

external review of the types of matters described in § 457.1130(b) and to leave States and their contractors the flexibility, within the confines of applicable law, to design review procedures to address any decisions or actions not required to be subject to review under the final regulation.

- Core Elements of Review § 457.1140

Comment: One commenter asserted that HCFA should specify the basic components of a fair hearing, that the State agency responsible for administering the separate child health program, rather than a managed care plan, should retain responsibility for eligibility and enrollment appeals, and that the preamble should encourage States to use the Medicaid fair hearing process for appeals of this kind. According to this commenter, a fair hearing requires the following components: (1) The right to an impartial hearing officer; (2) the right to review records that will be used at the hearing; (3) the right to review evidence and examine witnesses; (4) the right to represent oneself or be assisted by another; and (5) the right to obtain a timely written decision with an explanation of the reasons for the decision. One commenter specifically questioned the rationale for external review of eligibility decisions because those decisions do not require the medical judgement necessary in benefit denials.

One commenter argued that HCFA should adopt minimum standards for States that opt not to use their Medicaid fair hearing processes to ensure that: (1) Appeals and determinations are timely; (2) decisions are made by an impartial hearing officer or person; (3) hearings are held at reasonable times and places; and (4) enrollees have a right to: (a) Timely review their files and other applicable information necessary to prepare for the hearing; (b) be represented or represent oneself; and (c) present testimony and evidence.

Response: While we agree that a State agency review, such as the Medicaid hearing process, may be more appropriate for eligibility and enrollment matters than an internal and external review process developed under an insurance model for health services matters, we determined it was not appropriate to require a State agency review or the Medicaid process for separate child health programs. Instead, these final regulations establish a set of core elements that each State must address when it designates its review process.

Section § 457.1140 incorporates certain suggestions of commenters and requires that States, in conducting a

review, ensure that: (a) Reviews are conducted by an impartial person or entity in accordance with § 457.1150; (b) review decisions are timely in accordance with § 457.1160; (c) review decisions are written; and (d) applicants and enrollees have an opportunity to: (1) Represent themselves or have representatives of their choosing in the review process; (2) review their files and other applicable information relevant to the review of the decision; (3) fully participate in the review process, whether the review is conducted in person or in writing, including by presenting supplemental information during the review process; and (4) receive continued enrollment in accordance with § 457.1170.

Comment: Two commenters noted that § 457.361(c) establishes that notices of eligibility decisions must include information about the right of applicants to request a "hearing." Proposed § 457.365, on the other hand, requires States to provide enrollees in separate child health programs with an opportunity to file "grievances and appeals" for denial, suspension, or termination of eligibility. These commenters expressed that the multiple reviews suggested by both these provisions of the proposed rule have the potential to create unnecessary administrative expenses for the State and to confuse consumers.

One of these commenters agreed that an applicant should receive an explanation, preferably in writing, if an application is denied. This notice is particularly important when the State uses a variety of "helpers," such as community organizations or other program staff, to assist in the enrollment process. In such situations, the commenter believed that opportunities for misinformation or miscommunication arise. For Medicaid programs, the commenter noted the word "hearing" is used to mean the entire State fair hearing process, which is a formal and often lengthy procedure. For separate child health programs, however, a much simpler process, such as review by a senior staff member, is appropriate according to this commenter, given that there is no individual entitlement to benefits under title XXI. This commenter therefore recommended that § 457.361(c) be amended to make it clear that separate child health programs need not employ the Medicaid hearings process and that the State should provide an opportunity for review of such decisions that need not take the form of a hearing.

Response: We recognize that we may have created confusion in using different terminology in §§ 457.361(c)

and 457.365. We therefore clarified the review process that will be applicable to adverse eligibility matters in § 457.1140 of the final regulation.

We appreciate the commenter's concern that certain enrollee protections may create an additional administrative expense for some States. However, on balance, the importance of ensuring an enrollee's basic right to a fair and efficient decision regarding eligibility for health benefits coverage justifies the administrative expenses that may be incurred. We note, furthermore, that these final regulations accord States broad flexibility to design review processes that operate efficiently without undue administrative costs. We also appreciate the support for the requirement that notice must be provided in writing.

As for the concerns about the mechanics of the review process, States with separate child health programs do not have to use the Medicaid fair hearing process as the mechanism for review of adverse eligibility and enrollment matters. While an opportunity for review of such matters is required, we left it to the States' discretion to develop the details of the review process for their separate programs, provided the process meets the minimum guidelines set forth in §§ 457.1140, 457.1150(a), 457.1160(a), 457.1170, and 457.1180.

Comment: One commenter asked that HCFA clarify what kinds of procedures will be necessary if a State does not elect to use its Medicaid program or does not have existing State law. One commenter expressed their view that the language of proposed § 457.985 could be interpreted to mean that States without existing State laws requiring internal and external review procedures need not establish any procedures for children enrolled in SCHIP. One commenter stated their view that a choice between Medicaid and State insurance practices is appropriate for issues other than eligibility and disenrollment determinations.

Response: We agree with the comment that our proposed rule could leave children in some States without access to a review process. Since State law varies and some States do not have applicable State laws, in order to assure some minimum standard of protections for all children, we elected to adopt in § 457.1140 minimum standards for conducting reviews of matters identified in § 457.1130. In addition, under §§ 457.1130(b) and 457.1150(b) of this final regulation, a State is required to ensure that enrollees have the opportunity for an external review of certain health services matters,

regardless of whether external review is required under existing State law. Internal reviews are not required by these regulations.

- Impartial Review § 457.1150 (proposed § 457.985(b)).

We proposed under § 457.985(d) that States must establish and maintain written procedures for addressing grievances and appeal requests, including processes for internal review by the contractor and external review by an independent entity or the State agency. We proposed that these procedures must comply with State-specific grievance and appeal requirements currently in effect for health insurance issuers (as defined in section 2791(b) of the Public Health Service Act) in the State.

Comment: One commenter recommended the language at § 457.985(b) be amended to read “* * * process for internal review by the contractor and independent external review by the State agency * * *.” This commenter noted it has established a strong independent review process through the State insurance agency. The commenter said that the term “independent entity” when used to describe an external review can be interpreted to mean an organization separate from the health plan, but chosen by the plan to do the reviews. The commenter noted that such an arrangement is a clear conflict of interest and indicated that the independence of reviewers can be best assured if the review goes through a neutral State agency. The commenter did not support the NAIC’s Health Carrier External Review Model Act.

Response: We appreciate the concern related to the independence of external reviews and have made some modifications to clarify and emphasize the need for an impartial review. To afford States the greatest flexibility in how they implement their external review process, we did not change the language to allow only for external review by a State agency. Consistent with applicable State law, States may choose the entity that will provide external review.

However, under § 457.1150(b), with respect to an external review of health services matters, we did specify that the external review must be independent and conducted by the State or a contractor other than the contractor responsible for the matter subject to external review. To the extent that a State relies on a contractor to conduct such reviews, we expect that States will closely monitor the review process to assure that enrollees are in fact receiving an independent review of

their case. We also encourage community organizations and advocates to work closely with families to assist them in navigating the process and to assist the State in identifying issues related to impartiality or conflicts of interest if they arise. We would also like to note that in the review of eligibility and enrollment matters, we require under § 457.1150(a) that a review must be conducted by an impartial person or entity who has not been directly involved in the matter under review.

Comment: One commenter expressed the view that the automatic placement of adverse decisions on the docket of a State fair hearing system is critical to ensuring that the rights of enrollees are fully vindicated, given that the State hearing system is the first time the enrollees receive an independent review. This commenter believed the burden placed on the fair hearing system would not outweigh the Constitutional deficiency of not requiring an automatic filing for a fair hearing after an adverse decision by a non-impartial decision maker. This commenter said that due process concerns are significant, and that enrollees may not truly comprehend that they have a right to an external review despite the best efforts at notice on the part of a State/contractor and assuming they understood the notice of their rights. The commenter believed that automatic referral would reduce these problems, improve public perception about health care decisions given the review by an impartial decision maker, and improve the overall quality of care by encouraging correct treatment decisions at the outset.

The commenter noted that the number of cases proceeding through the State fair hearing process, even with automatic referral, may not be substantial or costly. According to the commenter, in Medicare where automatic referral occurs, the cost is generally less than \$300 per case. In 1997, automatic referral resulted in only 1.65 cases per 1000 managed care enrollees. Yet, this commenter stated, access to an outside impartial review is clearly significant for enrollees. The commenter pointed to a Kaiser Family Foundation study on State external review laws that found almost 50 percent of cases considered through an external appeals review overturned the managed care organization’s initial decisions. The commenter noted that while States have financial concerns in maintaining a streamlined external review process, such concerns should not overrule an enrollee’s right to due process.

Response: As noted above, States do not need to use the State fair hearing process as the independent external review process required under §§ 457.1130(b) and 457.1150(b). External review can be done either by a State agency or a contractor other than the contractor responsible for the matter subject to external review. While we appreciate the commenter’s concerns, we elected not to require States with separate child health programs to ensure the automatic referral of adverse decisions to external review. We did, however, adopt minimum procedural protections related to the right to an independent external review in certain situations, consistent with the requirements of due process.

We acknowledge the important information contained within the study cited by the commenter relating to the minimal administrative cost of automatic referral. Given the low cost of such a process, and the added protections and accountability it can provide in some circumstances, we encourage States to consider this option carefully when establishing their review process.

- Timeframes § 457.1160 (proposed §§ 457.361(c), 457.985(b) and 457.995(g)(2)).

In proposed § 457.985(b) and § 457.995(g), respectively, we required that “resolution of grievances and appeal requests will be completed within a reasonable amount of time” and that “grievances and appeals must be conducted and resolved in a timely manner that is consistent with the standard health insurance practices in the State in accordance with § 457.985.” In proposed § 457.361(c), we provided that “the State must send each applicant a written notice of the 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.”

Comment: Several commenters noted that the regulation should require that grievances and appeals be decided in a timely fashion. Several commenters asserted that if HCFA decides to maintain its proposed policy on grievances and appeals, strict minimal timelines should be incorporated to ensure that grievances and appeals are conducted in an expedited manner. A different commenter, representing providers, noted that it saw no reason why providers should not be expected to respond within seven days to a request for treatment. That commenter noted that if a State/contractor denied such a request, an enrollee would not receive any new benefits until the final

resolution of the grievance process. A State/contractor could request an extension if it could show the extension would be in the enrollee's best interest. The commenter also believed that HCFA should establish minimum requirements for an expedited procedure to meet the needs of enrollees with severe medical conditions.

This commenter also suggested a requirement of 14 days for a response to a standard grievance. Two commenters acknowledged that suggested time frames are different from the 30 day time frames in Medicare+Choice and Medicaid managed care, but argued that SCHIP enrollees do not have the opportunity to get services elsewhere while they are waiting for the appeal to be resolved. One commenter also noted that when Medicaid and SCHIP individuals are denied treatment, they often have no other recourse except the proposed grievance process. They recommended that HCFA reduce the standard resolution time frame in Medicaid managed care from 30 to 14 days. A different commenter recommended providing for an accelerated process where there is an initial denial of services that poses the risk of serious medical harm.

Several commenters recommended HCFA define maximum time frames, and one commenter recommended HCFA define a "reasonable" time period and indicate what maximum time frame would still meet the "reasonable" requirement. This second commenter also believed that a lengthy grievance process might be held to violate an enrollee's due process rights. The commenter recommended a maximum time frame of fourteen days for responding to a standard grievance, which may be to review a provider's decision not to provide requested items or services, or to review a provider's decision to deny, suspend, or terminate eligibility, reduce or deny benefits, or disenroll the enrollee for failure to pay cost sharing. The commenter noted that, in many cases, the State/contractor will have an established policy and will not need the full fourteen days. This commenter also noted that even in cases which involve an assessment of an individual's condition, fourteen days is ample time. The commenter advocated that States be allowed to set a time frame of less than fourteen days. The commenter noted that a State/ subcontractor does not necessarily save money by delaying resolution of a grievance, because the State remains financially responsible for the care and may have to reimburse the family for expenses incurred prior to enrollment. In certain cases, it might cost the State/

subcontractor more to delay treatment because the treatment ultimately required might cost more than the initial requested treatment.

Response: As reflected in the proposed regulation, we agree that a review process should be completed in a timely fashion and, as reflected in the final regulation, that there is a need for minimum timeliness standards. As in the proposed regulation, in § 457.340(c) of this final regulation, we prescribed maximum time frames for eligibility determinations. In this final regulation, we also separately address the timeliness of review of eligibility and enrollment matters, and the timeliness of review of adverse health services matters. Under § 457.1130(a), a State must ensure that an applicant or enrollee has an opportunity for review of a: (1) denial of eligibility; (2) failure to make a timely determination of eligibility; or (3) suspension or termination of enrollment, including disenrollment for failure to pay cost sharing. Under § 457.1160(a), the State must complete the review of the matters described in § 457.1130(a) within a reasonable amount of time. In order to ensure that delays in the review process do not cause a gap in coverage, under § 457.1170, States are required to provide an opportunity for the continuation of enrollment pending the completion of review of a suspension or termination of enrollment, including a decision to disenroll for failure to pay cost sharing. We also require the State to consider the need for expedited review when there is an immediate need for health services. Under § 457.1120 we require States to describe these time frames in their State plans.

In light of concern about the time frames for review of health services matters, we specified a time standard for the resolution of external reviews (and any internal review if available), including expedited time frames, in § 457.1160(b). Health services matters subject to review include: (1) delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; or (2) failure to approve, furnish, or provide payment for health services in a timely manner. Reviews must be completed in accordance with the medical needs of the patient. Under the standard time frame, a State must ensure that external review of a decision as described in § 457.1150(b) is completed within 90 calendar days of the date an enrollee initially requests external review (or an internal review if available) of the decision. Under the expedited time frame, a State must ensure that internal

review (if available), or external review as required by § 457.1150(b), is completed within 72 hours of the time an enrollee initially requests a review if the enrollee's physician determines that operating under the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. If the enrollee has access to internal and external review, then each level of review must be completed within 72 hours (for a possible total of 144 hours). The State must provide an extension to the 72-hour period of up to 14 days if the enrollee requests such an extension. This provision for an expedited time frame reflects our agreement with the comments calling for an accelerated process if the passage of the standard time allowed for the process poses serious harm to the enrollee.

Comment: One commenter recommended that in order to ensure an enrollee's rights to obtain timely medical care, both the internal grievance process and the State fair hearing process should conclude within 90 days. They noted that current State fair hearing regulations require a State to complete the fair hearing within 90 days from the request for the hearing.

This commenter also stated the proposed regulations did not provide guidance on what happens if a State/contractor fails to meet its grievance and appeals procedures and recommended HCFA establish minimum standards to address noncompliance. The commenter said that even with standard health insurance practices, there is no guarantee that a State/contractor will comply in a timely fashion. The commenter recommended the approach of the Medicare+Choice regulations that provide that an managed care organization's failure to meet initial determination and reconsideration time frames is automatically considered an adverse decision that is referred to the next level of review. This commenter advocated that HCFA adopt this policy in the SCHIP regulations as well. The commenter believed this position, coupled with minimum time frames, would best protect enrollees' rights without causing undue hardships on providers.

This commenter also recommended that HCFA should grant States the authority to impose monetary fines upon participating contractors for failure to meet time frames as a means to enforce compliance. The commenter recommended amending § 457.935 to include language requiring States that contract with participating contractors to impose sanctions if the State determines that a participating

contractor fails to provide medically necessary services that the participating contractor is required to provide, or fails to meet specified time frames.

Response: Under § 457.1160(b)(1), we defined the standard time frame for the review of a health services matter. A State must ensure that external review, as described in § 457.1150(b), is completed within 90 calendar days of the date an enrollee requests external review (or internal review if available). We expect that an enrollee will be provided notice of the outcome of the review within the 90-day time frame. As described above, the final regulations provide an opportunity for expedited review, under § 457.1160(b)(2).

