SUPPORTING STATEMENT A
Generic Clearance for Medicaid and CHIP State Plan,
Waiver, and Program Submissions
CMS-10398, OMB 0938-1148

## Background

The Centers for Medicare & Medicaid work in partnership with States to implement Medicaid and the Children's Health Insurance Program (CHIP). Together these programs provide health coverage to millions of Americans. Medicaid and CHIP are based in Federal statute, associated regulations and policy guidance, and the approved State plan documents that serve as a contract between CMS and States about how Medicaid and CHIP will be operated in that State. When modifications or enhancements to the program are prescribed by Congress through legislation, each State's program must be amended to comply. For example, in March 2010, Congress passed (and the President signed into law) the Affordable Care Act, which enacted comprehensive reform of the Medicaid 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.

As demonstrated below in section 15, this 2026 iteration requests OMB's approval to raise our active burden ceiling by 1,112,707hours (from 450,000 to 1,562,707 hr) while extending our 0938-1148 control number for 3-years. The increase is mostly needed to account for the Working Families Tax Cut (WFTC) legislation (Pub. L. 119-21) and the implementing provisions in our June 3, 2026, Interim Final Rule with Comment Period (CMS-2454-IFC; RIN 0938-AV98) entitled, "Medicaid Program; Community Engagement Requirement for Certain Individuals.

## A. Justification

### 1. Need and Legal Basis

Section 1901 of the Social Security Act (42 U.S.C. 1936) requires that States must establish a State plan for medical assistance that is approved by the Secretary to carry out the purpose of Title XIX. CHIP has a corresponding statutory requirement for a State plan outlined in Section 2101 to carry out the purpose of Title XXI. The State plan functions as a contract between the State and Federal government describing how the State will implement its program in accordance with Federal laws and regulations in order to secure Federal funding.

The Act also provides the Secretary with some discretion in waiving program requirements when it does not have a negative financial impact (cost effectiveness, cost neutrality, and budget neutrality) and promotes the objectives of the program. For instance, Section 1915(b) allows for the waiver of Medicaid provisions to allow for the implementation of managed care programs. Additionally, Section 1115 of the Act provides the Secretary flexibility to waive program requirements in Section 1902 and provide Federal funding for costs that are otherwise

unmatchable. Written applications from States are required for these programs that outline what the State proposes to do and the financial impact it will have.

2. Information Users

State Medicaid and CHIP agencies are responsible for developing submissions to CMS, including State plan amendments and requests for waivers and program demonstrations. States use templates when they are available and submit the forms to CMS to review for consistency with statutory and regulatory requirements (or in the case of waivers and demonstrations whether the proposal is likely to promote the objectives of the Medicaid program). If the requirements are met, CMS approves the State's submission giving the State the authority to implement the flexibilities. For a State to receive Medicaid Title XIX funding, there must be an approved Title XIX State plan.

The development of streamlined submission forms enhances the collaboration and partnership between States and CMS by documenting CMS policy for States to use as they are developing program changes. Streamlined forms improve efficiency of administration by creating a common and user-friendly understanding of the information needed by CMS to quickly process requests for State plan amendments, waivers, and demonstration, as well as ongoing reporting.

3. Improved Information Technology

The forms for the States to use are available in electronic format. We expect every submittal to be forwarded to CMS using the electronic format. The forms create streamlined and structured data, decreasing the time required by States to develop their submissions to CMS.

4. Duplication

There is no duplication of similar information.

5. Small Business

There is no burden on small businesses.

6. Less Frequent Collection

Under Medicaid and CHIP State plans, there is no need to resubmit information once it is approved, unless the State elects to change its program. For waiver and demonstration programs, renewals of the programs are required on cycles that vary across statutory authority from 2 – 5 years. However, within the approved waiver cycle, States are not asked to resubmit information once it is approved unless the State elects to change its program.

7. Special Circumstances

The implementation of these templates is often time sensitive and must be coordinated with the release of guidance documents such as regulations and policy letters. Additionally, some of the

templates that would be approved under this collection must be available to States to implement the changes timely.

8. Federal Register Notice/Prior Consultation

Serving as our 60-day notice, our Interim Final Rule with Comment Period (CMS-2454-IFC; RIN 0938-AV98) published in the Federal Register on June 3, 2026 (91 FR 33348).

