Supporting Statement Part A
State Children's Health Insurance Program and Supporting Regulation
CMS-R-308, OMB 0938-0841

Background

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act by adding a new title XXI, enacted in 1997 by the Balanced Budget Act.

This iteration does not revise any requirements. Rather, it proposes to: (1) remove burden which is duplicative (approved under other control numbers), (2) remove the burden for one-time requirements which have been met, and (3) remove the burden for requirements that are exempt from the PRA.

Of the existing 1,473,855 hour burden estimate, this iteration removes and adjusts 994,715 of those hours leaving 479,140 hours for eligibility screening and facilitation of Medicaid enrollment under 42 CFR 457.350, enrollment reporting under §457.740, public schedule under §457.525 and notices under §457.1180.

A. Justification

1. Need and Legal Basis

The legal authority for this collection is title XXI of the Social Security Act. 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. All 50 states, the District of Columbia and the territories have a CMS-approved CHIP state plan that encompasses all of the child health assistance being provided using Title XXI funding. It is important to note that once a CHIP state 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. Most provisions of title XXI have been met through the approved state plan. There are provisions related to enrollment requirements and its burden is discussed in section 12 of this Supporting Statement.

2. Information Users

Information provided in the state plan, state plan amendments, enrollment reporting, and from other information collection by CMS 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 effect 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 send CMS information regarding the state plan, state plan amendments, state expenditure and statistical information, including the number of children the state program covers, to generate notices to participants and beneficiaries regarding eligibility determinations and to provide public notices and enrollee rights to file grievances and appeals.

4. Duplication of Similar Information

There is no duplication of this information.

5. Small Businesses

The collection of information is provided by the States. There is no impact on 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. All 50 states, the District of Columbia and the territories have a CMS-approved CHIP state plan that encompasses all of the child health assistance being provided using Title XXI funding. It is important to note that once a CHIP state 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. Most provisions of title XXI have been met through the approved state plan. There are provisions related to enrollment requirements and its burden is discussed in section 12.

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

The reporting frequency as it applies to the requirements and burden under section 12 is quarterly as well as annually. It is important to note that once a CHIP state 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. 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.

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by the Office of Management and Budget (OMB);
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register Notice/Outside Consultation

The 60-day notice published in the Federal Register on February 17, 2017 (82 FR 11040). We did not receive any comments.

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 statistical reporting that provide basic information about enrolled populations and their participation in federally-funded children's health insurance programs – CHIP and Medicaid. 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 associated with this collection. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

12. Burden Estimate (Total Hours & Wages)

Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' (BLS) 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)
Compliance Officer	13-1041	33.77	33.77	67.54

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.

Information Collection Requirements and Associated Burden Estimates

Eligibility screening and facilitation of Medicaid enrollment (§ 457.350) Section 457.350(e) requires that a state which 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.

In §457.350(f), 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:

(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; 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 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.

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.

All States with separate child health insurance programs (43) use a screening process. We estimate that on average, there will be 176,300 new or renewing applicants in each of these 43 States during each year. We estimate that it will take no longer than 3 minutes (depending on the medium) at $67.54/hr for a compliance officer to transmit applications or relevant information to the Medicaid agency or to give the family or caretaker the required information. This results in an annual burden of 379,045 hours (176,300 responses/state x 43 states x 3 min/60) at a cost of $25,600,699 (379,045 hr x $67.54/hr).

Annual Enrollment Report Section 457.740 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; gender, race, and ethnicity; service delivery; and income categories described in §457.740(a) and (b).

States report child enrollment through the Internet-based Statistical Enrollment Data System (SEDS) using forms CMS-21E; CMS-64.21E; CMS-64.EC; and Gender, Race, Ethnicity. The data reported by states represents a point-in-time unduplicated number of children ever enrolled in Medicaid and CHIP as of the date of reporting. All states and the District of Columbia are required to provide these data to CMS, and CMS publishes the annual enrollment data from states on Medicaid.gov each Spring.