We do not see a need to create further compliance standards or enforcement mechanisms beyond those that have been already implemented pursuant to section 2106(d)(2) of the Act. This provision requires States to comply with the requirements under title XXI and allows HCFA to withhold funds from States in the case of substantial noncompliance with such requirements. It is within the State's discretion to determine whether to include in contracts monetary fines for failure to meet time frames as a means to enforce compliance with required time frames. States are, of course, required to administer their programs in accordance with the law and their State plans. At a minimum, therefore, States are responsible for monitoring the conduct of their contractors and ensuring that their conduct fully complies with these regulations and the State plan.

Comment: One commenter noted that the regulations do not make clear the relationship between the internal and external review processes. In most instances, State law requires exhaustion of the internal review process (as does the NAIC model) before a consumer can move to the external review. However, a number of States also include timelines and exceptions (for example, when the harm has already occurred) to ensure that this does not impede the process unnecessarily, and the commenter recommended that HCFA do the same. Another commenter expressed that HCFA should prohibit States from requiring exhaustion of internal plan processes. If HCFA does not prohibit such a requirement, according to this commenter, it must include adequate safeguards so that plans do not benefit from delay at the enrollee's expense. Specifically, HCFA should require that States set strict timetables for review and determination, assure aid continuing pending a determination, and provide for expedited review when the failure to authorize a required level

of treatment or to provide or continue a service jeopardizes the enrollee's health.

Another commenter noted that some States may require an enrollee to exhaust a plan's internal grievance procedures before allowing access to the State fair hearing process and believed these State practices may violate enrollee's due process rights. The commenter requested that we ensure that enrollees not be required to exhaust internal grievance procedures before accessing the State fair hearing process. The commenter was concerned that the internal grievance process does not provide impartial review. They noted that even under the proposed Medicaid managed care regulations, the individual conducting the internal review, while not familiar with the case file, is employed by the plan provider. According to this commenter, this individual has an inherent pecuniary interest to resolve the grievance in favor of the State/contractor. Because the enrollee is effectively denied benefits until the process is complete, States/contractors have little incentive to resolve the grievances quickly. The commenter argued that if the enrollee is forced to exhaust the internal grievance process, the enrollee would be deprived of due process. The commenter recommended HCFA amend § 457.985(b) to permit the enrollee to request a State fair hearing on a grievance at any time.

Response: It should be noted that the State fair hearing process is the process for external review under Medicaid managed care. While States have the option to use the Medicaid fair hearing process to satisfy the requirement for external review under this regulation, we do not require this process for separate child health programs. We also left to States the discretion to decide whether plans should be required to conduct an internal review and whether, if they do so, they should require exhaustion of internal plan processes before an enrollee could pursue an external review. Nonetheless, we believe it is important for enrollees to have certain minimum procedural protections consistent with due process and have therefore adopted minimum requirements and time frames for reviews. Under §§ 457.1130(b) and 457.1150(b), States must provide enrollees access to an external review of certain health services matters. Pursuant to § 457.1150(b), review decisions must be independent and made by the State or a contractor other than the contractor responsible for the matter subject to external review. While a State may require an enrollee to request and pursue an internal review, any

procedures developed by the State or its contractors relating to internal review cannot interfere with the enrollee's right to complete the external review within 90 days from the date a review (either internal or external) is requested.

- Continuation of Enrollment § 457.1170 (Proposed § 457.985(c)).

We received a number of comments urging us to require continuation of enrollment pending completion of the review.

Comment: Several commenters were particularly concerned that children receiving benefits under separate child health programs may be as poor as those who receive Medicaid in other States, and believed that States should therefore be required to continue assistance at pre-termination levels until an impartial review of a child's case is completed. Multiple commenters argued that even though the SCHIP statute does not include the same entitlement as Medicaid, constitutional due process may require minimal protections that are not included in the proposed rule. A few commenters underscored the need for due process protections in title XXI because of the lack of entitlement to benefits under the program and recommended the Medicaid procedures. Other commenters echoed the specific suggestion that there be circumstances in which benefits continue for current recipients pending appeal.

One commenter specifically recommended that continuation of services pending appeal should occur in circumstances where termination or reduction of services poses serious medical harm and to provide for an accelerated process where there is an initial denial of services that pose such harm. Two commenters noted that continuation of benefits is especially important for enrollees terminated for failure to pay cost sharing or other financial contributions, which do not relate to an enrollee's actual eligibility for benefits. These commenters recommended that HCFA require that enrollees must affirmatively request termination of benefits. One commenter recommended the language at § 457.985 be amended by adding: "Unless an enrollee affirmatively requests that items or services not be continued, the State/contractor must continue the enrollee's benefits until the issuance of the final grievance decision or State fair hearing decision."

Response: We appreciate the commenters' concerns about the need to protect children enrolled in separate child health programs who have very limited incomes and whose families have little or no ability to pay for costly but necessary health services, and we

have adopted provisions related to continuation of enrollment, as described below.

Section § 457.1170 requires States to ensure the opportunity for continuation of enrollment pending review of termination or suspension of enrollment, including a decision to disenroll for failure to pay cost sharing. A State may limit the time period during which such coverage is provided by arranging for a prompt review of the eligibility or enrollment matter. However, not all such matters are subject to the continuation of coverage requirement; under § 457.1130(c), a State is not required to provide an opportunity for review of such a matter if the sole basis for the decision is a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances. Therefore, if the situation is such that the State is not required to provide an opportunity for review according to this regulation, then the State does not have to provide the opportunity for continuation of enrollment. We also note that the costs of providing continued benefits are not administrative costs subject to the 10 percent cap, regardless of the outcome of the review. With respect to disenrollment due to failure to pay cost sharing, we have added a provision in § 457.570(b) to ensure that the disenrollment process afford an enrollee the opportunity to show that the enrollee's family income has declined prior to disenrollment for nonpayment of cost-sharing charges. Finally, we note that services need not be continued pending a review of a health services matter, although, as described above, expedited review processes must be available when the physician or provider determines that the enrollee's life or health or ability to function will be jeopardized.

- Notice § 457.1180 (proposed §§ 457.361(c), 457.902, 457.985(a), and 457.995(g)).

In the preamble to the proposed regulation at § 457.985, we stated that a State should make available to families of targeted low-income children information about complaint, grievance, and fair hearing procedures. We proposed to require that the State and its "participating providers" give applicants and enrollees written notice of their right to file grievances and appeals. In proposed § 457.361(c), we required that "the State must send each

applicant a written notice of the decision on the application and, if eligibility is denied or terminated, the specific reasons or reasons for the action and an explanation of the right to request a hearing within a reasonable amount of time."

Comment: A commenter on § 457.340 and § 457.361 expressed strong support for the inclusion of rules setting minimum standards for procedural fairness, including the basic due process protections of opportunity to apply without delay, assistance in completing applications, required notices, and timely eligibility decisions. This commenter noted that notice is a basic due process right required by the U.S. Constitution under well-settled law whenever a citizen is denied a public benefit, and that the rules should specify that notice must be timely. The commenter also recommended that for current recipients, notice of an adverse action should be in advance of the action. In the commenter's view, the notice should inform people of the right to be accompanied by a representative as well as the right to appeal.

Another commenter on § 457.340 suggested that rules should specify that notice of denial or adverse action must be timely and in advance of adverse action for current benefits, with benefits continuing through an appeal process, should an appeal be initiated. In this commenter's view, notice should be required to be timely and include information regarding the right to appeal and to be accompanied to the hearing by a representative.

Response: We appreciate the support for these standards, and the effort to establish rules that are consistent with due process requirements. We agree that notice should be timely and have added this to the language at § 457.1180. As in the proposed regulation, the final regulation sets forth maximum time frames for eligibility determinations in § 457.340(c). Additionally, in the case of redetermination of eligibility, under § 457.340(d), the regulations require that in the case of a suspension or termination of eligibility, the State must provide sufficient and timely notice to enable the child's parent or caretaker to take any appropriate actions that may be required to ensure ongoing coverage. For example, if continued enrollment pending a review is allowed when a review is requested before enrollment is scheduled to end, notice of the action and the opportunity for review must be provided to the family with enough advance notice to allow the family to request the review and to keep their child enrolled pending review. Under § 457.1160(a), a State must complete

review of an eligibility or enrollment matter within a reasonable amount of time. In setting time frames, the State must consider the need for expedited decisions when there is an immediate need for health services. Additionally, under § 457.1140(d)(2) we require that applicants and enrollees have a right to timely review of their files and other applicable information relevant to the review of the decision. Under this final regulation, however, while States have discretion to determine the precise timing of the notices in light of their own administrative needs, the notice of the outcome of the review must be delivered within the prescribed overall time frames for review.

We addressed the issue of notice in § 457.1180, in which we required States to ensure that applicants and enrollees are provided timely written notice of any determinations required to be subject to review under § 457.1130 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. Section § 457.340(d) cross references the notice requirements of § 457.1180. Under § 457.1140(d)(1) States must ensure that applicants and enrollees have an opportunity to represent themselves or have representatives of their choosing in the review process. As for continuation of enrollment, the regulations require States under § 457.1170 to continue enrollment pending the completion of a review of a suspension or termination of enrollment including a decision to disenroll for failure to pay cost sharing.

Comment: One commenter requested clarification on the relationship of § 457.361(c) to the requirement in § 457.360(c). This commenter expressed a belief that every family should be notified of the status of each child's application and whether: (1) the application for enrollment in the separate child health program has been approved; (2) the application has been referred to Medicaid; or (3) the child had been found ineligible for both programs.

Response: The State must provide written notice of any determination of eligibility under §§ 457.340(d) and 457.1180. So, if the State determines that an applicant is ineligible for coverage under its separate child health program, the State must provide written notice of that determination. If the application is a joint Medicaid/SCHIP application, a State would then need to

comply with Medicaid requirements in providing notice about an applicant's eligibility for Medicaid. In the case of termination or suspension of eligibility, under § 457.340(d), the regulations require that the State must provide sufficient notice to enable the child's parent or caretaker to take any appropriate actions that may be required to ensure ongoing coverage.

Comment: One commenter suggested that HCFA limit requirements that providers furnish notice to enrollees. According to this commenter, some States permit treating providers and managed care plans to provide SCHIP applications and perform direct marketing activities, but some do not. In this commenter's view, providers in States that do not allow such involvement would have no opportunity to provide applicants with notices. This commenter also suggested that HCFA not require treating providers who serve SCHIP enrollees under a managed care contract to provide notice to enrollees. This commenter suggested that this would be more appropriately done by the managed care plan in the member information materials. Yet another commenter strongly supported the language in § 457.985(a) requiring that participating providers, in addition to States, provide applicants and enrollees written notice of their right to file grievances. This commenter argued that it is important that applicants and enrollees have access to information about their grievance and appeal rights at the points of direct contact—which is most often the provider.

Response: In § 457.1180, we specified the general content of the notice but left States the flexibility to determine who should provide the notice. We do not consider general statements of procedure in initial member information materials sufficient notice of the review process available for a particular determination.

Comment: One commenter noted that enrollees should be informed of their right to appeal any adverse decision to an independent body.

Response: We agree with the need for enrollee notification. Section 457.1180 requires timely notice of determinations subject to the review process specified in this regulation, including matters subject to external review by an independent entity.

- Application of Review Procedures where States Offer Premium Assistance for Group Health Plans § 457.1190.

We note that under this final rule we use the term "premium assistance program" instead of "employer-sponsored insurance model" to describe a situation where a State pays part or all

of the premiums for an enrollee or enrollees' group health insurance coverage or coverage under a group health plan. Our responses to comments referring to "employer-sponsored insurance models" reflect this change in terminology.

Comment: One commenter noted that for coverage provided under a premium assistance program, the State does not contract for services and is not in a position to dictate compliance with requirements included in § 457.985.

Response: We acknowledge that States' SCHIP programs do not have direct authority over group health plans that may be providing coverage under premium assistance programs. At the same time, there is no basis for providing children fewer procedural protections because they may be enrolled in a premium assistance program under SCHIP. In order to balance these concerns, the regulations provide States flexibility so that they may offer premium assistance through plans that do not meet the review standards set out in these regulations, as long as families are not required to enroll their children in these plans. Under § 457.1190, a State that has a premium assistance program through which it provides coverage under a group health plan that does not meet the requirements of §§ 457.1130(b), 457.1140, 457.1150(b), 457.1160(b), and 457.1180 must give applicants and enrollees the option to obtain health benefits coverage through its direct coverage plan. The State must provide this option at initial enrollment and at each redetermination of eligibility.

Comment: One State expressed concern that the level of detail of the CBRR provisions in the proposed regulation inhibits States from developing effective premium payment systems for premium assistance programs. Another commenter noted that under premium assistance programs, there is no contractual mechanism through which to enforce requirements, given that the employer, not the State, contracts with the health plan. This commenter said that requiring States to apply these requirements under such a model will mean that employer plans will never qualify for premium assistance. This commenter assumed that HCFA did not intend these requirements to apply to premium assistance programs, and recommended that HCFA clarify its position.

Response: While we appreciate the commenters' concern, States must comply with the requirements of this regulation regardless of whether coverage is provided through a group

health plan. Under title XXI, the standards and protections apply to all children receiving SCHIP coverage, including children receiving SCHIP-funded coverage through group health plans. We do recognize that States do not have direct contractual relationships with premium assistance programs and accounted for this constraint in § 457.1190.

K. Expanded Coverage of Children Under Medicaid and Medicaid Coordination

The proposed regulations discussed in this subsection are changes to Medicaid regulations found in parts 433 and 435. These rules apply to Medicaid only.

Section 2101 of the Act requires that States coordinate child health assistance under title XXI with other sources of health benefits coverage for children. Section 2102(b)(3)(B) of the Act requires that children found through the SCHIP screening process to be potentially eligible for Medicaid under the State's Medicaid plan shall be enrolled for such assistance.

Section 4911 of the BBA, amended by section 162 of the DC Appropriations Act, Public Law 105-100, enacted on November 19, 1997, established a new optional categorically-needy eligibility group known as "optional targeted low-income children." The law provides for an enhanced Federal matching rate for Medicaid services provided to children eligible under this group. The BBA also provides for States to receive this enhanced Federal matching rate for services to children who meet the definition of "optional targeted low-income children" and whom the State covers by expanding an existing Medicaid eligibility group (for example, poverty-related children). "SCHIP" itself is not a new or separate Medicaid eligibility group. A State that implements a Medicaid expansion program under SCHIP, may expand eligibility to the new optional Medicaid eligibility group just mentioned, expand eligibility to optional targeted low-income children through expanding an existing Medicaid eligibility group, or implement a combination of the two options. We note that Medicaid expansion programs are subject to all the rules and requirements set forth in title XIX of the Act and its implementing regulations, and the State Medicaid plan. Section 4912 of the BBA added a new section 1920A to the Act to allow States to provide Medicaid services to children during a period of presumptive eligibility.

In addition to modifications to the proposed regulations made in response

to the comments discussed below, we have amended part 436 of this subchapter to reflect the changes made by the BBA to eligibility for Medicaid in Guam, Puerto Rico and the Virgin Islands. The changes made to part 436 by these regulations mirror those made to part 435, governing Medicaid eligibility in the States, District of Columbia, the Northern Mariana Islands and American Samoa. Specifically, new § 436.3 corresponds to new § 435.4; modifications to §§ 436.229, 436.1001 and 436.1002 correspond to the modifications made to §§ 435.229, 435.1001 and 435.1002; and new §§ 436.1100–1102 correspond to new §§ 435.1100–1102. Our failure to amend part 436 in the proposed rules was an oversight. There are no distinctions in policy or requirements with respect to the regulations pertaining to the States, District of Columbia, the Northern Mariana Islands and American Samoa versus those pertaining to Guam, Puerto Rico and the Virgin Islands. And any changes made to the proposed rules pertaining to expanded coverage of children under Medicaid and Medicaid coordination in these final regulations are also reflected in the amendments to part 436. We received a number of general comments on this subpart and one comment relating to the screen and enroll requirements set forth in subpart C which is relevant to this section. We will address these comments below.

