours.

$23.63 per hour X 436,600 hours per year = $10,316,858 per year.

$10,316,858 X 30 percent (State share) = $3,095,057

Section 457.350 -- Eligibility screening and facilitation of Medicaid enrollment

Section 457.350(e) states that a State that uses a screening procedure other than a full determination of Medicaid eligibility under all possible eligibility groups, and the screening process reveals that the child does not appear to be eligible for Medicaid, the State must provide the child's family with the following in writing:

(1) A statement that based on a limited review, the child does not appear eligible for Medicaid, but Medicaid eligibility can only be determined based on a full review of a Medicaid application under all Medicaid eligibility groups;

(2) Information about Medicaid eligibility and benefits; and

(3) Information about how and where to apply for Medicaid under all eligibility groups.

Under paragraph (f) of this section, if the screening process reveals that the child is potentially eligible for Medicaid, the State must establish procedures in coordination with the Medicaid agency that facilitate enrollment in Medicaid and avoid duplicative requests for information and documentation and must:

(1) If a State uses a joint application for its Medicaid and separate child health programs, promptly transmit the application, or the information obtained through the application, and all relevant documentation to the Medicaid agency; or

(2) If a State does not use a joint application for its Medicaid and separate child health programs:

(i) Promptly inform the child's parent or caretaker in writing and orally if appropriate that the child has been found likely to be eligible for Medicaid; provide the family with a Medicaid application and offer information about what, if any, further information, documentation, or other steps are needed to complete the Medicaid application process; and offer assistance in completing the application process;

(ii) Promptly transmit the separate child health program application; or the information obtained through the application, and all other relevant information and documentation, including the results of the screening process, to the Medicaid agency for a final determination of Medicaid

eligibility in accordance with the requirements of §431.636 and §457.1110 of this chapter; or

(3) Establish other effective and efficient procedures, in coordination with the Medicaid agency, as described and approved in the State plan that ensure that children who are screened as potentially eligible for Medicaid are able to apply for Medicaid without delay and, if eligible, are enrolled in Medicaid in a timely manner.

The burden associated with these requirements is the one-time effort for a State to create the notice, which is not reflected in the burden described in this re-certification, and the ongoing effort for a State to (1) transmit applications or the required information to the Medicaid agency; (2) inform the parent or caretaker in writing that the child has been found to be potentially eligible or ineligible for Medicaid; and (3) for applications that are not joint applications, if the child is found to be potentially eligible for Medicaid, provide the family with a Medicaid application and offer information about what, if any, further information, documentation, or other steps are needed to complete the Medicaid application process.

All States with separate child health insurance programs (37) use a screening process. We estimate that on average, there will be 118,000 new or renewing applicants in each of these 37 States during each year. We estimate that it will take no longer than 3 minutes (depending on the medium) to transmit applications or relevant information to the Medicaid agency or to give the family or caretaker the required information. This will result in a burden of 5,900 hours (118,000 x 3÷ 60 = 5,900) per State, and a national burden of 218,300 (5,900 x 37 = 218,300) hours annually.

Under paragraph (g) of this section, the State must provide the child's family with information, in writing, about the State's Medicaid program and eligibility rules that prohibit children who have been screened eligible for Medicaid from being enrolled in a separate child health program, other than provisional temporary enrollment while a final Medicaid eligibility determination is being made.

The burden associated with this requirement is the time it takes a State to prepare the notice and materials and to give them out. Preparation of the notice was a one-time burden and is not included in the burden for this re-certification. The burden associated with furnishing the notices to applicants is included in the burden for furnishing the notices required by paragraph (e) and (f) of this section.

Record Keeping and Reporting Burden

37 entities (States and Territories) X 5,900 hours = 218,300 hours.

$23.63 per hour X 218,300 per year = $51,584 per year

$51,584 X 30 percent (State share) = $15,475 per year

Section 457.431 -- Actuarial report for benchmark-equivalent coverage

In summary, §457.431 requires a State that wants to obtain approval for benchmark-equivalent benefits coverage described under §457.430, to submit to CMS an actuarial report that; 1) compares the actuarial value of coverage of the benchmark package to the State-designed benchmark-equivalent benefit package, 2) demonstrates through an actuarial analysis of the benchmark-equivalent package that coverage requirements under §457.430 are met, and 3) meets the requirements of §457.431(b).