States that serve low-income pregnant women in CHIP through the state plan option also complete form CMS-21PW. States that serve adults in CHIP through a Section 1115 waiver also complete forms CMS-21 Waiver and Waiver Gender, Race, Ethnicity. Additionally, Informational forms 21E, 21PW, 64.21E, 64EC, and 21 Waiver collect information on children or eligible adults enrolled in employer sponsored insurance or dental wrap-around services for the applicable program. These data are subsets of the enrollment data already reported through forms CMS-21E, CMS-64.21E, and CMS-64.EC. The attached SEDS instructions document provides the guidance for state data entry. (Note: CMS-21E, CMS-64.21E, and CMS-64.EC should not be confused with the CMS-21 and CMS-64 series of forms approved under OMB control number 0938-1265 (CMS-10529). Those forms are associated with the MBES reporting system while this packages' CMS-21E, CMS-64.21E, and CMS-64.EC forms are associated with the SEDS system).

We estimate that, on average, it will take a state 40 hours at $67.54/hr for a compliance officer to complete and submit the state's report, for a total burden of all 56 states and territories of 2,240 hours (56 states and territories x 40 hours) at a cost of $115,405 (2,240 hr x $67.54/hr) or $34,622 when adjusting for the states' 30 percent share.

Public Schedule Section 457.525(b) requires a state to make the public schedule required under §457.525(a) available to the following groups:
(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; and
(4) the general public.

The burden associated with this requirement includes the time for a state to prepare and make available its public schedule to the four groups. We estimate approximately 20 of the 43 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 2 hours to prepare its revised schedule for a burden of 40 hours at a cost of $2,702, and it will take each State/Territory and additional 3 minutes each to disseminate no more than 176,300 copies of the revised schedule on an annual basis for a burden of 8,815 hours at a cost of $595,365. We estimate a total burden of 8,855 hours at a cost of $598,067 or $179,420 when adjusting for the states' 30 percent share.

Written Notice Under §457.1180, 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 consists of the one-time effort for a state to produce a standardized form into which enrollee-specific information may be inserted. Since all states have met this requirement, the associated burden is not set out in this iteration's estimates.

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 (8.9 million x 0.20 = 1,780,000) will receive a notice under this provision, for a total burden of 89,000 hours (3 min x 1,780,000 notices) at a cost of $6,011,060 (89,000 x $67.54/hr) or $1,803,318 when adjusting for the states' 30 percent share.

Burden Summary

CFR Section(s)	# Respondents	Total Annual Responses	Time (per response)	Total Annual Time	Wage ($/hr)	Total Cost ($)*
457.350 (Eligibility Screening)	43	7,580,900	3 min	379,045	67.54	7,680,210***
457.740 (Enrollment Report)	56	56	40 hr	2,240	67.54	34,622**
457.525(b) (Public Schedule)	43	20	2 hr	40	67.54	811***
	43	176,300	3 min	8,815	67.54	178,610***
457.1180 (Written Notice)	56	1,780,000	3 min	89,000	67.54	1,803,318***
TOTAL	**56**	**9,537,276**	**Varies**	**479,140**	**67.54**	**9,697,571**

*Costs are adjusted for the states' 30 percent share.
**Reporting.
***Third-party Disclosure.

Information Collection Instruments and Instruction/Guidance Documents

SEDS Instructions for Data Entry (§457.740, Enrollment Report)

Please note that each state would not fill out the entire SEDS report as several pages are not applicable to all states.

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

Summary

This iteration does not revise any requirements. Rather, it proposes to:

(1) remove burden which is duplicative (approved under other control numbers),
(2) remove the burden for one-time requirements which have been met,
(3) remove the burden for requirements that are exempt from the PRA (having fewer than

10 respondents under 5 CFR 1320.3(c)),

(4) remove the burden for requirements that are exempt from the PRA (are associated with an administrative action under 5 CFR 1320.4(a)(2) and (c),

(5) remove from the current Supporting Statement, under section 12, the *discussion* of requirements that are exempt from the PRA (applies to §§457.440 and 457.965), and

(6) correct burden regarding §457.525.

With regard to reduced burden, the removed actions include reporting requirements and third-party disclosure (TPD) requirements.

Of the existing 1,473,855 hour burden estimate, this iteration removes and adjusts 1,373,760 of those hours leaving 100,095 hours for enrollment reporting under 42 CFR 457.740, public schedule under 457.525 and notices under 457.1180.

The most recent ICR submission had inadvertently lumped all burden under reporting when it should have been distributed among reporting and third party disclosure requirements. This iteration corrects that oversight.