For new and revised GenICs, we will continue to publish 14-day Federal Register notices that will provide interested parties with an opportunity to review and comment on the generic information collection request. Instructions for obtaining the GenIC's documents and for submitting comments will be set out in each Federal Register notice.

However, new or revised GenICs that are affiliated with SMD (State Medicaid Director) or SHO (State Health Official) letters we may publish the 14-day Federal Register notice before, on, or after the issuance of the OMB's approval of the generic collection of information request. Requests that are not tied to such letters must publish the 14-day notice a minimum of 14 days prior to OMB's approval.

For SMD and SHO letter-related GenICs, when the 14-day Federal Register notice's comment period closes after OMB's approval of the GenIC, CMS shall submit a subsequent GenIC that includes all public comments as well as CMS' response to those comments. If the collection of information requirements and/or burden need to be revised, the subsequent GenIC must also address the proposed changes.

9. Payment/Gift to Respondents

There is no payment or gift to respondents.

10. Confidentiality

Program submissions to CMS from States are public information, and there is no personal identifying information collected in the documents. No assurance of confidentiality is provided to respondents.

11. Sensitive Questions

There are no questions of a sensitive nature.

12. Burden Estimates

As demonstrated below in section 15 this 2026 iteration requests OMB's approval to raise our active burden ceiling to 1,562,707 hours.

Cost estimates are dependent on our requirements and the respondent's BLS Occupation Title and wage. Since this information will not be known until upcoming GenICs are developed, our

cost estimates will be set out when each GenIC package is submitted to OMB for approval.

While this generic umbrella lays the groundwork for the content of the GenICs that fall under this umbrella, the GenICs specify the collection of information requirements and burden that are associated with those requirements. It also sets forth the collection's reporting instruments (if any) and instructions.

13. Capital Costs

There are no capital costs associated with this information collection.

14. Costs to Federal Government

With respect to the PRA and the definition of "collection of information" under 5 CFR 1320.3(c), respondent labor-related costs are typically dependent on federal legislation, our implementing regulations, and current BLS occupation and wage data. Respondents may also have non-labor costs (postage is one example). Since this information will not be known until upcoming GenICs are developed, the Federal match or cost (if any) will be set out when each GenIC is submitted to OMB for approval.

15. Program/Burden Changes

As demonstrated below, this 2026 iteration requests OMB's approval to raise our active burden ceiling by 1,112.707 hours (from 450,000 to 1.562,707 hr) while extending our 0938-1148 control number for 3-years. The increase is mostly needed to account for the Working Families Tax Cut (WFTC) legislation (Pub. L. 119-21) and the implementing provisions in our June 3, 2026, Interim Final Rule with Comment Period (CMS-2454-IFC; RIN 0938-AV98) entitled, "Medicaid Program; Community Engagement Requirement for Certain Individuals.

The increase considers our currently approved burden ceiling, our active time estimates, time needed for CMS-2454-IFC, active time estimates that are no longer needed, our projected needs for 2026 – 2029, and the time needed for unanticipated GenICs.

15.1. Currently Approved Burden Ceiling

450,000 hours (see attached NOA, dated July 29, 2026)

15.2. Currently Approved GenICs

231,896 hours (see attached NOA, dated July 29, 2026)

For the GenICs that we propose to keep active, we are not making any program changes or adjustments.

15.3. Community Engagement Requirement for Certain Individuals (CMS-2454-IFC; RIN 0938-AV98)

The following changes that are associated with our June 3, 2026 IFC.