The burden associated with this requirement for a State that wants to obtain approval for benchmark-equivalent benefits coverage described under §457.430, is the time and effort to prepare and submit its actuarial report to CMS for approval. Submission of this report was a one-time burden and is not reflected in the burden for this re-certification, however we believe annually 6 States will submit an amendment that would require an actuarial report. We estimate that, on average, it will take a State 40 hours to prepare and submit an actuarial report necessary for CMS approval for a total burden of 240 hours.

Record Keeping and Reporting Burden

6 entities (States and Territories) X 1 report X 40 hours = 240 hours.

$23.63 per hour X 240 hours per year = $5,671 per year.

$5,671 X 30 percent (State share) = $1,701.

Section 457.440 -- Existing State-Based Comprehensive Coverage

Under paragraph (b) of this section, a State may modify an existing comprehensive State-based coverage program described in paragraph (a) of the section if, among other items, the State submits an actuarial report when it amends its existing coverage.

The burden associated with this requirement is the time and effort a State needs to prepare an actuarial report. There are only three States that will

have this option, and we do not anticipate that more than one of them will modify its program in a given year. The collection of information requirements at 5 CFR 1320 are applicable to requirements affecting 10 or more entities. While this requirement is subject to the PRA, we believe it is exempt as specified at 5 CFR 1320.3(c)(4).

Section 457.525 -- Public schedule

In summary, §457.525(b) requires a State to make the public schedule required under paragraph (a) available to:

(1) Enrollees, at the time of enrollment and reenrollment after a re-determination of eligibility, and when cost-sharing charges and cumulative cost-sharing maximums are revised.
(2) Applicants, at the time of application.
(3) All participating providers.
(4) The general public.

The burden associated with this requirement is the time and effort for a State to prepare and make available its public schedule to these four groups. We estimate approximately 20 of the 37 States/Territory with a separate child health program will need to revise their public schedule, and that on average, it will take each State/Territory 120 minutes to prepare its revised schedule for a total burden of 40 hours, and it will take each State/Territory and additional 3 minutes each to disseminate no more than 118,000 copies of the revised schedule on an annual basis for a burden of 5,900 hours per State/Territory, and a total burden of 118,040.

Record Keeping and Reporting Burden

20 entities (State/Territories) x 120 ÷ 60 = 40 hours.
20 entities (State/Territory) x 5,900 x 1 public schedule = 118,000 hours.
118,000 hours + 40 hours = 118,040

$23.63 per hour X 20,040 hours per year = $473,545 per year.

$473,545 X 30 percent (State share) = $142,064

Section 457.560 Cumulative cost sharing maximum

Paragraph (d) of this section requires that a State must inform the enrollee's family in writing and orally, if appropriate, of their individual cumulative cost-sharing maximum amount at the time of enrollment and reenrollment.

The burden associated with this requirement is the time and effort involved in informing the enrollee's family. This burden is covered in the burden imposed by §457.350(g).

Section 457.570 Disenrollment protections

Under paragraph (a) of this section, a State must give enrollees reasonable written notice of and an opportunity to pay past due premiums, co-payments, coinsurance, deductibles or similar fees prior to disenrollment.

The burden associated with this requirement is the time and effort for a State to prepare a standardized notice and to fill out and give the enrollees the notice. We estimate that it will take each of the 37 States/Territories with separate child health programs four hours to create a notice, for a national burden of 148 hours. Creation of a written notice is a one-time burden and is not counted in this re-certification.

We anticipate that it will take a State no longer than 10 minutes per enrollee to fill out the notice and give it to the enrollee; we estimate that approximately five per cent of the approximate 4.4 million children enrolled in 37 States with separate child health programs will be given notices annually (4,400,000 x .05 = 220,000 notices). We therefore estimate the total burden to be 36,667 hours.

Record Keeping and Reporting Burden

220,000 X 10 ÷ 60 = 36,667 hours.

$23.63 per hour X 36,667 hours per year = $866,433 per year.

$866,433 X 30 percent (State share) = $259,930

Section 457.740 -- State expenditure and statistical reports

In summary, §457.740 requires a State to submit a report to CMS that contains quarterly program expenditures and statistical data, no later than 30 days after the end of each quarter of the federal fiscal year. The quarterly program expenditure information must be provided by States, and is used by CMS to prepare the grant awards to States for the SCHIP program. The quarterly statistical submission must include: the number of children under 19 years of age who are enrolled in the title XIX Medicaid program, the separate child health program, and in the Medicaid expansion program, as appropriate, by the following categories:

(i) Age (under 1 year of age, 1 through 5 years of age, 6 through 12 years of age, and 13 through 18 years of age).