1. General Comments

Comment: With respect to the screen and enrollment requirements of section 2102(b)(3)(B) of the Act, two commenters recommended that the regulations require that, even if a separate application for a separate child health program (as opposed to a joint application with Medicaid) is used, the application form and any supporting verification must be transmitted to the appropriate Medicaid office for processing without further action by the applicant to initiate a Medicaid application. One commenter recommended that if an applicant for a separate child health program, who has been determined potentially eligible for Medicaid, is to be required to take any additional steps in order to apply for Medicaid, the Medicaid agency must inform the family of the action required.

Response: The obligations of the State agency or contractor responsible for determining eligibility for a separate child health program with respect to the requirement that children screened potentially eligible for Medicaid be enrolled in that program are discussed in the preamble to subpart C and are set

forth in § 457.350 of the final regulations.

We have added a new § 431.636 to clarify the obligations of the State Medicaid agency with respect to the screen-and-enroll requirement. Specifically, we have added this section to require that State Medicaid agencies adopt procedures to complete the Medicaid application process for, and facilitate the enrollment of, children for whom the Medicaid application and enrollment process has been initiated pursuant to § 457.350(h)(2) in subpart C of these regulations. Such procedures shall ensure (1) that the Medicaid application is processed in accordance with the regulations governing eligibility for Medicaid in the States and District of Columbia, 42 CFR part 435 or the regulations governing Medicaid eligibility in Guam, Puerto Rico and the Virgin Islands, 42 CFR part 436, as appropriate; and (2) that the applicant is not required to provide any information or documentation that has been provided to the State agency or contractor responsible for determining eligibility under the State's separate child health program and forwarded by such agency or contractor to the Medicaid agency on behalf of the child pursuant to § 457.350(h)(2) of this subchapter.

When a State Medicaid agency receives an application—either a joint SCHIP-Medicaid application or separate Medicaid application—for a child screened potentially eligible for Medicaid, the application must be processed in accordance with title XIX, Medicaid regulations, and the State plan. If the Medicaid agency has all the information it needs to process the Medicaid application, no further follow-up is needed until the State is ready to make a final eligibility determination. If additional information is needed, the agency must contact the family and explain what is needed to complete the Medicaid application process.

If a separate application is used, the State Medicaid agency should promptly follow up with the family as soon as it receives information about the child. If the family has not already completed a Medicaid application, the Medicaid agency should provide the family with an appropriate application and inform the family about any additional steps that must be taken or additional information which must be provided in order to complete the Medicaid application process.

Comment: We received a number of comments urging HCFA to seek statutory changes expressly authorizing more flexibility for States. The suggested changes include allowing

States more flexibility under presumptive eligibility and a longer period of presumptive eligibility, and giving States the option of establishing their own filing unit rules by eliminating the prohibition on deeming income from anyone other than from a parent to a child or a spouse to a spouse.

Response: We will take these suggestions into consideration in developing future legislative proposals.

Comment: One commenter also suggested that States be allowed to “out-source” (privatize) Medicaid eligibility determinations.

Response: We have previously considered requests by States to privatize Medicaid eligibility determinations. Medicaid policy requires that most activities included in the eligibility determination process be performed by employees of a public agency. Therefore, we do not have the discretion to allow States to “out source” Medicaid eligibility determinations.

Comment: One commenter indicated that the regulations should clarify that, if a State chooses to provide continuous eligibility under section 1902(e) of the Social Security Act, as added by section 4731 of the BBA, it must provide continuous eligibility for all children who are eligible for Medicaid.

Response: These regulations do not address changes made by the BBA that are not directly related to title XXI. A separate Notice of Proposed Rulemaking will be published addressing other changes made by the BBA to the Medicaid program.

Comment: One commenter noted that, for new eligibility groups, States often have no eligibility determination experience and may be reluctant to ease the documentation and verification requirements for fear of increasing the error rate under the Medicaid eligibility quality control (MEQC). Two organizations supported waiving MEQC errors for new eligibility groups created by PRWORA, which we explained in the preamble to the proposed rule we would be willing to do. One State asked if the MEQC waiver of errors extended to the section 1931 group or to child-only groups.

Response: Section 1903(u) of the Act, which provides the statutory basis for MEQC, does not give HCFA the authority to grant a grace period for eligibility errors. However, the statute does provide that a State can request a waiver of a Federal financial disallowance relating to eligibility errors on the basis that it made a good faith effort to meet the 3-percent error rate limit. Implementing regulations at 42 CFR 431.865 include sudden and

unanticipated workload changes that result from changes in Federal law as an example of circumstances under which HCFA may find that a State made a good faith effort. Under this authority, we have offered in the past to waive errors in cases of pregnant women and infants that occurred during the first 6 months in which States were implementing a new Federal law mandating coverage of these groups (the Medicare Catastrophic Coverage Act of 1988). Our intent in offering this waiver was to encourage States to expand coverage to pregnant women and infants without the concern of fiscal penalties. It also allowed States time to develop the experience necessary to accurately determine Medicaid eligibility for these new groups.

We recognize that the sweeping changes in law brought by welfare reform and title XXI presented similar opportunities as well as many challenges to States. The PRWORA of 1996 established a new eligibility category for families with children, which is not linked to welfare. The BBA of 1997 established a new coverage group for children and established an enhanced match rate to encourage expanded coverage of children under this new group or other existing Medicaid groups. HCFA has encouraged States to take advantage of the title XXI funds to expand coverage for children, and we have encouraged States to simplify their enrollment procedures to reduce barriers to participation for all Medicaid-eligible children and their families. As we explained in the preamble to the proposed rule we would waive MEQC eligibility errors attributable to the coverage of these new and expanded groups of children and families. Our intent is to give States the opportunity to gain experience in making accurate eligibility determinations for these newly covered children without relying on lengthy applications or requiring excessive eligibility verification requirements due to State concern with fiscal penalties.

Although we are making MEQC waivers available, States are unlikely to face MEQC fiscal penalties. States have maintained a national error rate below 2-percent for over ten years. In addition, welfare reform implementation problems have resulted in eligible children and families being denied or terminated from Medicaid rather than ineligible children and families being enrolled in Medicaid. MEQC errors arise when a State makes erroneous payments. There are likely very few cases in which such erroneous payments have been made due to section 1931 implementation.

Finally, we have encouraged States to develop alternative MEQC programs because this option can be a particularly effective means of focusing on error-prone areas. Thirty-one States are currently operating alternative MEQC programs either as pilots or as part of a section 1115 waiver (most since 1994). For the duration of the pilot or section 1115 waiver, the error rates for these States are frozen at below 3 percent, and the States are not subject to disallowances.

In terms of the scope of the waiver, we agree with the comment that any waiver should apply to the section 1931 group as well as other groups pertaining to children. Therefore, we have determined that we should grant a MEQC waiver for eligibility errors directly attributable to the implementation of: (1) coverage for children and families determined eligible after October 1, 1996 for Medicaid under section 1931 or section 1925 of the Act; (2) coverage for children determined eligible after October 1, 1997 for Medicaid under the optional group of targeted low-income children under age 19 (or reasonable groups of these children) who are otherwise ineligible for Medicaid, have a family income below a certain State-specified level and have no health insurance (see section 1902(a)(10)(A)(ii) of the Act); and (3) coverage of children determined or redetermined eligible for Medicaid after October 1, 1997 whose disabled status is protected under section 4913 of the BBA. This waiver does not apply to children covered under separate child health programs because the MEQC process does not apply to such programs.

We are limiting the waivers to one year beginning with the publication date of this final rule rather than the first year of implementation of the legislation as we did previously with new coverage of pregnant women and infants. In recent months, we have learned that many States still need to adapt their systems to assure that children eligible for Medicaid under section 1931 receive Medicaid. Thus, at this point, limiting the waivers to one year after implementation of the statute would not accomplish the intended purpose. Since many States are still expanding coverage to children and are adopting new approaches to simplify their eligibility and redetermination procedures, waivers effective for one year following the promulgation of these regulations should enable States to finish updating their systems to ensure effective implementation of section 1931 eligibility without incurring financial penalties as they do so. The incidence

of erroneous Medicaid denials and terminations should diminish as States gain experience, and that MEQC waivers should encourage States to move quickly to make the changes necessary to determine eligibility consistent with the requirements of the law.

Because the regulations currently provide the basis for waiver requests and the good faith waiver process is administrative in nature, it is not necessary to amend regulations at 42 CFR 431.865 to include this specific waiver exclusion. In the unlikely event that a State experiences an error rate above 3 percent over the next year, we will provide that State with instructions for applying for a good faith waiver.

Comment: One commenter expressed strong support for the conclusion that all Medicaid rules, including those related to EPSDT, apply to Medicaid expansion programs.

Response: We appreciate the support. A State that expands eligibility for children under Medicaid must apply all the title XIX rules to the expansion population including children for whom the State receives enhanced FMAP at the title XXI rate.

2. Disallowance of Federal Financial Participation for Erroneous State Payments (§ 431.865)

We proposed to amend § 431.865(b) to exclude from the definition of "erroneous payment" payments made for care and services provided to children during a period of presumptive eligibility. We received no comments on this section and are implementing it as proposed. We are, however, also making a technical amendment to the definition of erroneous payment in § 431.865(b). Specifically, we are changing the word "in" in paragraph (1) to "if" so that the definition reads: "Erroneous payments means the Medicaid payment that was made for an individual or family under review who—(1) Was ineligible for the review month or, if full month coverage is not provided, at the time services were received." The use of "in" instead of "if" clearly was a typographical error.

3. Rates of FFP for Program Services (§ 433.10)

We proposed to add a new paragraph (c)(4) to state that the FFP for services provided to uninsured children under an SCHIP Medicaid expansion program would be the enhanced FMAP established by SCHIP. We received no comments on this section and are implementing it as proposed.

4. Enhanced FMAP Rate for Children (§ 433.11)

Section 4911 the BBA, as amended by section 162 of Public Law 105-100, authorized an increase in the Federal medical assistance percentage (FMAP) used to determine the Federal share of State expenditures for services provided to certain children. Federal financial participation for these children will be paid at the enhanced FMAP rate determined in accordance with § 457.622, provided that certain conditions are met. The State's allotment under title XXI will be reduced by payments made at this enhanced FMAP, consistent with § 457.616.

Under proposed § 433.11(b) in order to be eligible to receive Federal payments at the enhanced FMAP, a State must:

- (1) Not adopt income and resource standards and methodologies for determining a child's eligibility under the Medicaid State plan that are more restrictive than those applied under the State plan in effect on June 1, 1997;
- (2) Have sufficient funds available under the State's title XXI allotment to cover the payments involved; and
- (3) Maintain a valid method of identifying services eligible for the enhanced FMAP.

Under § 457.606, the State must also have an approved State plan in effect. For purposes of determining whether an income or resource standard or methodology is more restrictive than the standard or methodology under the State plan in effect on June 1, 1997, we proposed to compare it to the standard or methodology that was actually being applied under the plan on June 1, 1997. For purposes of this section, a pending Medicaid State plan amendment that would establish a more restrictive standard or methodology, but that has an effective date later than June 1, 1997, would not be considered "in effect" on June 1, 1997, regardless of when it was submitted. However, while States that adopt more restrictive income or resource standards or methodologies than those in effect on June 1, 1997 would not be eligible for enhanced FMAP, the proposed rule provided that if a State drops an optional eligibility group entirely, the prohibition against receiving enhanced FMAP does not apply.

In § 433.11, we proposed that the enhanced FMAP would be used to determine the Federal share of State expenditures for services provided to three categories of children. The first category for whom the enhanced FMAP would be available in the proposed rule

was the new group of "optional targeted low-income children" described in proposed § 435.229. Under this category, the State would expand eligibility to a new group of children.

Under the second category the State would cover children who meet the definition of "optional targeted low-income child" by expanding coverage under existing Medicaid groups. Thus, a State would not need to adopt the new eligibility group of optional targeted low-income children in order to receive the enhanced match. As long as the newly-covered children under an expanded Medicaid group met the definition of targeted low-income child, including the requirements that they be uninsured and not eligible for Medicaid under the State plan in effect on March 31, 1997, the State could receive the enhanced match for them. (Note that the State could claim the regular FMAP for children covered by an expansion, who do not meet the definition of optional targeted low-income children because they are covered by private insurance.) These first two categories of children are reflected in proposed § 433.11(a)(1), which implements sections 1905(u)(2)(C) and 1902(a)(10)(A)(ii)(XIV) of the Act.

The third category for whom the State may receive the enhanced FMAP consists of children born before October 1, 1983 who would not be eligible for Medicaid under the policies in the Medicaid State plan in effect on March 31, 1997, but to whom the State subsequently extends eligibility by using an earlier birth date in defining eligibility for the group of poverty-level-related children described in section 1902(l)(1)(D) of the Act. The enhanced FMAP is available for services to children in this third category even if they have creditable health insurance, as defined at 45 CFR 146.113. We note that, as the statutory phase-in of poverty-level-related children under age 19 proceeds, the numbers of children in this third category will diminish; by October 1, 2002, all the children in this category will be included in the mandatory group of children described in section 1902(l)(1)(D) of the Act, and State spending for services to them will be matchable at the State's regular FMAP.

Concerning the second category above, it is unlikely that Congress intended to provide enhanced FMAP for services provided to children who, although not eligible under the policies in effect in the Medicaid State plan in effect on March 31, 1997, became eligible after that date due solely to a Federal statutory change or an already scheduled periodic cost-of-living

increase. These types of changes are inherent in the State plan policies in effect on March 31, 1997. Enhanced FMAP will be available only when children are made eligible due to a change in State policy, which expands eligibility to cover previously ineligible children.

Federal payments made at the enhanced FMAP rate reduce the title XXI appropriation in accordance with section 2104(d) of the Act. Thus, HCFA must apply such payments against a State's title XXI allotment until that allotment is exhausted. After the title XXI allotment is exhausted, expenditures will be matched at the State's regular FMAP rate.

Comment: Three commenters objected to our proposal to allow a State to receive enhanced FMAP if the State drops an optional eligibility group that was covered on March 31, 1997 because the maintenance of effort provision in the statute was intended to prevent States from dropping Medicaid coverage in order to put children in a separate child health program. The commenters argued that our proposal is contrary to the statutory intent.

Response: We appreciate the commenters' concern. However, while the maintenance of effort provisions of the statute explicitly speak to more restrictive income and resource standards and methodologies, they do not reference other conditions of eligibility or other State actions, such as dropping optional eligibility groups.

Prior to the enactment of SCHIP, the overwhelming majority of children under 19 who were eligible for Medicaid under an optional category received coverage under the States' medically needy programs. By that time, children previously covered under other optional groups largely had been subsumed by the mandatory poverty-related eligibility groups. Given the further recent expansion of eligibility under the poverty-related groups and through the use of less restrictive income and resource standards and methodologies permitted under section 1931 of the Act, the number of children in these other groups has further diminished. Most of the children who remain covered under an optional group—other than those in a medically needy group—fall into the optional categorically needy group of children eligible under section 1902(a)(10)(A)(ii)(I) of the Act, often referred to as "Ribicoff children."

Under section 1902(a)(10)(C)(ii)(I) of the Act, States cannot drop only children under 19 from their medically needy programs. It is highly unlikely that a State would drop its entire

medically needy program in order to place a few children in SCHIP. Since the number of children in other optional eligibility groups is very small, there is little financial incentive for States to drop any of these groups either. The only reason a State might potentially drop one of its optional groups would be to cover the children under another, broader group. Such simplifications likely will promote enrollment of children and should not be discouraged.

In this context, two additional points are pertinent to understanding our decision. First, under the proposed regulation, States that eliminate an optional eligibility category will not be able to receive the enhanced FMAP for any children who would have been eligible for Medicaid under the eligibility standards for the dropped group in effect on March 31, 1997. Thus, the proposed regulations do not permit States to transfer any children from coverage under an optional Medicaid group to a stand-alone SCHIP program or to receive enhanced FMAP for such children under a Medicaid expansion. States simply would not be precluded from receiving the enhanced match for other children in its SCHIP program, which is what would happen if a State reduced coverage under a mandatory category.