CFR Section	Response Type	Existing Time (hr)	Justification *	Ending Time Estimate (hr)	Difference
457.60	Reporting	3,200	1	0	(3,200)
457.70	Reporting	38	2	0	(38)
457.340	TPD	758,090	2 and 6	0	(758,090)
457.431	Reporting	240	3	0	(240)
457.525(b)	TPD	176,300	7	8,815	(167,485)
457.570	TPD	67,500	2	0	(67,500)
457.750	Reporting	2,240	5	0	(2,240)
457.810	Reporting	200	3 and 5	0	(200)
457.940	Reporting	43	2	0	(43)
457.945	Reporting	3,440	2	0	(3,440)
457.985	Reporting	215	2	0	(215)
457.1005	Reporting	24	3	0	(24)
457.1180	TPD	81,000	7	89,000	8,000
	TOTAL	**1,092,530**	**n/a**	**97,815**	**(994,715))**

*Justification:

[1]The burden is currently approved by OMB under control number 0938-1148 (CMS-10398 (#34)), Template for Child Health Plan Under Title XXI of SSA, CHIP. The submission of an amendment by a respective state reflects any changes to the language within the model template or non-template state plan.

[2]The burden is removed since all states have met this requirement.

[3]Estimate is for fewer than 10 respondents, the information collection requirements are exempt (5 CFR 1320.3(c)) from the requirements of PRA.

[4]The burden associated with §457.740 for state expenditures is currently approved by OMB under control number 0938-1265 (CMS-10529), Quarterly Medicaid and CHIP Budget and Expenditure Reporting for the Medical Assistance Program and CHIP (MBES).

[5]The burden associated with §457.750 is currently approved by OMB under control number 0938-1148 (CMS-10398 (#1)), CHIP Annual Report Template System (CARTS).
[6]The requirement is in response to an administrative action which are exempt from the PRA under 5 CFR 1320.4(a)(2) and (c).
[7]Correction.
[8]Burden adjustment.

Removed Requirements and Burden

State Plan Amendments (42 CFR 457.60) Requires a state to submit to CMS for approval an amendment to its approved state plan, when 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 currently approved by OMB under control number 0938-1148 (CMS-10398 #34).*

(Minus 3,200 hours)

Program Options (42 CFR 457.70) Requires a state to choose an option for the health benefits coverage under the state plan. A state may elect to provide coverage as a separate child health program, a Medicaid expansion program or a combination program of both. If a state elects to obtain health benefits coverage through a Medicaid expansion program, it must submit an amendment to the state's Medicaid state plan as appropriate, demonstrating that it meets the requirements in subparts A B, F, G, and J of part 457 and in the applicable Medicaid regulations. *The burden associated with this requirement has been met since all 50 states, the District of Columbia and the territories have a CMS-approved state plan with a chosen option.*

(Minus 38 hours)

Application for and enrollment in a separate child health program (42 CFR 457.340) Section 457.340(b) requires a state with a separate child health program (42 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 associated burden includes the time for a state to prepare and provide the notice and materials. *Preparation of the notice was a one-time effort that has been met.*

Section 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), the specific reason or reasons for the action and an explanation of the right to request a hearing within a reasonable time. *Since the notice is associated with an administrative action (5 CFR 1320.4(a)(2) and (c)), the requirement is exempt from the requirements of the PRA.*

(Minus 758,090 hours)

Actuarial report for benchmark-equivalent coverage (42 CFR 457.431) Requires a state that wants to obtain approval for benchmark-equivalent benefits coverage (as 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 includes the time for a state to prepare and submit its actuarial report to CMS for approval. *Submission of this report was a one-time effort that has been met.*

(Minus 240 hours)

Existing State-Based Comprehensive Coverage (42 CFR 457.440) Under §457.440(b), a state may modify an existing comprehensive state-based coverage program described §457.440(a) if, among other items, the state submits an actuarial report when it amends its existing coverage.

