

Generic Supporting Statement
Model Application Template and Instructions for State Child Health Plan Under Title XXI of the
Social Security Act, State Children's Health Insurance Program
CMS-10398 #34, 0938-1148

The contents of this Supporting Statement and the associated attachments have been reviewed and, if needed, revised, to ensure that they are consistent with the Trump administration's policies, goals, and objectives.

We note that we may anticipate submitting additional revisions to this package that affect this collection to address any further requirements and corresponding burden associated with other provisions of the Working Families Tax Cut (WFTC) legislation as those provisions take effect and the remaining operational and reporting parameters are confirmed.

A. Background

The Centers for Medicare & Medicaid Services (CMS) work in partnership with States to implement Medicaid and the Children's Health Insurance Program (CHIP). Together these programs provide health coverage to millions of Americans. Medicaid and CHIP are based in Federal statute, associated regulations and policy guidance, and the approved State plan documents that serve as a contract between CMS and States about how Medicaid and CHIP will be operated in that State. CMS works collaboratively with States in the ongoing management of programs and policies, and CMS continues to develop implementing guidance and templates for States to use to elect new options available as a result of the Affordable Care Act or to comply with new statutory provisions. CMS also continues to work with States through other methods to further the goals of health reform, including program waivers and demonstrations, and other technical assistance initiatives.

The Balanced Budget Act of 1997 created the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. Title XXI enables states to initiate and expand health insurance coverage for uninsured children. In order to be eligible for payment under this legislation, each state submitted an initial CHIP state plan for approval by the Secretary that details how the state intends to use the funds. States may also amend their plans at any time by submitting an amendment for approval by the Secretary.

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. States apply for changes to their CHIP state plan utilizing the revised CHIP state plan template and instructions developed by CMS in cooperation with the states to reduce the burden associated with the information collection requirements to a minimal level.

Under the law, a state plan or a state plan amendment is considered approved in 90 days unless the Secretary notifies the state in writing that the plan is disapproved or that specified additional

information is needed. As is currently done, states are asked to submit only the applicable parts of the template for their amendment request. They do not have to resubmit their state plan in its entirety using this template.

Section 71103 of the WFTC Legislation

Section 71103 of the WFTC legislation adds new paragraph (88) under section 1902(a) of the Social Security Act (the Act) for Medicaid, with corresponding amendments to section 2107(e) (1) of the Act to apply these requirements to separate CHIPs. These amendments create new State plan requirements related to address verification. Beginning no later than January 1, 2027, the 50 States and the District of Columbia must regularly obtain updated address information from reliable data sources and Medicaid/CHIP managed care contracts must require prompt transmission to the state of updated address information obtained or verified directly with the individual. The reliable data sources described in statute include returned mail from the United States Postal Service with a forwarding address, the National Change of Address Database, address information from specified managed care entities when the address was provided directly by or verified directly with the individual, and other data sources approved by the Secretary.

CMS Interoperability and Prior Authorization Final Rule

The CMS Interoperability and Prior Authorization final rule (CMS-0057-F) establishes shorter determination timeframes for prior authorization requests in CHIP for items and services, excluding drugs. Effective January 1, 2026, in accordance with the medical needs of the enrollee, a prior authorization determination must be made within 7 calendar days after receiving the request for a standard determination and no later than 72 hours after receiving the request for an expedited determination. The state may grant a possible extension of up to 14 days if the enrollee requests the extension or if the physician or health plan determines the additional information is needed. Alternately, the state may implement shorter prior authorization determination timeframes in accordance with existing state law. The state must provide the enrollee with notice of the prior authorization determination and their review rights.

Additionally, CMS-0057-F requires states to annually post on their website prior authorization data, excluding data on drugs, by March 31 for the previous calendar year beginning in 2026.

The state must post the following prior authorization data:

- (1) A list of all items and services that require prior authorization.
- (2) The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
- (3) The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
- (4) The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
- (5) The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.
- (6) The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.

(7) The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.

(8) The average and median time that elapsed between the submission of a request and a determination by the State, for standard prior authorizations, aggregated for all items and services.

(9) The average and median time that elapsed between the submission of a request and a decision by the State for expedited prior authorizations, aggregated for all items and services.

B. Description of Information Collection

The 2023 iteration of this Supporting Statement proposed to revise the State plan template by adding the vaccine coverage requirements in Sections 2103(c)(1)(D) and 2103(c)(12) of the Social Security Act. CMS added a new section 6.5-Vaccine coverage, which consisted of three new assurances to the state plan template to report.