For details see the following table and attached generic collection of information requests.

| Requirement | No. Respondents | Total Responses | Time per Response (hr) | Total Time (hr) | Wage ($/hr) | Total Cost ($) | Federal Share ($) | State Share ($) |
|---|---|---|---|---|---|---|---|---|
| **GenIC #11 (MAGI-Based Eligibility Verification Plan)** | | | | | | | | |
| Verification Plan | 44 Jurisdictions | 44 | 124 | 5,456 | Varies | 505,226 | 252,613 | 252,61 |
| Verification Plan Updates | 5 | 5 | 11 | 55 | Varies | 5,211 | 2,606 | 2,606 |
| *Subtotal: GenIC #11* | *44* | *49* | *varies* | *5,511* | *varies* | *510,437* | *255,219* | *255,21* |
| **GenIC #35 (Eligibility and Enrollment Performance Indicators)** | | | | | | | | |
| One-Time Burden for Monitoring Community Engagement (PI data) | 44 | 44 | 162 | 7,128 | Varies | 797,350 | 598,012 | 199,33 |
| Annual Reporting for Monitoring Community Engagement (PI data) | 44 | 1,056 | 4 | 4,224 | Varies | 488,907 | 366,680 | 122,22 |
| *Subtotal: GenIC #35* | *44* | *1,100* | *varies* | *11,352* | *varies* | *1,286,257* | *964,692* | *321,56* |
| **GenIC #66 (Eligibility Processing Data Report)** | | | | | | | | |
| One-Time Burden for Monitoring Community Engagement (EP data) | 44 | 44 | 162 | 7,128 | Varies | 797,350 | 598,012 | 199,33 |
| Annual Reporting for Monitoring Community Engagement (EP data) | 44 | 1,056 | 4 | 4,224 | Varies | 488,907 | 366,680 | 122,22 |
| *Subtotal: GenIC #66* | *44* | *1,100* | *varies* | *11,352* | *varies* | *1,286,257* | *964,692* | *321,56* |
| **GenIC #100 (Medicaid Community Engagement: Good Faith Effort Exemptions and Quarterly Reporting)** | | | | | | | | |
| Good Faith Effort Exemption Request and Workplan | 10 | 10 | 28 | 280 | Varies | 26,125 | 13,063 | 13,063 |
| Good Faith Quarterly Reporting | 2 | 12 | 13 | 150 | Varies | 13,371 | 6,686 | 6,686 |
| *Subtotal: GenIC #100* | *10* | *22* | *varies* | *430* | *varies* | *39,496* | *19,749* | *19,749* |
| **GenIC #101 (Medicaid Community Engagement: Short-term Hardship Exception Requests)** | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Initial State Requirements to Establish and Document Short-Term Hardship Exceptions | 44 | 44 | 116 | 5,104 | Varies | 479,931 | 359,948 | 119,98 |
| Initial State Requirements for Short-Term Hardship Exception Notices | 44 | 44 | Varies | 4,928 | Varies | 458,367 | 343,775 | 114,59 |
| Initial Mailing State Requirements for Short-Term Hardship Exception Notices: Total Labor Burden | 44 | 30,000,000 | 0 | 510,000 | 39 | 19,716,600 | 9,858,300 | 9,858,3 0 |
| Initial Mailing State Requirements for Short-Term Hardship Exception Notices: Total Non-Labor Burden | 44 | 30,000,000 | n/a | 0 | n/a | 24,060,000 | 12,030,000 | 12,030, 00 |
| Annual State Maintenance Requirements for Short-Term Hardship Exception Notices | 44 | 44 | Varies | 1,232 | Varies | 114,592 | 85,944 | 28,648 |
| Ongoing State Requirements for Mailing Short-Term Hardship Exception Notices – Annual Updates: Total Labor Burden | 44 | 22,500,000 | 39 | 382,500 | Varies | 14,787,450 | 7,393,725 | 7,393,7 5 |
| Ongoing State Requirements for Mailing Short-Term Hardship Exception Notices – Annual Updates: Total Non-Labor Burden | 44 | 22,500,000 | n/a | 0 | n/a | 18,045,000 | 9,022,500 | 9,022,5 0 |
| Short-Term Hardship Exception Notifications for Emergencies or Disasters | 20 | 20 | 22 | 440 | Varies | 40,128 | 20,064 | 20,064 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Short-Term Hardship Exception Requests for Unemployment | 20 | 40 | 104 | 4,160 | Varies | 370,560 | 185,280 | 185,28 |
| Beneficiary Burden for Short-Term hardship Exception Requests for Institution/ Inpatient Stays or Travel | 300,000 | 300,000 | 1 | 300,000 | 13 | 3,876,000 | 0 | 0 |
| Annual Mailing State Requirements for Expiration of a Short-Term Hardship Event Described in § 435.555(d)(2) and (3): Total Labor Burden | 44 | 18,200,000 | 0 | 309,400 | 39 | 11,961,404 | 5,980,702 | 5,980,7 2 |
| Annual Mailing State Requirements for Expiration of a Short-Term Hardship Event Described in § 435.555(d)(2) and (3): Total Non-Labor Burden | 44 | 18,200,000 | n/a | 0 | n/a | 14,596,400 | 7,298,200 | 7,298,2 0 |
| *Subtotal: GenIC #101* | *300,044* | *141,700,192* | *varies* | *1,517,764* | *varies* | *108,506,432* | *52,578,438* | *52,051, 94* |
| **TOTAL** | **600,810** | **283,404,877** | **varies** | **1,546,409** | **varies** | **111,628,879** | **54,782,790** | **52,970, 92** |