Second, all Ribicoff children under age 19 will be subsumed by the mandatory poverty-level group by October 1, 2002, so any savings generated from eliminating this group, which, as discussed above would be nominal, would also be short-lived.

Accordingly, there is little incentive for States to eliminate any non-medically needy eligibility categories under Medicaid. In the highly unlikely event that a State nonetheless chose to do so, the number of children who would be affected would be minimal. The small number of potentially (but unlikely to be) affected children does not justify restricting States' ability to simplify their Medicaid programs in this regard.

Comment: One commenter requested that we add "with or without creditable insurance" to § 433.11(a)(2), to make it clear that the enhanced FMAP is available for children born before October 1, 1983 who would be described in section 1902(l)(1)(D) of the Act (the poverty-level children's group) if they had been born on or after that date and would not qualify for medical assistance under the State plan in effect on March 31, 1997, even if they have creditable health coverage.

Response: We have added "with or without group health coverage or other

health insurance coverage" to § 433.11(a)(2) to clarify this point.

5. *Optional Targeted Low-Income Children (§ 435.229)*

Section 4911 of the BBA amended the Social Security Act by adding a new section 1902(a)(10)(A)(ii)(XIV) to establish an optional categorically-needy group of children referred to as "optional targeted low-income children," and described in section 1905(u)(2)(C) of the Act. Section 1905(u)(2)(C), as added by section 4911 of the BBA, was subsequently revised by section 162 of Public Law 105-100 and, in the process, "(C)" was changed to "(B)". In an apparent oversight, no conforming change was made to section 1902(a)(10)(A)(ii)(XIV) of the Act to refer to section 1905(u)(2)(B), rather than to 1905(u)(2)(C). Since it appears that this was simply a drafting error, we consider the reference to 1905(u)(2)(C) in this section to be a reference to 1905(u)(2)(B).

Section 1905(u)(2)(B) defines an optional targeted low-income child as a child who meets the definition of a targeted low-income child in section 2110(b)(1) of title XXI of the Act and who would not qualify for Medicaid under the Medicaid State plan in effect on March 31, 1997. Because only a child under 19 can qualify as a targeted low-income child under section 2110(b)(1) of the Act (see section 2110(c) of the Act), to be covered as an optional targeted low-income child under Medicaid, an individual also must be under 19 (even though individuals between 19 and 21 can qualify for Medicaid under other eligibility groups).

The very specific cross reference in section 1905(u)(2)(B), to section 2110(b)(1), for the definition of an optional targeted low-income child indicates that the Medicaid definition of "optional targeted low-income child" is based only on section 2110(b)(1). Thus, the definition of "targeted low-income child" for Medicaid does not include the exclusions described in section 2110(b)(2) that apply to the definition of "optional targeted low-income child" for separate child health programs under title XXI. Specifically, the following groups of children are excluded from eligibility for a separate child health program under title XXI, but are not excluded from eligibility for Medicaid: (1) children who are inmates of public institutions and patients in institutions for mental diseases (IMD); and (2) children who are eligible for health benefits coverage under a State health benefits plan on the basis of a

family member's employment with a public agency in the State.

Under existing Medicaid eligibility rules, there is no eligibility exclusion for children who are inmates of a public institution, patients in an IMD, or children eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State, although restrictions on Federal financial participation (FFP) apply under some circumstances. Specifically, no FFP is available under Medicaid for services provided to inmates of public institutions or patients in an IMD. We note that under Medicaid, if, under section 1905(a)(16) of the Act, a State elects to cover inpatient psychiatric services for individuals under age 21, FFP is available for services furnished to children in psychiatric facilities for individuals under age 21 that meet certain standards and conditions (see § 441.150ff).

Turning to the proposed rule, the definition of optional targeted low-income child at section 1905(u)(2)(B) of the Act excludes children who would have been eligible for medical assistance under the State plan in effect on March 31, 1997 on any basis, thus including those who would have been eligible under a State's medically needy group. This exclusion was set forth in proposed § 435.229(a)(2). We explained in the preamble to the proposed rule that we would interpret section 1905(u)(2)(B) to exclude children who would have been eligible as medically needy based on their current financial status without a "spend-down," an amount that can be spent on medical care before the child can become eligible. However, children who would have been eligible for Medicaid under the State plan in effect on March 31, 1997 only after paying a spend down would not be excluded, because they would not have been eligible for Medicaid until the spend-down had been met.

We explained in the preamble for proposed § 435.229 that the regular Medicaid financial methodologies that govern eligibility of children in a State, that is, the income and resource methodologies under the State's AFDC plan in effect on July 16, 1996, must also be used to determine whether a child is eligible under the new group of optional targeted low-income children. However, a State may use the authority of section 1902(r)(2) of the Act to adopt less restrictive methods of determining countable income and resources for this group.

States that choose to cover a group of optional targeted low-income children also must apply uniform income and

resource eligibility standards for the group throughout the State. States also are required to provide all services covered under the plan, including EPSDT services, to optional targeted low-income children. Indeed, as we explained in the preamble to the proposed rule, States must apply all regular Medicaid rules. We thought it worth emphasizing that this includes Medicaid rules pertaining to immigration status.

States are not required to provide coverage to all children who meet the definition of an optional targeted low-income child. As with the existing Medicaid rules, eligibility under the optional group can be limited to a reasonable group or reasonable groups of such children. However, this option, reflected in proposed § 435.229(b)(2), does not allow States to limit a group by geographic location because of the requirement in section 1902(a)(1) of the Act that a State plan be in effect in all political subdivisions of the State. Also, as explained in the preamble to the proposed rule, we do not consider it reasonable to limit a group by age other than by those age groups specified by Congress in section 1905(a)(1) and referenced in section 1902(a)(10)(A)(ii). We believe that if Congress had intended to allow other uses of age to establish categories of eligibility, the statute would not have specified any age groups. We note that, in the case of the group of optional targeted low-income children, a State does not have the option to cover a reasonable category of children under age 21 or 20, because for purposes of defining "targeted low-income child" for title XXI programs and "optional targeted low-income child" for Medicaid expansion programs, "child" is defined in section 2110(c)(1) of the Act as a child under age 19. (This age limitation applies to all optional targeted low-income children, not only those in the optional group.)

Section 2110(b)(1)(B) refers to the Medicaid applicable income level, which, under 2110(b)(4), explicitly recognizes potentially different levels based upon the age of a child. The income standard for the optional categorically-needy group of optional targeted low-income children may be different for infants, children under age 6, and children between ages 6 and 18 (that is, under age 19) if the State's Medicaid applicable income levels for these age groups differ.

We did not propose to require or allow States to apply eligibility-related private health insurance substitution provisions, such as periods of uninsurance, to the "optional targeted low-income children" group because

such eligibility conditions are inconsistent with the entitlement nature of Medicaid and are therefore not permitted by the Medicaid statute in the absence of a section 1115 waiver.

Finally, we explained in the preamble to the proposed rule that States are obligated to continue to provide services to eligible optional targeted low-income children after its title XXI allotment is exhausted, unless the Medicaid State plan is amended to drop the group of optional targeted low-income children. Once the title XXI allotment is exhausted, Medicaid matching funds are available for these children at the regular matching rate rather than the enhanced rate.

Comment: Two commenters requested that the Medicaid regulations include a definition of optional targeted low-income child because they found the cross-reference to the title XXI regulations is confusing. They also noted that some provisions in title XXI, such as permitting States to limit eligibility by geographic region, do not apply in Medicaid.

Response: We accept the commenters' request to clarify the definition of optional targeted low-income child in the Medicaid regulations, rather than cross-reference § 457.310(a). In proposed § 435.229(a), the cross-reference to § 457.310(a) resulted in the inclusion of some provisions of the definition of targeted low-income child that only apply to separate child health programs. Therefore, we have removed the cross-reference in § 435.229 to § 457.310(a) and added a Medicaid-specific definition of optional targeted low-income child to § 435.4 (for the States, the District of Columbia, the Northern Mariana Islands, and American Samoa) and to § 436.3 (for Guam, Puerto Rico, and the Virgin Islands). The definition of optional targeted low-income child applies to the optional categorically needy group of optional targeted low-income children under § 435.229 and § 436.229 for whom the enhanced FMAP is available.

Specifically, §§ 435.4 and 436.3 include the following children in the definition of "optional targeted low-income child": (1) children who have family income at or below 200 percent of the Federal poverty line for a family of the size involved; (2) children who reside in a State which does not have a Medicaid applicable income level, as that term is defined in § 457.10; or (3) children who reside in a State that has a Medicaid applicable income level and has a family income that exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points; or (4)

children whose income does not exceed the effective income level specified for such child to be eligible for medical assistance under the policies of the State plan under title XIX on June 1, 1997. As noted, we have revised the definition to clarify that an optional targeted low-income child that resides in a State that has a Medicaid applicable income level may have family income that exceeds the Medicaid applicable income level, but does not exceed the effective income level that has been specified under the policies of the State plan under title XIX on June 1, 1997. This provision effectively allows children who became eligible for Medicaid as a result of an expansion after March 31, 1997 but before June 1, 1997 may be considered optional targeted low-income children. It also means that children who were below the Medicaid applicable income level, but were not Medicaid eligible due to financial reasons that were not related to income (for example, due to an assets test) can be covered by SCHIP.

Furthermore, the definition in § 435.4 and § 436.3 requires that an optional targeted low-income child must not be: (1) Eligible for Medicaid under the policies of the State plan in effect on March 31, 1997; or (2) covered under a group health plan or under health insurance coverage unless the health insurance coverage program is offered by the State, has been in operation since before July 1, 1997, and the State receives no Federal funds for the program's operation. A child would not be considered covered under a group health plan if the child did not have reasonable geographic access to care under that plan. These criteria mirror the provisions of proposed § 457.310, except those that apply only to separate title XXI child health programs.

Comment: Three commenters indicated that children who were covered by section 1115 demonstration projects with a limited benefit package should not be considered to have been recipients of Medicaid, and therefore should not be excluded from the definition of optional targeted low-income children. They urged HCFA to provide a regulatory clarification so that children eligible under a section 1115 demonstration project that only provided a limited range of services would be eligible for enhanced matching under the definition of an "optional targeted low-income child."

Response: We agree with the commenters and have therefore revised the definition of the term "Medicaid applicable income level" at § 457.10, to address their concerns. Specifically, in § 457.10 we clarify that, for purposes of the definition of "Medicaid applicable

income level," the term "policies of the State plan" includes policies under most section 1115(a) Statewide demonstration projects; however, the term does not include section 1115(a) demonstrations that granted coverage to a new group of eligibles but which did not provide inpatient hospital coverage, or which limited eligibility both by allowing only children who were previously enrolled in Medicaid to qualify and imposing premiums as a condition of participation in the demonstration. This exception does not apply to waivers that extended the time period or conditions under which an individual could receive transitional medical assistance.

The exclusion of children eligible for medical assistance under the State plan in effect as of March 31, 1997 was intended to ensure that States did not transfer coverage of low-income children who would have been eligible under their Medicaid program at the regular Federal matching rate to the enhanced matching rate established by SCHIP. However, this provision does not specifically address the treatment of children who could have been covered under a section 1115 demonstration project in effect on March 31, 1997.

Our understanding is that the provision was not intended to preclude States from claiming enhanced matching funds for expanded coverage to children whose income is below the demonstration project eligibility thresholds in place as of March 31, 1997, if those programs did not offer comprehensive coverage or limited eligibility to individuals who were previously enrolled in Medicaid and imposed premiums as a condition of participation. Demonstrations that had these types of restrictions are significantly more limited in scope (either in coverage or eligibility) than "traditional" Medicaid programs. Our experience with SCHIP and our increased understanding of how this provision is affecting States' ability to expand coverage have led us to agree with the commenters that an overly broad interpretation of the exclusion contained in section 1905(u)(2)(B) of the Act would be contrary to the intent of the statute. Furthermore, because enrollment in these types of demonstrations is relatively small, any supplantation of State dollars would be minimal. Therefore, we have clarified this provision in the final rule.

Comment: Several commenters supported the proposal that EPSDT policies apply to optional targeted low-income children. One of these commenters also agreed that there should not be a required period of

uninsurance for these children and encouraged HCFA to explicitly prohibit such a requirement.

Response: EPSDT applies to this group of children because they are in a Medicaid group and entitled to all benefits and protections provided to children under Medicaid law and regulations. With respect to periods of uninsurance, we have not included the prohibition against requiring a period of uninsurance in the regulation text for this provision since periods of uninsurance are already prohibited by the Medicaid statute and regulations. We believe that this prohibition is inherent in the entitlement nature of Medicaid. States may not impose conditions of eligibility other than those specifically allowed by statute, regulation, or waiver. We will work with States that have such policies in place to assure that the requirements of the statute are met.

6. Furnishing a Social Security Number (§ 435.910)

Section 1137(a)(1) of the Act requires applicants and recipients of Medicaid to furnish the State with their social security number(s) as a condition of eligibility. While the United States Supreme Court in *Bowen v. Roy*, 476 U.S. 693 (1986) upheld this requirement, it did so in a plurality decision in which some of the Justices held that the challenge was moot because the claimant had obtained a social security number. As a result, that decision did not foreclose someone else with religious objections to applying for a social security number from challenging the constitutionality of section 1137(a)(1) of the Act. The Religious Freedom Restoration Act of 1993 also raised questions about the requirements of section 1137(a)(1) of the Act in cases involving religious objections.

Consequently, in 1995 HCFA announced a policy that permits States to obtain or assign alternative identifiers to eligible individuals who object to obtaining an SSN on religious grounds. This policy was adopted in order to enable States to administer Medicaid in the most efficient manner possible. In § 435.910 of the proposed rule we attempted to accommodate the purpose of section 1137(a)(1) with the Constitution's protection of freedom of religion and the dictates of the 1993 Act by permitting alternative identifiers.

We received no comments on this section. However, we wish to clarify that the statute requires an SSN of applicants and recipients only. States may request but may not require other individuals in the household to provide

their SSN's. For example, if application is made on behalf of a child and the parent is not applying, the State may request the parent's SSN but must note that the SSN is not required and may not deny the child's eligibility if the parent does not provide his/her own SSN.

7. FFP for Services and FFP for Administration (§ 435.1001 and § 435.1002)

Section 1920A of the Act allows States to provide services to children under age 19 during a period of presumptive eligibility. The implementation of this provision is discussed below. In accordance with this new option, we proposed to amend § 435.1001 to provide FFP for necessary administrative costs incurred by States in determining presumptive eligibility for children and providing services to presumptively eligible children. In § 435.1002 we proposed to provide FFP for services covered under a State's plan which are furnished to children during a period of presumptive eligibility. We received no comments on either of these sections and are implementing them as proposed.

8. Exemption From the Limitation on FFP for Categorically Needy, Medically Needy, and Qualified Medicare Beneficiaries (§ 435.1007)

Section 162 of Public Law 105-100 amended 1903(f)(4) of the Act to add the optional group of optional targeted low-income children and other children for whom enhanced FMAP is available to the list of those who are exempt from the limitations on FFP found in section 1903(f). All previous citations in section 1903(f) were references to Medicaid eligibility groups, whereas this new provision adds not an eligibility group per se, but rather children on whose behalf enhanced FMAP is available.

With certain exceptions, section 1903(f) limits FFP to families whose income does not exceed 133 $\frac{1}{3}$ percent of the amount that ordinarily would have been paid to a family of the same size without any income or resources, in the form of money payments under the Aid to Families with Dependent Children program. This provision effectively limits the use of the authority under section 1902(r)(2) to expand eligibility through the use of less restrictive income and resource methodologies for those groups that are not exempt from the limitation.

However, section 162 of Public Law 105-100 could result in extending the exemption from the FFP limitation to children other than (1) children in the optional eligibility group of optional

targeted low-income children or (2) children in other groups already exempt from the FFP limitation. If this were to occur, a conflict with the comparability requirements of section 1902(a)(17) and § 435.601(d)(4) of the Medicaid regulations could arise. If, for example, a State sought to use more liberal income methodologies for counting income in determining the medically-needy eligibility of optional targeted low-income children than used for counting income in determining the medically-needy eligibility of other children, the comparability requirements would be violated.