(ii) Service delivery system (managed care, fee-for-service, and primary care case management).

(iii) Family income as a percentage of the Federal poverty level as described in paragraph (b) of section 457.740.

The burden associated with this requirement is the time and effort necessary for a State to prepare and submit the Quarterly Statement of Expenditures and related statistical information. Since this collection requirement is currently approved by OMB under OMB# 0938-0731 with an expiration date of 6/30/2008, and is counted in the supporting statement for Quarterly State Children's Health Insurance Program Statement of Expenditures for title XXI, we did not include it in the burden calculated for this re-certification.

In addition, §457.740 also requires a State to submit an annual enrollment report, thirty days after the end of the Federal fiscal year, of an unduplicated count for the Federal fiscal year of children who are enrolled in the title XIX Medicaid program, and the separate child health and Medicaid-expansion programs, as appropriate, by age, service delivery, and income categories described in paragraphs (a) and (b) of this section.

The burden associated with this requirement is the time and effort for a State to prepare and submit its annual enrollment report to CMS. We estimate that on average, it will take a State 40 hours to complete and submit its report. We estimate that all 56 States/Territories will submit a plan for a total burden of 2,240 hours.

Record Keeping and Reporting Burden
56 entities (States and Territories) X 1 plan X 40 hours = 2,240 hours.

$23.63 per hour X 2,240 hours per year = $52,931 per year.

$52,931 X 30 percent (State share) = $15,879

Section 457.750 -- Annual report
In summary, §457.750 requires a State to submit a report to the Secretary by January 1 following the end of each preceding federal fiscal year, on the results of the State's assessment of operation of the State child health plan.

The burden associated with this requirement is the time and effort for a State to prepare and submit its annual report on the results of the State's assessment of operation of the State child health plan. We estimate that on average, it will take each State 40 hours to complete and submit their report. We estimate that all 56 States/Territories will submit an annual report for a total burden of 2,240 hours.

Record Keeping and Reporting Burden
56 entities (States and Territories) X 1 report X 40 hours = 2,240 hours.

$23.63 per hour X 2,240 hours per year = $52,931 per year.

$52,931 X 30 percent (State share) = $15,879.

Section 457.810 -- Premium assistance programs: Required protections against substitution

A State that operates a premium assistance program, as defined at §457.10, must provide the protections against substitution of SCHIP coverage for coverage under group health plans specified in this section. The State must describe these protections in the State plan; and report on results of monitoring of substitution in its annual reports.

The burden associated with this requirement is the time and effort for a State to describe the protections in the State plan and to report on the results of monitoring of substitution in its annual reports. The burden imposed is subsumed in the burden for §457.50 and §457.750.

In summary, §457.810(d) requires a State that uses title XXI funds to provide premium subsidies under employer-sponsored group health plans to collect information to evaluate the amount of substitution that occurs as a result of the subsidies and the effect of subsidies on access to coverage.

The burden associated with this requirement is the time and effort for a State to collect the necessary data to evaluate the amount of substitution that occurs as a result of the subsidies and the effect of subsidies on access to coverage. We estimate that on average, it will take a State 20 hours to collect the necessary data for their evaluation. We estimate that 10 States/Territories with separate child health programs will also have premium assistance programs. We estimate that these 10 States/Territories will submit a plan for a total burden of 200 hours.

Record Keeping and Reporting Burden

10 entities (States and Territories) X 1 evaluation X 20 hours = 200 hours.

$23.63 per hour X 200 hours per year = $4,726 per year.

$4,7266 X 30 percent (State share) = $1,418

Section 457.940 -- Procurement standards

Under paragraph (a), a State with a separate child health program must submit to CMS a written assurance that title XXI services will be provided in an effective and efficient manner. The burden associated with this requirement is the time and effort for a State to write this assurance. We believe that the time involved will be minimal and assign one hour per State for this requirement for a total

burden of 37 hours.

Record Keeping and Reporting Burden
37 entities (States and Territories) X 1 written assurance X 1 hour = 37 hours.

$23.63 per hour X 37 hours per year = $874 per year.

$874 X 30 percent (State share) = $262

Section 457.945 Certification for contracts and proposals

Entities that contract with the State under a separate child health program must certify the accuracy, completeness, and truthfulness of information in contracts and proposals, including information on subcontractors, and other related documents, as specified by the State.

The burden associated with this requirement is the time and effort for a contractor to review and certify its submissions. We estimate that it will take each contractor 8 hours to review and certify its submissions, and that there will be an average of 10 contractors per state for a total burden of 2,960 hours.