15.4. Revised GenICs

Since the beginning of our current active iteration (October 3, 2024) we have added roughly 39,000 hours (38,946 hr) of revised burden. Given that was approximately 22 months ago we estimate an average of 1,773 hr of revisions per month (39,000 hr/22). For the upcoming 3-year approval period, we estimate an additional need of 63,828 hours (1,773 hr x 36 months).

15.5. Discontinued GenICs

| | Time (hr) |
|---|---|
| GenIC #71 (Reporting Requirements for State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services During the COVID–19 Emergency) | (640) |
| GenIC #81 (Improving Quality of Care and Outcomes Data for Pregnant Medicaid Beneficiaries and Newborn Infants through Linkage and Evaluation of VR, BC, DC, and TAF) | (104) |
| TOTAL | (744) |

15.6. Projected GenICs

For the upcoming 3-year approval period (2026 - 2029), we estimate the time involved for completing a template is 20 hours for shorter/less complex templates and 40 hours for templates that are more comprehensive/complex. Under the above scenario, each State could spend 1,080 hours to produce 38 responses including 16 complex templates requiring 40 hours and 22 shorter templates requiring 20 hours (1,080 hours = [16 templates * 40 hours] + [22 templates * 20 hours]). If all 56 respondents spent 1,080 hours over the 3-year period, the total 3-year burden would be 60,480 hours (1,080 hours * 56 States).

When considering GenICs #48 and #99, the total is 155,744 hours (60,480 hr + 94,984 hr + 280 hr).

| Title | Target Rollout Date | Projected Time Per Response (hr) | Projected Time (hr) |
|---|---|---|---|
| GenIC #48 (Certified Behavioral Health Clinic Quality Data Reporting) | 2026 | 224 | 94,984 |
| GenIC #99 (Medicaid Certified Community Behavioral Health Clinic (CCBHC)) | 2026 | 5 | 280 |
| ACA Sec 2001: Benchmark | TBD | 40 | 2,240 |
| ACA Sec 2003: Premium Assistance for ESI | TBD | 20 | 1,120 |
| ACA Sec 2202: Presumptive Eligibility by Hospitals | TBD | 20 | 1,120 |
| ACA Sec 2301: Coverage of Freestanding Birth Centers | TBD | 20 | 1,120 |
| ACA Sec 2302: Concurrent Hospice Care | TBD | 20 | 1,120 |
| ACA Sec 2303: Coverage of Family Planning Services | TBD | 20 | 1,120 |
| ACA Sec 2404: Spousal Impoverishment | TBD | 20 | 1,120 |
| ACA Sec 4106: Preventive Services for Adults | TBD | 20 | 1,120 |
| ACA Section 1312: Residency | TBD | 40 | 2,240 |
| ACA Section 1331: Basic Health Plan | TBD | 40 | 2,240 |
| ACA Section 1411: Appeals Process | TBD | 40 | 2,240 |
| ACA Section 1413 /2201 HUB verification sources | TBD | 20 | 1,120 |
| ACA Section 1413: Alternative Streamlined Application Template (CMS) | TBD | 20 | 1,120 |
| ACA Section 1413: Verifications (Financial and non-Financial) | TBD | 20 | 1,120 |