Because the exemption from the FFP limit did not override the comparability requirement of the Medicaid statute, we proposed to continue to apply the FFP limitations described in § 435.1007 to all children who are covered as medically-needy and to any optional categorically-needy group which is subject to the FFP limit. States may use more liberal methodologies under section 1902(r)(2) of the Act for the optional categorically-needy group composed exclusively of optional targeted low-income children without reference to the FFP limitations of section 1903(f). We received no comments on this section and have adopted this portion of the rule as proposed.

9. Presumptive Eligibility for Children (Part 435, Subpart L)

Section 4912 of the BBA added a new section 1920A to the Act to allow States to provide services to children under age 19 during a period of presumptive eligibility, prior to a formal determination of Medicaid eligibility. We set forth the basis and scope of subpart L in proposed § 435.1100.

Under section 1920A of the Act, only a "qualified entity" can determine whether a child is presumptively eligible for Medicaid on the basis of preliminary information about the child's family income. In accordance with section 1920A(b)(3)(A) of the Act, we define a qualified entity in § 457.1101 as an entity that is determined by the agency to be capable of making determinations of presumptive eligibility for children and that— (1) furnishes health care items and services covered under the approved Medicaid State plan and is eligible to receive payments under the approved plan; (2) is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act; (3) is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided

under the Child Care and Development Block Grant Act of 1990; or (4) is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966. In addition, the Benefits Improvement and Protection Act of 2000 (BIPA) (P.L. expanded this list of qualified entities to include an entity that (5) is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801); (6) is an elementary or secondary school operated or supported by the Bureau of Indian Affairs; (7) is a State or Tribal child support enforcement agency; (8) is an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act; (9) is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or (10) is an entity that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 *et seq.*) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*); or (11) any other entity the State so deems, as approved by the Secretary.

Finally, section 1920A(b)(3)(B) also authorizes the Secretary to issue regulations further limiting those entities that may become qualified entities. We note that, although State agency staff can receive and process applications for regular Medicaid, they cannot make presumptive eligibility determinations unless they themselves meet the definition of a "qualified entity" under § 457.1101.

We note that the date that the completed regular Medicaid application form is received by the Medicaid State agency is the Medicaid filing date for Medicaid eligibility, unless State agency staff are located on site at the qualified entity, in which case the Medicaid filing date is the date that the onsite State agency staff person receives the completed form. Alternatively, the State can opt to consider the date the determination of presumptive eligibility is made as the Medicaid application date.

In accordance with section 1920A(b)(2), we also proposed in § 435.1101 that the period of presumptive eligibility begins on the day that a qualified entity makes a

determination that a child is presumptively eligible. The child would then have until the last calendar day of the following month to file a regular Medicaid application with the Medicaid agency. If the child does not file a regular Medicaid application on time, presumptive eligibility ends on that last day. If the child files an application for regular Medicaid, presumptive eligibility ends on the date that a determination is made on the regular Medicaid application.

Finally, proposed § 435.1101 defined "applicable income level" as the highest eligibility income standard established under the State plan which is most likely to be used in determining the Medicaid eligibility of the child for the age involved. We note that there may be different applicable income levels for children in different age groups. For example, the standards for presumptive eligibility might be 133 percent of the Federal poverty level (FPL) for children under 6 and 100 percent FPL for children age 6 through 19, if these were the highest standards applicable to children of the specified ages under a State's Medicaid plan.

We proposed in § 435.1102(a) to provide limited flexibility to States in calculating income for purposes of determining presumptive eligibility. We also explained in the preamble to the proposed rule that under § 435.1102(a) we would allow States to require that qualified entities request and use general information other than information about income, as long as the information can be obtained through the applicant's statements and is requested in a fair and nondiscriminatory manner. With respect to income, in States that adopt the most conservative approach to presumptive eligibility, the qualified entity would use gross family income. The qualified entity would compare gross family income to the applicable income level, as defined in § 435.1101.

For States wishing to adopt a more liberal approach, however, we specifically proposed to allow States to require that qualified entities apply simple income disregards, such as the general \$90 earned income disregard. However, as explained in the preamble we did not propose to allow States to require that qualified entities deduct the costs of incurred medical expenses in order to reduce income to the allowed income level. We solicited comments on whether States should be allowed to require that qualified entities make certain adjustments to gross income and ways that these adjustments could be limited.

Proposed §§ 435.1102(b)(1) and (b)(2) implement the provisions of section

1920A(b)(1) of the Act. Section 435.1102(b)(1) requires that States provide qualified entities with regular Medicaid application forms (defined in proposed § 435.1101) as well as information on how to assist parents, guardians, and other persons in completing and filing such forms. At a minimum, we proposed that States must furnish qualified entities with the applications used to apply for Medicaid under the poverty-related groups described in section 1902(l)(1) of the Act.

Proposed § 435.1102(b)(2) requires States to establish procedures to ensure qualified entities—(1) notify the Medicaid agency that a child is presumptively eligible within 5 working days; and (2) provide written information to parents and custodians of children determined to be presumptively eligible, explaining that a regular Medicaid application must be filed by the last day of the following month in order for the child to continue to receive services after that date and that if an application is timely filed on the child's behalf, the child will remain presumptively eligible until a determination of the child's eligibility for regular Medicaid has been made; and (3) provide written information to parents and custodians of children determined not to be presumptively eligible of the reason for the determination and that the child has a right to apply to regular Medicaid.

While we are requiring such notification, we are considering presumptive eligibility to be a special status, distinct from regular Medicaid eligibility. Therefore, we did not propose to apply to a decision on presumptive eligibility the notification requirements, found in §§ 435.911 and § 435.912 and part 431, subpart E, that a State must meet when it makes a decision on a regular Medicaid application. Nor did we propose to grant rights to appeal a denial or termination of services under a presumptive eligibility decision because a determination of presumptive eligibility is not considered to be a determination of Medicaid eligibility. If a regular Medicaid application is filed on the child's behalf and is denied, the child would have the right to appeal that denial.

Because presumptive eligibility is a special status, we considered whether States should be required to provide all services to presumptively eligible children or whether they should be permitted to limit the services provided. In § 457.1102(b)(3), we proposed to require that States provide all services covered under the State plan, including

EPSDT, to presumptively eligible children.

Although section 1920A places no restrictions on the number of periods of presumptive eligibility for a child, it undermines the intent of the provision to provide a child with an unrestricted number of periods. Therefore, we proposed in § 435.1102(c) to allow States to establish reasonable methods of limiting the number of periods of presumptive eligibility that can be authorized for a child in a given time frame. We solicited comments on what would constitute a reasonable limitations and whether specific limitations on the number of periods of presumptive eligibility should be imposed by regulation.

Existing regulations at § 435.914 permit States to provide Medicaid for an entire month when the individual is eligible for Medicaid under the plan at any time during the month. However, as explained in the preamble to the NPRM, because a determination of presumptive eligibility is not, by definition, a determination of Medicaid eligibility, but simply a decision of temporary eligibility based on a special status, and because section 1920A(b)(2) of the Act expressly defines the period of presumptive eligibility, we did not propose to permit States to provide full-month periods of presumptive eligibility.

Section 4912 of the BBA provides that, for purposes of Federal financial participation, services that are covered under the plan, furnished by a provider that is eligible for payment under the plan, and furnished to a child during a period of presumptive eligibility, will be treated as expenditures for medical assistance under the State plan. This provision is reflected in proposed § 435.1001. We note that in the event that a child determined to be presumptively eligible is not found eligible for Medicaid after a final eligibility determination, the services provided during the presumptive eligibility period that otherwise meet the requirements for payment will be covered. See § 447.88 and § 457.616 for a discussion of the options for claiming FFP payment related to presumptive eligibility.

Comment: We received one comment that the regulations should clarify that a State can provide a joint SCHIP/Medicaid application or a shortened Medicaid application used for pregnant women and children as well as a "regular Medicaid application."

Response: We agree that a qualified entity may provide parents and caretakers with either a shortened application that is used to establish

eligibility for pregnant women and children under the poverty-level-related groups described in section 1902(l) of the Act or a joint application for a separate child health program and Medicaid that is used to establish eligibility of children. We have revised the definition of "application form" in § 435.1101 to include the joint SCHIP/Medicaid application for a Medicaid and a separate child health program.

We would like to clarify that, under Federal law, no application form for presumptive eligibility itself is required. Thus, qualified entities can make presumptive-eligibility determinations based strictly on oral information. (The qualified entity would need to record the pertinent information, but the parent or caretaker (or other responsible adult) would not themselves need to complete an application.) This would not preclude qualified entities from assisting families in completing and filing the regular Medicaid application to the extent permitted under law, and we strongly encourage them to do so.

Alternatively, a State may choose to use a written application for presumptive eligibility, although it cannot require the parent or caretaker to provide information other than the information on income necessary to make the determination.

We encourage States that choose to use a written application, particularly those with simplified Medicaid application forms, to use the same form for presumptive eligibility as that used for regular Medicaid, as this will eliminate the need for the child's family to complete two forms. The parent or caretaker can be encouraged to complete the application and assisted in doing so. But, again, so long as pertinent information on income is provided, presumptive eligibility in a State that has elected this option cannot be denied because the full application is not completed.

In either event, of course, the State must provide qualified entities with information on how to assist families in completing and filing the application and ensure that they give presumptive-eligibility applicants a Medicaid application form. We also strongly encourage States, in turn, to encourage qualified entities to provide such assistance to the extent permitted under Medicaid law and regulations.

Comment: One commenter specifically supported the requirement that presumptive eligibility must be provided Statewide and one commenter specifically objected to this requirement. A third commenter objected to requiring each qualified entity to conduct Statewide

presumptive eligibility outreach and determination.

Response: We have considered the commenters' suggestions and have retained proposed § 435.1102(b)(4) related to Statewide availability of presumptive eligibility. Section 1920A(b)(3)(C) provides States with the authority to limit the classes of entities that may become qualified entities; and therefore may limit the population that have the opportunity to become presumptively eligible. For example, States could designate WIC agencies to make determinations of presumptive eligibility only for the clients who have applied for or are receiving WIC, but all of the WIC agencies across the State would be required to offer presumptive eligibility. Therefore, a State could effectively limit the availability of presumptive eligibility by designating particular qualified entity to offer it.

Comment: One commenter noted that schools would not be able to do determinations of presumptive eligibility for pre-schooled, home-schooled, drop-outs or graduates.

Response: Although schools are not likely to be in regular contact with children falling into one of these groups, and as a practical matter may not be in a position to make presumptive eligibility decisions for them, schools that are Medicaid providers would not be precluded from determining the eligibility of a child simply because the child did not attend the school. Thus, schools would also be authorized to determine the presumptive eligibility of the children identified by the commenter.

Comment: We received one comment concerning verification of information used to determine presumptive eligibility. The recommendation was that the regulations specifically require that "self-attestation" be used for determinations of presumptive eligibility if income disregards are used and that in other cases, HCFA encourage States to allow applicants to attest to information required for a determination of presumptive eligibility without providing documentation.

Response: We have revised § 435.1102 to make it clear that an estimate of income is to be used for purposes of presumptive eligibility determinations even when a State has chosen to apply simple disregards. The statute provides that determinations of presumptive eligibility are based on "preliminary information" and we do not believe that requiring documentation is consistent with the intent that the process be simple for both the applicant and the provider and result in immediate eligibility. Therefore, an applicant's self-

attestation as to income is all that would be required to establish the amount of income for presumptive eligibility determinations, regardless of whether income disregards are used or not. This is consistent with the proposed rules pertaining to presumptive eligibility for pregnant women, published March 23, 1994 (59 FR 13666).

Comment: One commenter specifically supported allowing only simple disregards in determinations of presumptive eligibility. Another commented that States should be free to decide whether to use gross or net income for determinations of presumptive eligibility.

Response: We appreciate the support and agree in part with the second commenter. States are free to use only gross income. States may also apply simple disregards to gross income such as a general earned income disregard. However, it would not be consistent with statutory intent to allow States to require that qualified entities apply complicated income disregards or make complicated determinations. Therefore, we have not revised proposed § 457.1102(a) in this final regulation.

Comment: Three commenters expressed support for requiring that, in proposed § 457.1102(b)(3), presumptive eligibility include EPSDT services. One of these commenters urged that the preamble discuss the steps that States should take to assure that EPSDT services are provided.

Response: We are not including any specific EPSDT guidance in this regulation. The regular Medicaid policies which pertain to EPSDT, including policies about providing information about EPSDT services to families and generally informing families about the benefits of preventive health, would apply when a child is found presumptively eligible for Medicaid.

Comment: We received several comments concerning written notices provided to the family and the responsibilities of qualified entities. One comment was that it would be difficult for schools to issue the notice of presumptive eligibility and the temporary enrollment card and the State should be allowed to do this instead. Another was that it would be difficult for schools to send a written notice to those found not to be presumptively eligible and might result in the family's confusion and anger. One comment was that, generally, HCFA should encourage States to develop procedures that are not burdensome to providers, provide adequate training and provider relations, and keep the provider apprized of the status of the application

so that, if not completed at the time of any follow-up visit, the provider can encourage the family to complete the process, as necessary.

Response: Our understanding is that the intent of the legislation is to minimize the burden placed on qualified entities, including schools and other providers. However, the statute specifically requires that the qualified entity inform the family that an application for Medicaid must be filed by the end of the following month. It is also clear that qualified entities are expected to provide Medicaid applications and assistance in completing and filing such applications. We certainly encourage States to simplify the presumptive eligibility process to the greatest extent allowed under the law. It is not unnecessarily burdensome for the qualified entity to provide written notices to those found presumptively eligible or ineligible, as these notices could be pre-printed notices provided by the State.

Although we have not required it, it would not be unnecessarily burdensome for a State to require a qualified entity to provide a temporary enrollment card to enable the child to access services during the period of presumptive eligibility particularly when the qualified entity itself does not provide medical services. We also encourage States to keep qualified entities apprized of the status of the child's application if the entity is willing to follow up with families whose application has not been completed.

Comment: One commenter suggested that § 435.1102(b)(2)(iii) should be amended to require that qualified entities tell individuals who are not found presumptively eligible for Medicaid that they may file for coverage under a separate child health program as well as Medicaid and provide applications for both programs as well as information on how to complete and file them.

Response: We have not required that qualified entities provide information about a separate child health program. However, we encourage States to do this as part of their outreach programs and coordination efforts. In addition, as noted above, we have amended § 435.1101 to make it clear that the application provided by a qualified entity may be a joint Medicaid/SCHIP application.

Comment: One commenter urged HCFA to encourage States to simplify the enrollment process and provide prompt, easy-to-understand information to the family about the eligibility determination process and any remaining steps that the family must

take. Another expressed concern that States are not required to send a notice at the end of a presumptive-eligibility period, which would alert families who sent in a Medicaid application that was never received.

Response: HCFA has encouraged States to simplify both the eligibility requirements and the enrollment procedures to the greatest extent possible and will continue to do so. We also encourage States to make all information provided to families understandable and will provide technical assistance in this area. We encourage States to notify families that the child's presumptive eligibility will be terminated and that no Medicaid application has been received. We also encourage States to establish other procedures to follow-up with families of presumptively-eligible children early on in the presumptive-eligibility period. However, requiring States to do so is beyond the intent of the statute, and could discourage some States from adopting presumptive eligibility for children at all. We will not mandate that States institute such procedures.

Comment: We received several comments in response to our specific request related to limitations on the number of periods of presumptive eligibility available to a child. One commenter believed that no more than one period of presumptive eligibility within 24 months would be reasonable, but recommended that States be allowed to set their own standards. Another commenter agreed it would be unreasonable to provide unlimited periods of presumptive eligibility, but believed that it would be reasonable to allow only one period per lifetime. A third recommended that there be no lifetime limit on the number of periods, but a limit on the number of periods within a specific time-frame (for example, one period of presumptive eligibility within a twelve-month period). A final commenter believed that it would be difficult for providers, who are considered qualified entities, to track the number of presumptive-eligibility any child has enjoyed.