Beginning October 1, 2023, states were required to cover CHIP vaccines for targeted low-income children recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration, without cost sharing, as required in 42 CFR §§ 457.410(b)(2) and 457.520(b)(4). States that elect to cover targeted low-income pregnant individuals under their State plan were required to cover adult vaccines recommended by the ACIP and their administration, without cost sharing, as required in Section 2103(c)(12). States that elect to cover the from-conception-to-end-of-pregnancy population (previously referred to as the “unborn”) option under their state plan were required to cover age appropriate (child or adult) vaccines recommended by the ACIP, and their administration, without cost-sharing, to benefit the unborn child. We believe all States have updated their CHIP state plan to include the three new assurances related to vaccine coverage to comply with these requirements and as such the burden for these requirements no longer exists.

This 2026 iteration adds several new State assurances and updates existing CHIP requirements in the CHIP state plan template.

The State must attest that each contracted managed care entity or plan promptly transmits to the State any enrollee address information it receives directly from the enrollee or verifies directly with the enrollee and that the State regularly obtains updated address information for Medicaid and CHIP enrollees from reliable data sources.

Additionally, this iteration amends the quality assurance for prior authorizations in the CHIP state plan template, consistent with CMS-0057-F. States must provide a narrative description of methods used to ensure prior authorization determination timeframes are met within 7 calendar days for standard requests and 72 hours for expedited requests, consistent with 42 CFR 457.495(d). States must also provide an assurance that prior authorization data will be posted on the state’s website by March 31 for data from the previous calendar year, consistent with 42 CFR 457.732(c). We estimate all states with a separate CHIP will be required to submit a SPA to attest to compliance with the provisions of CMS-0057-F.

Thus, the revisions to the template require the State to attest that it has a process to regularly obtain address information for enrolled individuals, to attest that it uses reliable data sources for updated address information and requires the state to describe its quality oversight for prior authorization determination timeframes. The information collected through the Title XXI State Plan Template is used by CMS to review State compliance with Federal statutory and regulatory requirements, approve State plan submissions and SPAs, document required assurances and descriptions, and support oversight of State administration of CHIP. The revisions in this package support CMS review of State processes for obtaining and using updated enrollee address information.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

Wage Data

To derive average costs, we used data from the BLS' May 2025 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 BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
Business Operations Specialist, All Other	13-1199	45.18	45.18	90.36

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate the total cost is a reasonably accurate estimation method.

Collection of Information Requirements and Associated Burden Estimates

Based upon CMS's experience with state plan amendments, we estimate that on average, it will take a state 4 hours at \$90.36 for a Business Operations Specialist to complete and submit the revised SPA template. We also expect that a total of 41 jurisdictions (40 states and D.C.) will submit at least one SPA. However, States will not need to address these provisions in the same SPA and may submit separate SPAs to come into compliance with each requirement individually. Therefore, so as not to underestimate the burden associated with these requirements, we estimate that each of the 41 jurisdictions will submit two separate SPAs that address the WFTC Section 71103 and CMS-0057-F requirements separately, for a total of 82

SPAs (41 jurisdictions x 2 SPAs). We estimate a total annual burden of 328 hours (41 jurisdictions x 2 SPAs x 4 hours) at an estimated cost of \$29,638 (328 hours x \$90.36/hr).

Burden Summary

Cost Report	No. Respondents	Total No. Responses	Time per response (hr)	Total Time (hr)	Adjusted Hourly Wage (\$/hr)	Total Cost (\$)
Active Burden	40	40	4	160	79.50	12,720
2026 Burden	41	82 (41 x 2 SPAs)	4	328	90.36	29,638
CHANGE	+1	+42	No Change	+168	+10.86	+16,918

Although this collection of information request proposes 328 hours of burden, this iteration only requests the addition of 168 hours (160 hr [active] - 328 hr [proposed]) to avoid double counting our active burden estimate of 160 hours.

Information Instruments and Instruction/Guidance Documents

- Title XXI State Plan Template (Revised)

E. Timeline

Our 14-day notice published in the Federal Register on July 16, 2026 (91 FR 43643). Although comments were due July 30, none were received.

CMS requests OMB approval on/by August 1, 2026 to help ensure compliance with the provisions of the WFTC legislation.