The burden associated with this requirement incorporates the time for a state to prepare an actuarial report. There are only three states that have this option, and we do not anticipate that more than one of them will modify its program in a given year. *Since we estimate fewer than ten respondents, the information collection requirements and burden are exempt (5 CFR 1320.3(c)) from the requirements of the PRA. (The exemption is in the current ICR, consequently there is no burden change.)*

Public Schedule Section 457.525(b) requires a state to make the public schedule required under §457.525(a). The most recent OMB had set out 176,300 hours when it should have set out 8,815 hours. The 176,300 figure should have been the number of respondents. In this iteration we are correcting by deducting 167,485 hours from our burden estimate. Section 12 of this Supporting Statement properly sets out 176,300 respondents and 8,815 hours.

(Minus 167,485 hours)

Disenrollment protections (42 CFR 457.570) Under §457.570(a), 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 includes the time for a state to prepare a standardized notice and to fill out and provide the notice to enrollees. *Creation of a written notice is a one-time effort that has been met.*

(Minus 67,500 hours)

State expenditure and statistical reports (42 CFR 457.740) Section 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 burden associated with this requirement includes the time for a state to prepare and submit the Quarterly Statement of Expenditures and related statistical information. *The burden associated with this requirement is currently approved by OMB under control number 0938-1265 (CMS-10529).*

(Minus 2,240 hours)

Annual report (42 CFR 457.750) Section 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. *This information collection requirement is currently approved by OMB under control number 0938-1148 (CMS-10398 #1).*

(Minus 2,240 hours)

Premium assistance programs: Required protections against substitution (42 CFR 457.810) A state that operates a premium assistance program, as defined in §457.10, must provide the protections against substitution of SCHIP coverage for coverage under group health plans specified 457.810. The state must describe these protections in the state plan and report on the results of monitoring of substitution in its annual reports. *The burden associated with this requirement is subsumed in the burden for §457.750 Annual Report (see control number 0938-1148, CMS-10398 #1).*

Section 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 includes the time for a state to collect the necessary data and 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 six states with separate child health programs have premium assistance programs and we do not anticipate that more than one of them will modify its program in a given year. *Since we estimate fewer than ten respondents, the information collection requirements and burden are exempt (5 CFR 1320.3(c)) from the requirements of the PRA.*

(Minus 200 hours)

Procurement standards (42 CFR 457.940) Under §457.940(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 has been met since all 50 states, the District of Columbia and the territories have a CMS-approved state plan with a written assurance. *The burden associated with the aforementioned requirement is a one-time effort that has been met.*

(Minus 43 hours)

Certification for contracts and proposals (42 CFR 457.945) 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 incorporates the time for a contractor to review and certify its submissions.
. Consequently, the burden is a usual and customary business practice that is exempt from the requirements of the PRA. (The exemption is in the current ICR, consequently there is no burden

change.)

(Minus 3,440 hours)

Documentation (42 CFR 457.965) Section 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. We believe that the time, effort, and financial resources necessary to comply with the requirement would be incurred by persons during the normal course of their activities and in the absence of federal regulation. *Consequently, the burden is a usual and customary business practice that is exempt from the requirements of the PRA. (The exemption is in the current ICR, consequently there is no burden change.)*

Integrity of professional advice to enrollees (42 CFR 457.985) Under §457.985, the state must guarantee, in all contracts for coverage and services, beneficiary access to information, in accordance with §§422.208, 422.210(a), and 422.21(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 includes the time for a state to add this guarantee in its contract. *The burden associated with the aforementioned requirement is a one-time effort that has been met.*

(Minus 215 hours)

Cost-effective coverage through a community-based health delivery system (42 CFR 457.1005) Section 457.1005 requires a state requesting a waiver for cost-effective coverage through a community-based health delivery system to submit documentation to CMS which demonstrates that it meets the requirements of §457.1005(b)(1) and (b)(2). Based on CMS' experience, we estimate that 1 state or territory will submit a request for approval and we do not anticipate that more than one of them will modify its program in a given year. *Since we estimate fewer than ten respondents, the information collection requirements and burden are exempt (5 CFR 1320.3(c)) from the requirements of the PRA.*

(Minus 24 hours)

Written Notice Under §457.1180, 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. Our most recent approval set out 1,620,000 affected enrollees and 81,000 hours. In this iteration we are adjusting the number of enrollees by to 1,780,000 and the number of hours to 89,000. Our per response figure is remains unchanged.

(Plus 900 hours)

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

The expiration date will be displayed.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collections of Information Employing Statistical Methods

This collection does not employ statistical methods.