Response: We have decided to require that States adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child within a given period of time. Under some circumstances, more frequent or numerous periods of presumptive eligibility may be justified and individual circumstances may be taken into account. We are not requiring that States establish a specific maximum number of periods for specific time frames in this final regulation. We

realize that the circumstances that result in a need for an additional period of presumptive eligibility will vary greatly from case to case. In addition, States may wish to have some experience before setting up a standard that qualified entities must follow. We expect States to monitor the use of presumptive eligibility to determine whether there is a need for specific limitations on the number of periods of presumptive eligibility to which a child is entitled.

We appreciate the support for our position that it would be unreasonable to provide unlimited periods of presumptive eligibility. However, if a State decides to establish set limits, we do not agree that one period of presumptive eligibility in a lifetime is reasonable given the changes in a child's circumstances that may occur over time. It would be reasonable, however, to limit the periods of presumptive eligibility to one per twelve or twenty-four month period, as suggested. Furthermore, it would be reasonable to connect limitations on presumptive eligibility to the length of time during which a child is not covered by Medicaid. For example, a State could prohibit an additional period of presumptive eligibility until the child had been disenrolled from Medicaid for a certain period of time. In response to the last commenter, after a State has established how it will restrict the number of periods of presumptive eligibility, we expect that the State will develop procedures for assuring that the restrictions are applied without unduly burdening the qualified entities, including providers.

L. Medicaid Disproportionate Share Hospital (DSH) Expenditures

Section 4911 of the BBA amended section 1905(b) of the Act to require that for expenditures under section 1905(u)(2)(A) (that is, medical assistance for optional targeted low-income children) or section 1905(u)(3) (that is, medical assistance for children referred to as "Waxman children"), the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b) of the Act unless the State has exhausted its title XXI allotment, in which case the State's regular FMAP would apply. In other words, under the statute, States that provide health insurance coverage to children as an expansion of their Medicaid programs may receive an enhanced match for services provided to the Medicaid expansion population.

Under the authority of section 1902(a)(13)(A)(iv) of the Act, States are required to take into account the

situation of hospitals that serve a disproportionate number of low-income patients with special needs when developing rates for Medicaid inpatient hospital services. Medicaid disproportionate share hospital (DSH) expenditures thus are payments made for hospital services rendered to Medicaid-eligible patients. Depending on the State's DSH methodology, some of the payments may be directly identifiable as expenditures for services for a child in a SCHIP-related Medicaid expansion program. HCFA concluded in the proposed rule that those identifiable payments must qualify for the enhanced FMAP.

We further proposed § 433.11 which set forth provisions regarding the enhanced FMAP rate available for State DSH expenditures related to services provided to children under an expansion to the State's current Medicaid program. However, based on the statutory changes included in the "Medicare, Medicaid, and CHIP Balanced Budget Refinement Act of 1999," this section is being deleted. Specifically, H.R. 3426 incorporated changes to section 1905(b) (42 U.S.C. 1396d(b)) by inserting the phrase "other than expenditures under section 1923," after "with respect to expenditures." By inserting this phrase, the statute specifically excludes Medicaid DSH expenditures from qualifying for enhanced FMAP.

III. Provisions of the Final Rule

In this final rule, we are adopting the provisions as set forth in the November 8, 1999 proposed rule with the following substantive revisions:

A. Part 431—State Organization and General Administration

We added a new § 431.636 to provide for coordination of Medicaid with the State Children's Health Insurance Program. This section provides that the State must adopt procedures to facilitate the Medicaid application process for, and the enrollment of children for whom the Medicaid application and enrollment process has been initiated.

B. Part 433—State Fiscal Administration

We removed proposed paragraph § 433.11(b)(3) regarding enhanced FMAP for disproportionate share hospital expenditures provided to certain children.

C. Part 435—Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa

- We added a definition of optional targeted low-income child at § 435.4.

- We revised § 435.229 to refer to optional targeted low-income children as defined at § 435.4.

- We revised § 435.910(h)(3) to provide that a State may use the Medicaid identification number established by the State to the same extent as an SSN is used for purposes described in paragraph (b)(3) of this section.

- At § 435.1101 we replaced the term “applicable income level” with the term “presumptive income level.” The definition for this term remains the same.

- We revised the requirement at proposed paragraph § 435.1102(b)(4) to provide that agencies that elect to provide services to children during a period of presumptive eligibility must allow determinations of presumptive eligibility to be made by qualified entities on a Statewide basis.

D. Part 436—Eligibility in Guam, Puerto Rico, and the Virgin Islands

In the proposed rule, we inadvertently omitted certain revisions to part 436. The following revisions parallel the changes made to part 435:

- We added a definition of optional targeted low-income children at § 436.3.

- We added a new § 436.229, regarding provision of Medicaid to optional targeted low-income children.

- We revised paragraph (a) of § 436.1001, regarding FFP for administration.

- We added a new paragraph (c) to § 436.1002, regarding FFP for services.

- We added a new subpart L, Option for Coverage of Special Groups.

E. Part 457—Allotments and Grants to States

- We replaced the term “Children’s Health Insurance Program” with the term “State Children’s Health Insurance Program” throughout the regulation.

- We replaced the term “beneficiary” with the term “applicant” or “enrollee” throughout the regulation.

Subpart A—Introduction; State Plans for State Child Health Insurance Programs and Outreach Strategies

Section 457.10

- We added definitions for the following terms: “applicant”, “cost sharing”, “enrollee”, “enrollment cap”, “health care services”, “health insurance coverage”, “health insurance issuer”, “health services initiatives”, “joint application”, “optional targeted low-income child”, and “premium assistance program”.

- For the following terms, we eliminated the cross reference and set forth the full text of the definition at

§ 457.10: “contractor”, “emergency medical condition”, “emergency services”, “health benefits coverage”, “managed care entity”, “post-stabilization services”.

- We revised the definition of American Indian/Alaska Native (AI/AN) by removing the provision that descendants in the first or second degree of members of Federally recognized tribes are considered AI/AN.

- We removed the definitions of “contractor”, “cost-effectiveness”, “employment with a public agency”, “grievance”, “legal obligation”, “post-stabilization services”, “premium assistance for employer sponsored group health plans”, and “State program integrity unit”.

Section 457.40

- We revised paragraph (c) to require that the State must identify, in the State plan or State plan amendment, by position or title, the State officials who are responsible for program administration and financial oversight.

Section 457.60

- We revised proposed paragraph (a)(1) (now paragraph (a)) to provide that a State must amend its State plan whenever necessary to reflect changes in Federal law, regulations, policy interpretations, or court decisions that affect provisions in the approved State plan.

- We revised proposed paragraph (a)(2) (now paragraph (b)) to provide that a State must amend its State plan whenever necessary to reflect changes in State law, organization, policy, or operation of the program that affect the following program elements: Eligibility, including enrollment caps and disenrollment policies; procedures to prevent substitution of private coverage, including exemptions or exceptions to periods of uninsurance; the type of health benefits coverage offered; addition or deletion of specific categories of benefits offered under the plan; basic delivery system approach; cost-sharing; screen and enroll procedures, and other Medicaid coordination procedures, review procedures, and other comparable required program elements.

- We revised proposed paragraph (a)(3) (now paragraph (c)) to provide that a State must amend its State plan to reflect changes in the source of the State share of funding, except for changes in the type of non-health care related revenues used to generate general revenue.

Section 457.65

- We added a new paragraph (d) to set forth requirements for amendments relating to enrollment procedures.

- We redesignated proposed paragraphs (d) and (e) as paragraphs (e) and (f), respectively.

- We removed proposed paragraph (d)(2), as this provision has been incorporated into § 457.60(c).

- We added a new paragraph (f)(2) to provide that an approved State plan continues in effect unless a State withdraws its plan in accordance with § 457.170(b).

Section 457.70

- We removed proposed paragraph (c)(1)(vi), which provided that Medicaid expansion programs must meet the requirements of subpart H of this final rule.

Section 457.80

- We revised paragraph (c) to provide that the State plan must include a description of procedures the State uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children.

Section 457.90

- We added a new paragraph (b)(3) to provide that outreach strategies may include application assistance, including opportunities to apply for child health assistance under the plan through community-based organizations and in combination with other benefits and services available to children.

Section 457.110

- We revised paragraph (a) to provide that the State must make linguistically appropriate information available to families.

- We revised paragraphs (a) and (b) to provide that the State must ensure that information is made available to applicants, and enrollees.

- We revised paragraph (b) to provide that States must have a mechanism in place to ensure that applicant and enrollees are provided specific information in a timely manner.

Section 457.120

- We added a new paragraph (c) to require that the State plan include a description of the method the State uses to ensure interaction of Indian Tribes and organizations on the implementation of procedures regarding provision of child health assistance to AI/AN children.

Section 457.125

- We revised paragraph (a) by removing language regarding consultation with Indian tribes, which has been incorporated into § 457.120(c).

Section 457.140

- We revised the introductory text of this section to provide that a State plan or State plan amendment must include a 1-year budget.

Section 457.170

- We revised this section to provide more specific rules regarding withdrawal of proposed State plans or plan amendments and withdrawal of approved State plans.

Section 457.190

- We moved the provisions of § 457.190 to new § 457.203.

*Subpart C—State Plan Requirements: Eligibility, Screening, Applications and Enrollment**Section 457.301*

- We removed our proposed definition of “employment with a public agency”.
- We added a definition of the term “joint application”.

Section 457.305

- We revised paragraph (a) to provide that the State plan must include a description of the methodologies used by the State to calculate eligibility under the financial need standard.
- We added a new paragraph (b) to clarify that the State plan must describe the State’s policies governing enrollment and disenrollment, including enrollment caps, and processes for instituting waiting lists, deciding which children will be given priority for enrollment, and informing individuals of their status on a waiting list.

Section 457.310

- We revised the financial need standard for a targeted low-income child at paragraph (b)(1).
- We revised paragraph (b)(2)(ii) to provide that a child would not be considered covered under a group health plan if the child did not have reasonable geographic access to care under that plan.
- We revised paragraph (c)(1)(ii) to clarify our policy concerning contributions toward the cost of dependent coverage.

Section 457.320

- We revised paragraph (b)(3) to specifically prohibit discrimination on the basis of diagnosis.

- We revised paragraph (c) to permit States to accept self-declaration of citizenship, provided that the State has implemented effective, fair, and nondiscriminatory procedures for ensuring the integrity of their application process with respect to self-declaration of citizenship.

- We revised paragraph (a)(7) and added a new paragraph (d) to address eligibility standards related to residency.

- We revised paragraph (a)(10) and added a new paragraph (e) regarding duration of eligibility.

Section 457.340

- We removed proposed § 457.340 and renamed this section, “Application for and enrollment in a separate child health program.” This section sets forth provisions regarding application assistance, notice of rights and responsibilities, timely determinations of eligibility, notice of decisions concerning eligibility, and effective date of eligibility.

Section 457.350

- We have revised this section for consistent use of the terms “found eligible” and “potentially eligible”.

- We removed the provisions of proposed paragraph (b) regarding screening with joint applications.

- We redesignated proposed paragraph (c) as paragraph (b) and proposed paragraph (d) as paragraph (c)

- We revised paragraph (b) (proposed paragraph (c)) to require that a State must use screening procedures to identify, at a minimum, any applicant or enrollee who is potentially eligible for Medicaid under one of the poverty level related groups described in section 1902(l) of the Act, section 1931 of the Act, or a Medicaid demonstration project approved under section 1115 of the Act, applying whichever standard and corresponding methodology generally results in a higher income eligibility level for the age group of the child being screened.

- We added a new paragraph (d) to provide that if a State applies a resource test and a child has been determined potentially income eligible for Medicaid, the State must also screen for Medicaid eligibility by comparing the family’s resources to the appropriate Medicaid standard.

- We have clarified the provisions of paragraph (e) (now paragraph (f)) regarding children found potentially eligible for Medicaid.

- We added new paragraphs (g) and (h) to specify requirements regarding informed application decisions and

waiting lists, enrollment caps and closed enrollment.

Section 457.353

- We added a new section, “Evaluation of screening process and provisional enrollment.” This section sets forth requirements regarding monitoring and evaluations of the screen and enroll process, provisional enrollment during the screening process, and expenditures for coverage during a period of provisional enrollment.

Section 457.360

- We removed this section.

Section 457.365

- We removed the provisions of proposed § 457.365, regarding grievances and appeals, and incorporated them into new subpart K.

Section 457.380 (proposed § 457.970)

- We moved the provisions of proposed § 457.970 to new § 457.380.

- We removed the provision at proposed § 457.970(d) that the State may terminate the eligibility of an applicant or beneficiary for “good cause.”

*Subpart D—Coverage and Benefits: General Provisions**Section 457.402*

- We revised § 457.402(a) to list surgical services separately at paragraph (a)(4).

- We moved the definitions of “emergency medical condition,” “emergency services,” and “health benefits coverage,” which were set forth at proposed paragraphs (b), (c), and (e) respectively, to § 457.10.

Section 457.410

- We revised paragraph (b)(1) to provide that the State must obtain coverage for well-baby and well-child care services as defined by the State.

- We revised paragraph (b)(2) to provide that the State must obtain coverage for age-appropriate immunizations.

Section 457.430

- We revised § 457.430 by clarifying that benchmark-equivalent health benefits coverage must meet the requirements of § 457.410(b) and by removing proposed paragraph (b)(4) regarding well-baby and well-child care and immunizations.

Section 457.440

- We revised paragraph (b)(2) to clarify that a State must submit an actuarial report when it amends its existing State-based coverage.

Section 457.450

- We revised paragraph (a) to provide that Secretary-approved coverage may include coverage that is the same as the coverage provided to children under the Medicaid State plan.

Section 457.490

- We revised § 457.490(a) to provide that the State must describe the methods of delivery of child health assistance including the methods for assuring the delivery of the insurance products and the delivery of health care services covered by such products to the enrollees, including any variations.

Section 457.495

- We removed the provisions of proposed § 457.495 regarding grievances and appeals and incorporated them into new subpart K.

- We moved the provisions of proposed § 457.735 to § 457.495, and renamed the section, “State assurance of access to care and procedures to assure quality and appropriateness of care”.

*Subpart E—State Plan Requirements: Beneficiary Financial Responsibilities**Section 457.500*

- We added a new paragraph (a)(1) to add section 2101(a) of the Act to the statutory authority for this subpart.

- We revised paragraph (c) to remove the provision that, with respect to a mandatory cost-sharing waiver for AI/AN children, subpart E applies to a Medicaid expansion program.

Section 457.505

- We added a new paragraph (c) to § 457.505 to provide that the State plan must include a description of the State’s disenrollment protections as required under § 457.570.

Section 457.510

- We revised paragraph (d) to provide that when a State imposes premiums, enrollment fees, or similar fees, the State plan must describe the consequences for an enrollee or applicant who does not pay a charge and the disenrollment protections adopted by the State.

Section 457.515

- We revised paragraph (d) to provide that the State plan must describe the consequences for an enrollee who does not pay a charge and the disenrollment protections adopted by the State.

- We removed the statement from paragraph (e) that a methodology that primarily relies on a refund is not an acceptable methodology.

Section 457.520

- We revised § 457.520(b) to provide that for the purposes of cost sharing, well-baby and well-child care services include routine examinations as recommended by the AAP’s “Guidelines for Health Supervision III”, or as described in “Bright Futures: Guidelines for Health and Supervision of Infants, Children and Adolescents,” Laboratory tests associated with the well-baby and well-child routine physical examinations, and immunizations as recommended and updated by ACIP.

Section 457.525

- We redesignated proposed paragraph (a)(4) as paragraph (a)(5) and revised this paragraph to provide that the public schedule must include information about consequences for an applicant or an enrollee who does not pay a charge including disenrollment protections.

- We added a new paragraph (a)(4) to provide that the public schedule must include information on mechanisms for making payments for required charges.

- We revised paragraph (b)(1) to require States to provide the public schedule to SCHIP enrollees at the time of reenrollment after a redetermination of eligibility, and when cost-sharing charges and cumulative cost-sharing maximums are revised.