| Title | Target Rollout Date | Projected Time Per (hr) | Projected Time (hr) |
|---|---|---|---|
| ACA Section 2002: Coordination with Exchange ( Medicaid and CHIP) | TBD | 20 | 1,120 |
| ACA Section 2004: Former Foster Care | TBD | 20 | 1,120 |
| ACA Section 2303: Family Planning - Eligibility | TBD | 40 | 2,240 |
| Designation of Single State Agency | TBD | 20 | 1,120 |
| Election of Tax Credit Disregards | TBD | 40 | 2,240 |
| EQRO Protocols | TBD | 20 | 1,120 |
| Implementation of Asset Verification System | TBD | 40 | 2,240 |
| Implementation of MEQC data for PERM data | TBD | 40 | 2,240 |
| Implementation of Premium Assistance in Medicaid | TBD | 40 | 2,240 |
| Implementation of the Alignment of LIS and MSP Asset Tests | TBD | 40 | 2,240 |
| Implementation of the Public Assistance Reporting Information System (PARIS) | TBD | 40 | 2,240 |
| Medicaid and CHIP Statistical Enrollment Data System (SEDS) | TBD | 40 | 2,240 |
| Medicaid Eligibility Cards for Homeless Individuals | TBD | 40 | 2,240 |
| Medical Child Support Cooperation | TBD | 40 | 2,240 |
| Option to Cover Certain Children and Pregnant Women lawfully residing in the US | TBD | 40 | 2,240 |
| Performance Measures | TBD | 40 | 2,240 |
| Secretarial Certification of health plans in the Exchange | TBD | 20 | 1,120 |
| Secretarial Issue Streamlined Application (CCIIO-CMS) | TBD | 20 | 1,120 |
| Systematic Alien Verification for Entitlements | TBD | 20 | 1,120 |
| Tobacco cessation coverage | TBD | 20 | 1,120 |
| Transitional MA for Low Income Families | TBD | 20 | 1,120 |
| Tribal Consultation | TBD | 20 | 1,120 |
| Tuberculosis coverage | TBD | 20 | 1,120 |
| Medicaid Premiums | TBD | 20 | 1,120 |
| | | TOTAL | 155,744 |

15.7. Unanticipated GenICs

We request 15,574 hours (155,744 x 0.10) of additional time for unanticipated informant collection requests. This figure accounts for a 10 percent margin of error with respect to our Projected GenIC time estimate for 2026 – 2029.

15.8. Summary of Burden Request

| Burden Type | Time (hr) |
|---|---|
| Available Time | |
| 15.1. Currently Approved Burden Ceiling (A) | 450,000 |
| 15.2. Currently Approved GenICs (B) | 231,896 |
| *Subtotal: Available Time (C = A - B)* | *218,104* |
| Time Needed (3-Years) | |
| 15.3. Community Engagement Requirement for Certain Individuals (CMS-2454-IFC; RIN 0938-AV98) (D) | 1,546,409 |
| 15.4. Revised GenICs (E) | 63,828 |
| 15.6. Projected New GenICs (F) | 155,744 |
| 15.7. Unanticipated GenICs (G) | 15,574 |
| *Subtotal: Burden Needed (H = D + E +F + G))* | 1,781,555 |
| Time No Longer Needed | |
| 15.5. Discontinued GenICs | (744) |
| *Subtotal: Burden No Longer Needed (J)* | (744) |
| **Requested Burden Ceiling (H – [C + J])** | **1,562,707** |

16. Publication and Tabulation Dates

There are no plans to publish the information for statistical use.

17. Expiration Date

CMS seeks to continue our exemption from displaying the expiration date on our generic instruments. The exemption would reduce work on replacing the expiration date every 3 years with the renewal of the Generic Umbrella package. We currently have more than 50 approved GenICs. Most of these may have multiple templates associated with them.

Moreover, in certain cases displaying the expiration date causes unnecessary burden and

confusion, especially in instances where the expiration date is near the approval date. In one real example, a GenIC was approved on October 29, 2014, while the expiration date was a few days later, on October 31, 2014. It would be confusing to respondents to forward templates on Oct 29th with an expiration date of Oct 31st of the same year. It would also be burdensome to produce and revise the expiration dates in such a short period of time.

18. Certification Statement

There are no exceptions.

## B. Collection of Information Employing Statistical Methods

The use of statistical methods does not apply for purposes of this collection.