Record Keeping and Reporting Burden
37 States/Territories x 10 contractors x 1 assurance x 8 hours = 2,960 hours.

$23.63 per hour X 2,960 hours per year = $69,945 per year.

$69,945 X 30 percent (State share) = $20,983

Section 457.950 - Contract and Payment Requirements Including Certifiaction of Payment-Related Information

Section 457.965 -- Documentation

In summary, §457.965 requires a State to include in each applicant's record facts to support the State's determination of the applicant's eligibility for SCHIP. While this requirement is subject to the PRA, we believe that the burden associated with this requirement is exempt from the PRA as defined in 5 CFR 1320(b)(3), because this requirement will be imposed in the absence of a Federal requirement.

Section 457.985 -- Integrity of professional advice to enrollees

Under this section, the State must guarantee, in all contracts for coverage and services, beneficiary access to information, in accordance with §'422.208 and 422.210(a) and (b), related to limitations on physician incentives or compensation arrangements that have the effect of reducing or limiting services and information requirements respectively.

The burden associated with this requirement is the time and effort for a State to include this guarantee in its contract. We estimate that it will take a token hour for each of the 37 States/Territories to comply with this requirement, and that each State/Territory will need to include the guarantee in 5 contracts for a total burden of 185 hours.

Record Keeping and Reporting Burden
37 entities (States and Territories) X 5 assurance X 1 hour = 185 hours.

$23.63 per hour X 185 hours per year = $4,372 per year.

$4,372 X 30 percent (State share) = $1,312

Section 457.1005 -- Cost-effective coverage through a community-based health delivery system

In summary, §457.1005 requires a State requesting a waiver for cost-effective coverage through a community-based health delivery system, to submit documentation to CMS that demonstrates that they meet the requirements of §457.1005(b)(1) and (b)(2).

The burden associated with this requirement is the time and effort for a State that wants to obtain a waiver to prepare and submit the necessary documentation to CMS that demonstrates that they meet the requirements of §457.1005.

We estimate that on average, it will take a State 24 hours to prepare and submit a waiver request for CMS approval. Based on experience to date, we estimate that 1 State/Territory will submit a request for a total burden of 24 hours.

Record Keeping and Reporting Burden
1 entities (States/Territories) X 1 waiver request X 24 hours = 24 hours.

$23.63 per hour X 24 hours per year = $567 per year.

$567 X 30 percent (State share) = $170

Section 457.1015 -- Cost effectiveness

In summary, §457.1015 requires a State to report to CMS in its annual report the amount it spent on family coverage and the number of children it covered. While this requirement is subject to the PRA, the burden associate with this requirement is captured in §457.750 (Annual report).

Section 457.1180 -- Notice

Under this section, a State must provide enrollees and applicants timely written notice of any determinations required to be subject to review under §457.1130, a notice that includes the reasons for the determination; an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, and the manner in which a review can be requested; and the circumstances under which enrollment may continue pending review.

The burden associated with this requirement is the time necessary to produce a standardized form into which enrollee-specific information may be inserted, and that producing the notice is a one-time effort of 4 hours. This one-time effort is not included in this re-certification.

For a State to prepare and give out the notice we estimate that it will take each State 3 minutes per enrollee to prepare and give out the notice. We estimate that approximately 20 percent of enrollees (4.4 million x .20 = 880,000) will receive a notice under this provision, for a total burden of 44,000 hours.

Record Keeping and Reporting Burden

880,000 enrollees x 3 minutes ÷ 60 = 44,000 hrs.

$23.63 per hour x 44,000 hours per year = $1,039,720 per year

$1,039,720 x .30 (State share) = $311,916

All of the burden estimated is predicated upon a State submitting a SPA for approval. All States, at this point, have a State Plan to administer a SCHIP program; thus, unless a State chooses to review its SCHIP State Plan, burden is not applicable.

13. Capital Costs

There are no start-up costs associated with this information collection.

14. Cost to the Federal Government

There is no cost to the Federal government.

15. Program/Burden Changes

There are no program/burden changes.

16. Publication and Tabulation Data

The information gathered from the State evaluations and annual reports will be released by CMS, on behalf of the Secretary. Information pertaining to States' plans and amendments is available on the CMS website.

17. Expiration Date

CMS is not seeking approval not to display the expiration date for OMB approval of the information collection.

18. Certification Statement

There are no exceptions to the certification statement.

C. Collections of Information Employing Statistical Methods

This collection does not employ statistical methods.