Section 457.535

States may not impose premiums, deductibles, coinsurance, copayments or any other cost-sharing charges on children who are American Indians and Alaska Natives, as defined in § 457.10.

Section 457.540

- We redesignated proposed paragraphs 457.550(a) and (b) as paragraphs 457.540(d) and (e).

- We redesignated proposed paragraph (e) as paragraph (f).

Section 457.545

- We removed the provisions of this section.

Section 457.550

- We eliminated this section and incorporated its contents into other sections of this subpart.

- We redesignated paragraphs (a) and (b) as § 457.540(d) and (e).

- We redesignated paragraph (c) as § 457.555(e).

Section 457.555

- We revised § 457.555(b) to indicate that cost sharing may not exceed 50 percent of the payment the State would make under the Medicaid fee-for-service

system for the first day of care in the institution.

- We added a new paragraph (c) to provide that any copayment that the State imposes on services provided by an institution to treat an emergency medical condition may not exceed \$5.00.

- We redesignated proposed paragraph (c) as paragraph (d).

- We removed proposed paragraph (d) regarding emergency room services provided outside and enrollee’s managed care network.

Section 457.560

- We reorganized this section for clarity.

Section 457.565

- We eliminated this section, as it has been incorporated into new subpart K.

Section 457.570

- We added the requirement, at paragraph (b), that the disenrollment process must afford the enrollee’s family the opportunity to show that his or her income has declined prior to disenrollment for nonpayment of cost-sharing and charges, and in the event that such a showing indicates that the enrollee may have become eligible for Medicaid or for a lower level of cost sharing, the State must facilitate enrolling the child in Medicaid or adjust the child’s cost-sharing category as appropriate.

- We added the requirement, at paragraph (c), that the State must provide the enrollee with an opportunity for an impartial review to address disenrollment from the program.

*Subpart G—Strategic Planning**Section 457.710*

- We added a new paragraph (e) to provide that the State’s strategic objectives, performance goals and performance measures must include a common core of national performance goals and measures consistent with the data collection, standard methodology, and verification requirements, as developed by the Secretary.

Section 457.735

- We moved the provisions of proposed § 457.735 to § 457.495.

Section 457.740

- We revised paragraph (a) to provide that Territories are exempt from the definition of “State” for purposes of quarterly reporting.

- We redesignated proposed paragraph (a)(2) as paragraph (a)(3) and added a new paragraph (a)(2) to

provide that the quarterly reports must include data on a "point-in-time" enrollment count as of the last day of each quarter of the Federal fiscal year.

- We added a new paragraph (a)(3)(ii) to provide that the quarterly report must include data on the number of children enrolled in Medicaid by gender, race, and ethnicity.

Section 457.750

- We revised paragraph (b)(1) to provide that in the annual report, the State must include information related to a core set of national performance goals and measures as developed by the Secretary.

- We added a new paragraph (b)(7) to provide that the annual report must include data regarding the primary language of SCHIP enrollees.

- We added a new paragraph (b)(8) to provide that the annual report must describe the State's current income standards and methodologies for its Medicaid expansion program and separate child health program as appropriate.

- We revised paragraph (c) to set forth requirements regarding the State's annual estimate of changes in the number of uninsured children in the State.

Section 457.760

- We removed this section.

Subpart H—Substitution of Coverage

Section 457.810

- We added introductory text to paragraph (a).

- We revised paragraph (a)(1) to provide that an enrollee must not have had coverage under a group health plan for a period of at least 6 months prior to enrollment in a premium assistance program. A State may not require a minimum period without coverage under a group health plan that exceeds 12 months.

- We revised paragraph (a)(2) to specify the circumstances in which States may permit reasonable exceptions to the requirement for a minimum period without coverage under a group health plan.

- We removed proposed paragraph (a)(3), which specified that a newborn is not required to have a period without insurance as a condition of eligibility for payment for employer-sponsored group health coverage.

- We added a new paragraph (a)(3) to require that the requirement for a minimum period without coverage under a group health plan does not apply to a child who, within the previous 6 months, has received coverage under a group health plan

through Medicaid under section 1906 of the Act.

- We added a new paragraph (a)(4) to specify that the Secretary may revise the 6-month waiting period requirement at her discretion.

- We revised paragraph (b) to provide that for health benefits coverage obtained through premium assistance for group health plans, the employee who is eligible for the coverage must apply for the full premium contribution available from the employer.

- We also removed paragraph (b)(1), which included the minimum 60 percent employer contribution requirement.

Subpart I—Program Integrity

Section 457.902

- We added a definition of the term "actuarially sound principles".

- We moved the definition of "managed care entity" to § 457.10.

- We eliminated the definitions of "contractor", "grievance" and "State program integrity unit".

Section 457.920

- We removed this section.

Section 457.940

- We revised paragraph (b)(2) to provide that a State must provide child health assistance in an effective and efficient manner by using payment rates based on public or private payment rates for comparable services for comparable populations, consistent with principles of actuarial soundness.

Section 457.950

- We revised paragraph (a)(3) to provide that a State must ensure that its contract with an MCE provides access for the State, HCFA, and the HHS Office of the Inspector General to enrollee health claims data and payment data.

- We redesignated proposed paragraph (b)(2) as paragraph (b)(3).

- We added a new paragraph (b)(2) to provide that a State that makes payments to fee-for-service entities under a separate child health program must ensure that fee-for-service entities understand that payment and satisfaction of the claims will be from Federal and State funds, and that any false claims may be prosecuted under applicable Federal or State laws.

Section 457.955

- We added a new paragraph (b)(2) to provide that States must ensure that MCEs are prohibited from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of a managed care entity for the

purpose of influencing the individual to enroll with the entity.

Section 457.970

- We removed this section and incorporated its provisions into § 457.380.

Section 457.975

- We removed this section.

Section 457.985

- We removed this section and incorporated its provisions into new subpart K.

subpart K. We added a new § 457.985, Integrity of professional advice to enrollees.

Section 457.990

- We removed this section and incorporated its provisions into new subpart K.

Section 457.995

- We removed this section and incorporated its provisions into new subpart K.

Subpart J—Allowable Waivers: General Provisions

Section 457.1000

- We revised paragraph (c) to provide that this subpart applies to a Medicaid expansion program when the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims for use of a community-based health delivery system. This subpart does not apply to demonstrations requested under section 1115 of the Act.

Section 457.1003

- We added a new § 457.1003 to provide that HCFA will review the waivers in this subpart as State plan amendments under the same timeframes for State plan amendments specified in subpart A.

Section 457.1005

- We revised § 457.1005(c) to provide that an approved waiver for cost-effective coverage through a community-based health delivery system remains in effect for no more than 3 years.

Section 457.1015

- We removed the requirement at paragraph (b)(2) regarding demonstrating cost-effectiveness through comparison with a child-only health benefits package.

Subpart K—Applicant and Enrollee Protections

- We relocated certain provisions involving applicant and enrollee

protections to this new subpart K, "Applicant and Enrollee Protections." Specifically, we moved to this subpart proposed § 457.985, which set forth requirements relating to grievances and appeals, and proposed § 457.990, which

set forth requirements for privacy protections.
 • We added the following sections in response to public comment:
 § 457.1140, Core elements of review;
 § 457.1170, Continuation of Benefits;

and § 457.1190, Premium assistance for group health plans.
 • The following table shows the disposition of the sections set forth in the proposed rule that have been incorporated into subpart K.

Proposed regulations	Final regulations
Definitions—Contractor. 457.902	Deleted.
Definitions—Grievance. 457.902	Deleted.
Denial, Suspension, or Termination of Eligibility 457.365	Revised 457.1130(a). Revised 457.1130(b).
Reduction or Denial of Services 457.495	Revised 457.1130(a). Revised 457.1180.
Disenrollment for Failure to Pay Cost Sharing 457.565	Revised 457.1130(a) and 457.1180. Revised 457.1130(a) and 457.1180. Revised 457.1130(b) and 457.1180.
Enrollees Rights to File Grievances and Appeals	Revised 457.1120, 1150(b), and 457.1160. Deleted. Deleted. Deleted. Deleted.
457.985(a)	Deleted.
457.985(a)(1)	Deleted.
457.985(a)(2)	Revised 457.985, Cross Reference 457.110(b)(5).
457.985(a)(3)	Revised 457.985, Cross Reference 457.110(b)(5). Revised 457.1110(b). Revised 457.1110.
457.985(b)	Revised 457.1110(a) and (d). Revised 457.1110(a) and (d).
457.985(c)	Revised 457.1110(a). Revised 457.1110(a). Revised 457.1110(a). Revised 457.1110(c) and (e). Revised 457.1110(a).
457.985(c)(1)	Deleted. Deleted.
457.985(c)(2)	Deleted. Deleted.
457.985(d)	Revised 457.1110(e).
457.985(e)	Revised 457.1120 and 457.1180, Cross Reference 457.110(b)(6).
457.985(e)(1)	Revised 457.1130(a). Revised 457.1130(b).
457.985(e)(2)	Revised 457.1130(a)(3).
Privacy Protections	Revised 457.1160.
457.990(a).	

F. Technical Corrections

In this final rule we are making the following technical corrections to subpart B, General Administration, and subpart F, Payments to States, of part 457. These subparts were published in final on May 24, 2000 (65 FR 33616).

Subpart B—General Administration—Reviews and Audits; Withholding for Failure To Comply; Deferral and Disallowance of Claims; Reduction of Federal Medical Payments

- We moved the provisions of proposed § 457.190 regarding administrative and judicial review to new § 457.203, as we believe these provisions are more appropriately located in subpart B.
- We revised § 457.204(d)(2) to clarify the meaning of the term "corrective action."
- We revised § 457.208(a) to cross refer to the provisions of new § 457.203.

- We removed § 457.234, State plan requirements, as these provisions duplicate § 457.50.

Subpart F—Payments to States

- We removed § 457.624, Limitations of certain payments for certain expenditures, as paragraphs (a) and (b) of this section duplicate the provisions of §§ 457.475 and 457.1010, respectively.

IV. Regulatory Impact Analysis

A. Impact Statement

Section 804(2) of title 5, United States Code (as added by section 251 of Public Law 104–121), specifies that a "major rule" is any rule that the Office of Management and Budget finds is likely to result in—

- An annual effect on the economy of \$100 million or more;
- A major increase in costs or prices for consumers, individual industries,

Federal, State, or local government agencies, or geographic regions; or

- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States based enterprises to compete with foreign based enterprises in domestic and export markets.

This final rule does not establish the SCHIP allotment amounts. However, it provides for the implementation and administration of the SCHIP program, and as such, is an economically significant, major rule.

We have examined the impacts of this final rule as required by Executive Order 12866, the Unfunded Mandate Reform Act of 1995 (Pub. L. 104–4), and the Regulatory Flexibility Act (RFA) (Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulations are

necessary, to select regulatory approaches that maximize net benefits (including potential economic environments, public health and safety, other advantages, distributive impacts, and equity).

The Unfunded Mandates Reform Act of 1995 requires that agencies prepare an assessment of anticipated costs and benefits before proposing any rule that may result in an expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100,000,000 or more (adjusted annually for inflation) in any one year. Because participation in the SCHIP program on the part of States is voluntary, any payments and expenditures States make or incur on behalf of the program that are not reimbursed by the Federal government are made voluntarily. These regulations implement narrowly defined statutory language and would not create an unfunded mandate on States, tribal or local governments.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain rural counties adjacent to urban areas, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

In addition, for purposes of the RFA, we prepare a regulatory flexibility analysis unless we certify that a rule will not have a significant economic impact on a substantial number of small entities. Small entities include small businesses, non-profit organizations, and governmental agencies. Most hospitals and other providers and suppliers are small entities, either by non-profit status or by having revenues of \$5 million or less annually. Individuals and State agencies are not included in the definition of small entity. As discussed in detail below, this final rule will have a beneficial impact, if any, on health care providers.

Therefore, we are not preparing an analysis for section 1102(b) of the Act because we have determined, and we certify, that this rule will not have a significant impact on a substantial number of small entities or on the operations of a substantial number of small rural hospitals.

B. Cost Benefit Analysis

This analysis addresses a wide range of costs and benefits of this rule. Whenever possible, we express impact quantitatively. In cases where quantitative approaches are not feasible, we present our best examination of determinable costs, benefits, and associated issues. This final regulation would implement all programmatic provisions of the State Children's Health Insurance Program (SCHIP) including provisions regarding State plan requirements, benefits, eligibility, and program integrity, which are specified in title XXI of the Act. This final regulation would have a beneficial impact in that it would allow States to expand the provision of health benefits coverage to uninsured, low-income children who previously had limited access to health care.

SCHIP is the largest single expansion of health insurance coverage for children since the creation of Medicaid in 1965. SCHIP was designed to reach children from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. As discussed in detail below, this initiative set aside \$40 billion over ten years for States to provide new health coverage for millions of children. To date, plans prepared by all 50 States, 5 U.S. territories, and the District of Columbia have been approved. We estimate that States enrolled at least 3 million children in fiscal year 2000. The implementation of SCHIP has significantly reduced the number of uninsured children nationwide. Previously uninsured children now have access to a range of health care services including well baby and well child care, immunizations, and emergency services. In addition to the obvious benefit of providing access to health care coverage for millions of children, as discussed in detail below, SCHIP will also have a beneficial impact on the private sector.

1. Disbursement of Federal Funds

Budget authority for title XXI is specified in section 2104(a) of the Act with additional funding authorized in Pub. L. 105-100. The total national amount of Federal funding available for allotment to the 50 States, the District of Columbia, and the Commonwealths and Territories for the life of SCHIP, is established as follows:

TOTAL AMOUNT OF ALLOTMENTS	
Fiscal year	Amount
1998	\$4,295,000,000

TOTAL AMOUNT OF ALLOTMENTS—
Continued

Fiscal year	Amount
1999	4,275,000,000
2000	4,275,000,000
2001	4,275,000,000
2002	3,150,000,000
2003	3,150,000,000
2004	3,150,000,000
2005	4,050,000,000
2006	4,050,000,000
2007	5,000,000,000

Under Public Law 105-277, an additional \$32 million was appropriated for allotment only to the Commonwealths and Territories, and only for FY 1999. In addition, we note that there was an additional allocation of \$20 million in FY 1998, which increases the FY 1998 total allotment amount to \$4.295 billion. Also, for each of the first five years, \$60 million of the allotment must be used for the special diabetes programs.

Section 702 of the Balanced Budget Refinement Act of 1999 (Pub. L. 106-113, BBRA) appropriated an additional \$249 million for Territories. In addition, section 703(c) of the BBRA requires that the Secretary conduct an independent evaluation of 10 States with approved child health plans and appropriates \$10 million for FY 2000 for this purpose. The additional allotments for Territories are established as follows:

INCREASED ALLOTMENTS FOR
TERRITORIES

Fiscal Year	Amount
2000	\$34,200,000
2001	34,200,000
2002	25,200,000
2003	25,200,000
2004	25,200,000
2005	32,400,000
2006	32,400,000
2007	40,000,000

We note that the Federal spending levels for the SCHIP program are based entirely on the spending and allocation formulas contained in the statute. The Secretary has no discretion over these spending levels and initial allotments of funds allocated to States. Both direct program and administrative costs are covered by the allotments.

2. Impact on States

SCHIP is a State-Federal program under which funds go directly to States, which have great flexibility in designing their programs. Specifically, within broad Federal guidelines, each State determines the design of its program, eligible groups, benefit packages,

payment levels for coverage and administrative and operating procedures. As such, it is difficult to quantify the economic impact on States beyond the obvious benefit of additional funding provided at an "enhanced" matching rate as compared to the matching rates for the Medicaid program. As stated above, the total Federal payments available to States are specified in the statute and are allocated according to a statutory formula based on the number of uninsured, low-income children for each State, and a geographic adjustment factor. For qualifying expenditures, States will receive an enhanced Federal matching rate equal to its current FMAP increased by 30 percent of the difference between its regular matching rate and 100 percent, except that the enhanced match cannot exceed 85 percent.

The following chart depicts estimated outlays for the SCHIP program. These estimates differ from the allotments referred to above in that the allotments allow the money to be spent over a period of three years.

FISCAL YEAR OUTLAYS

[In billions]

	1999	2000	2001	2002	2003
Federal share	0.6	1.3	1.9	2.5	3.0
State share	0.2	0.6	0.8	1.1	1.3
Total	0.8	1.9	2.7	3.6	4.3

Note: These estimates are based on State and Federal budget projections and have been included in the President's FY 2001 budget. Outlay estimates do not include costs for Medicaid expansion programs but only for separate child health programs.

Because the final rule largely confirms the provisions in the proposed rule, which were based on previously released guidance, most States' programs are already in compliance with these Federal requirements. In addition, this final rule includes a balance of provisions that provide additional flexibility for States with further clarification of the intent of the statute. Therefore, coupled with the fact that States are working with a limited amount of funds, we do not anticipate that the publication of this rule will have a significant or unexpected impact on States.

3. Impact on the Private Sector

We note that due to the flexibility that States have in designing and implementing their SCHIP programs it is not possible to determine the impact on individual providers groups of

providers, insurers, health plans, or employers. However, we anticipate that the SCHIP program will benefit the private sector in a number of ways. The program may have a positive impact on a number of small entities given that SCHIP funding will filter down to health care providers and health plans that cover the SCHIP population. Health plans that provide insurance coverage under the SCHIP program will benefit to the extent that children are generally a lower-risk population. That is, children tend to use fewer high-cost health care services than older segments of the population. Thus, by providing health insurance coverage for preventive care such as well-baby and well-child care and immunizations, SCHIP may benefit health insurers by reducing the need to provide more costly health care services for serious illnesses. Additionally, because SCHIP provides health insurance coverage to children who were previously uninsured, health care providers will no longer have to absorb the cost of uncompensated care for these children. The private sector may also benefit from SCHIP to the extent that children and families with health insurance coverage are more likely to use health care services. Thus, health care providers are likely to experience an increase in demand for their services. Small businesses that are unable to afford private health insurance for their employees will benefit to the extent that the employees, or their children qualify for SCHIP. However, because States have largely been operating their SCHIP programs in accordance with the proposed rule since the beginning of their programs, we do not anticipate the final rule will have a significant impact on the private sector, with the exception of the potential for additional program expansions.

4. Impact on Beneficiaries

The main goal of SCHIP is to provide health insurance coverage for children in families that are not eligible for Medicaid, but do not earn enough to afford private health insurance. SCHIP will allow a large number of children who were previously uninsured to have access to health insurance and the opportunity to receive health care services on a regular basis.

Subpart E of this final rule sets forth provisions regarding the costs that beneficiaries may incur (cost sharing) under SCHIP. In accordance with the statute, we set forth provisions concerning general cost sharing protection for lower income children and American Indians/Alaska Natives, cost sharing for children from families with certain income levels, and

cumulative cost-sharing maximums. Section 457.555 sets forth maximum allowable cost sharing charges on targeted low-income children in families with income from 101 to 150 percent of the FPL. This section specifies maximum copayment amounts that may be imposed under fee-for-service delivery systems and managed care organizations. Additionally, regarding cumulative cost sharing maximums, § 457.560 provides that cost sharing for children with family income above 150 percent of the Federal poverty level may not exceed 5 percent of total family income for the year. For children with family income at or below 150 percent of the Federal poverty level, cost sharing may not exceed 2.5 percent of total family income for the year.

We note that due to State flexibility in establishing cost-sharing amounts below the maximums and differing utilization patterns among beneficiaries, it is difficult to quantify the amount of cost sharing that families incur to participate in SCHIP. However, in light of the number of children enrolled in SCHIP, we believe that for most beneficiaries, the benefit of access to health insurance coverage outweighs the costs associated with participation in the program.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

We received the following comment on the impact analysis:

Comment: Several commenters believe that the regulation is administratively burdensome. Specifically, commenters asserted that the administrative funding for SCHIP is insufficient to effectively operate a State plan under the proposed regulations. The proposed rule fails to adequately acknowledge that State budgets for outreach and administrative activities are limited to 10 percent of total expenditures. Commenters believe this method of computing the administrative cap places States in a difficult position because in order to increase enrollment (and consequently the State's total expenditures), States must incur expenditures for outreach. Commenters recommended that we exclude outreach expenditures from the 10 percent cap.

Commenters also noted that the proposed regulations create additional administrative burdens that do not improve services and may force States to revise programs at additional costs to States. They indicated that for Medicaid expansion programs, Federally required systems changes are matched at 90 percent with no cap. However, the proposed regulations do not offer a similar provision for separate child

health programs required to make changes to existing systems. Additionally, separate child health programs are required to absorb these costs within the limited 10 percent administrative cap.

Commenters strongly recommended that we carefully consider the administrative feasibility and the cost of the proposed regulations for SCHIP eligibles and their families, States and MCEs. Commenters argued that the burden of high administrative costs will be particularly difficult for health plans to bear because per enrollee revenues are comparatively small under SCHIP. The commenters suggested that we evaluate carefully the costs and benefits of administrative requirements to avoid threatening the economic viability of SCHIP programs. The participation of private health plans can offer significant advantages in providing attractive plans for beneficiaries, organizing provider networks, controlling costs and delivering innovations from the employer-based market. However, the low cap on administrative expenses has served to deter some private plans from participating in SCHIP programs. Some private health plans have found it difficult to forecast the financial risk associated with covering children under this program and are concerned that they cannot provide for adequate reserves under the cap.

Response: Under section 2105(c)(2)(A) of the Act, States may receive funds at the enhanced FMAP for administrative expenditures, outreach, health services initiatives, and certain other child health assistance, only up to a "10 Percent Limit." The "10 Percent Limit" found in the statute specifies that the "total computable" amount of these expenditures (the combined total State and Federal share of benefit and administrative expenditures) for which FFP may be claimed cannot exceed 10 percent of the sum of the total computable expenditures made under section 2105(a) of the Act and the total computable expenditures based on the enhanced match made under sections 1905(u)(2) and (u)(3) of the Act.

It is important to note that States may mitigate the effect of little or no program expenditures on the calculation of the 10 percent limit in one fiscal year by delaying the claiming of administrative expenditures until a subsequent fiscal year. In that case, the delayed administrative expenditures could be applied against the subsequent year's 10 percent limit, which may be calculated using presumably higher program expenditures. This should prove helpful to States now that their programs are up and running and the original start up

costs are diminishing. In addition, as States gain more experience operating their programs, administrative costs should fall below the 10 percent cap on administrative expenditures.

In response to the comment that some health plans have found it difficult to foresee the risk associated with covering children under this program, we have no requirement for plan administrative costs. These costs are subject to negotiations between the individual health plan and the State in a risk based capitated arrangement.

V. Federalism

Under Executive Order 13132, we are required to adhere to certain criteria regarding Federalism in developing regulations. Title XXI authorizes grants to States that initiate or expand health insurance programs for low-income, uninsured children. A State Children's Health Insurance Program (SCHIP) under title XXI is jointly financed by the Federal and State governments and is administered by the States. Within broad Federal guidelines, each State determines the design of its program, eligible groups, benefit packages, payment levels for coverage and administrative and operating procedures. States have great flexibility in designing programs to best meet the needs of their beneficiaries. HCFA works closely with the States during the State plan and State plan amendment approval process to ensure that we reach a mutually agreeable decision.

Federal payments under title XXI to States are based on State expenditures under approved plans that could be effective on or after October 1, 1997. The short time frame between the enactment of the Balanced Budget Act (BBA) (August 5, 1997) and the availability of the funding for States required the Department to begin reviewing SCHIP plans submitted by States and Territories at the same time as it was issuing guidance to States on how to operate the SCHIP programs. The Department worked closely with States to disseminate as much information as possible, as quickly as possible, so States could begin to implement their new programs expeditiously.

To be more specific, the Department began issuing guidance to States within one month of enactment of the BBA. We provided information on each State's allotment through two **Federal Register** notices published on September 12, 1997 (62 FR 48098) and February 8, 1999 (64 FR 6102). We developed a model application template to assist State's in applying for title XXI funds. We provided over 100 answers to

frequently asked questions. We issued policy guidance through a series of 23 letters to State health officials. All of this information is currently available on our website located on the Internet at <http://www.hcfa.gov>. We have also provided technical assistance to all States in development of SCHIP applications.

On November 8, 1999 we published in the **Federal Register** a proposed rule that set forth all programmatic provisions for SCHIP (64 FR 60882). We received 109 timely comments on the proposed rule. Interested parties that commented included States, enrollee advocate organizations, individuals, and provider organizations. The comments received varied widely and were often very detailed. We received a significant number of comments on the following areas: State plan issues, such as when an amendment to an existing plan is needed; the exemption to cost sharing for American Indian/Alaska Native children; eligibility "screen and enroll" requirements; Medicaid coordination issues; eligibility simplification options such as presumptive eligibility; the definition of a targeted low-income child; substitution of private coverage; data collection on race, ethnicity, gender and primary language; grievance and appeal procedures; and premium assistance for employer-sponsored coverage. In this final rule we provide detailed responses to all issues raised by the commenters.

The final programmatic regulation incorporates much of the guidance that already has been issued to States. As the final regulation builds upon previously released guidance, most of the regulation represents policies that have been in operation for some time and are a result of the consultation process that is required as part of the implementation of SCHIP; specifically, the State plan approval process. In developing the interpretative policies set forth in this final rule, we also listened to the concerns of States through processes other than the State plan process as well, by attending conferences and meeting with various groups representing State and public interests. We consulted with State and local officials in the course of the design and review stages of State proposals, and many of the policies found in the proposed and this final rule are a direct result of these discussions and negotiations with the States. To the extent consistent with the objectives of the statute, to obtain substantial health care coverage for uninsured low-income children in an effective and efficient manner, we have endeavored to preserve State options in implementing

their programs. As we continue to implement the program, we have identified a number of areas in which we further elaborate on previous guidance or implement new policies. A summary of key issues is set forth at section II.A.1 of the preamble to this final rule.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirement discussed below. The following sections of this document contain information collection requirements:

Section 457.50—State Plan

In summary, § 457.50 requires a State to submit a child health plan to HCFA 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 XIX (as appropriate), title XXI, and the regulations in this chapter. The State plan contains all information necessary for HCFA 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 HCFA for approval. These collection requirements are currently approved by OMB under OMB_t 0938–0707.

Section 457.60—Amendments

In summary, § 457.60 requires a State to submit to HCFA 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 to prepare and submit any necessary amendments to its State plan to HCFA for approval. Based upon HCFA'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 10 States/territories will submit an amendment on an annual basis for a total burden of 800 hours.

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 specified requirements in subparts A, B, C, F, G and J 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 the necessary amendment to its Medicaid State plan to HCFA for approval. Based upon HCFA'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 HCFA approval. We estimate that 28 States/territories will submit an amendment for a total one-time burden of 56 hours.

Section 457.350—Eligibility Screening

In summary, § 457.350 requires a State that chooses to screen for Medicaid eligibility under the poverty level related groups described in 1902(l) of the Act, to provide written notification to the family if the child is found not to be Medicaid eligible.

The burden associated with this requirement is the time and effort for a State to prepare and provide written notification to the family if the child is found not to be Medicaid eligible. The average burden upon the State to prepare the notice is a one time burden estimated to be 10 hours and that it will take 3 minutes for the State to provide and the family to read the information. We estimate that on average, that each State will be required to provide 1

million notices on an annual basis for a total annual burden of 50,000 hours, per State. Therefore, the total estimated burden is calculated to be 2,700,000 hours on an annual basis.

Section 457.360—Facilitating Medicaid Enrollment

In summary § 457.360(c) requires a State to provide full and complete information, in writing to the family (that meets the requirements of (c)(1) through (c)(2) of this section), to ensure that a decision by the family not to apply for Medicaid or not to complete the Medicaid application process represents an informed decision.

The burden associated with this requirement is the time and effort for a State to prepare and provide written notice to the family to ensure that a decision by the family not to apply for Medicaid or not to complete the Medicaid application process represents an informed decision. The average burden upon the State to disseminate a standard notice to the family is estimated to be 3 minutes. We estimate that on average, each State will be required to provide 1 million notices on an annual basis for a total annual burden of 50,000 hours, per State. Therefore, the total estimated burden is calculated to be 2,700,000 hours on an annual basis.

Section 457.361—Application for and Enrollment in CHIP

In summary, § 457.361(b) requires a State 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 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. We estimate that on average, each State will be required to provide 1 million notices on an annual basis for a total annual burden of 50,000 hours, per State. Therefore, the total estimated burden is calculated to be 2,700,000 hours on an annual basis.

In summary, § 457.361(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 this requirement 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 1 million notices on an annual basis for a total annual burden of 50,000 hours, per State. Therefore, the total estimated burden is calculated to be 2,700,000 hours on an annual basis.

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 HCFA 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 is the time and effort for a State that wants to obtain approval for benchmark-equivalent benefits coverage described under § 457.430 to prepare and submit its actuarial report to HCFA for approval. We estimate that, on average, it will take a State 40 hours to prepare and submit a report for HCFA approval. We estimate that 6 States/territories will submit a plan for a total burden of 240 hours.

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 for a State needs to prepare an actuarial report. There are only three States that would have this option; we do not anticipate that more than one of them would modify its program in a given year. It would take that State an average of 40 hours to prepare the report.

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) SCHIP enrollees, at the time of enrollment and reenrollment after a redetermination of eligibility, and when cost-sharing charges and cumulative cost-sharing maximums are revised.
- (2) SCHIP applicants, at the time of application.
- (3) All SCHIP 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 available to these four groups. We estimate that on average, it will take each State/Territory 120 minutes to prepare its public schedule and 3 minutes to disseminate no more than 20,000 copies of its schedule on an annual basis for a total annual burden of 1000 hours, per State/Territory. Therefore, the total estimated burden is calculated to be 54,000 hours on an annual basis.

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, copayments, 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 State four hours to create a notice, for a national burden of 216 hours. We anticipate that it will take 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 enrollees will be given notices. If there are 2.6 million children enrolled, as projected, the burden nationally will be 21,700 hours of burden [(2.6 million × 5 percent × 10 minutes) ÷ 60].

Section 457.740—State Expenditure and Statistical Reports.

In summary, § 457.740 requires a State to submit a report to the Secretary 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 is the time and effort for a State to prepare and submit its report to the Secretary. These collection requirements are currently approved by

under OMB approval number OMB# 0938-0731, with a current expiration date of 1/31/2002.

In addition § 457.740 requires a State to submit an annual 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 report to the Secretary. We estimate that on average, it will take a State 40 hours to complete and submit their report. We estimate that 54 States/territories will submit a plan for a total burden of 2160 hours.

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 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 a State 40 hours to complete and submit their report. We estimate that 54 States/territories will submit a plan for a total burden of 2160 hours.

Section 457.810—Premium Assistance for Employer-Sponsored Group Health Plans: Required Protections Against Substitution

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 54 States/territories will submit a plan for a total burden of 1,080 hours.

Section 457.940—Procurement Standards

Under paragraph (a), a State must submit to HCFA 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.

Section 457.950—Contract and Payment Requirements Including Certification of Payment-Related Information

This section, in paragraph (b), requires a State that makes payments to fee-for-service entities under a separate child health program to—

(1) Establish procedures to certify and attest that information on claim forms is truthful, accurate, and complete.

(2) Ensure that fee-for-service entities understand that payment and satisfaction of the claims will be from federal and State funds, and that any false claims may be prosecuted under applicable federal or State laws.

(3) Require, as a condition of participation, that fee-for-service entities provide the State, HCFA and/or the HHS Office of the Inspector General with access to enrollee health claims data, claims payment data and related records.

The burden associated with this requirement is the time and effort for a State to establish procedures. It is also the time and effort required for a fee-for-service entity to certify and attest that information on claim forms is truthful, accurate, and complete and to provide access to the required data to the State, HCFA and/or the HHS Office of the Inspector General. Depending on the situation, we estimate that the time required to complete such a certification would be 8 hours per certification, per year. Therefore, 8 hours × 51 States and Territories for a total burden of 408 hours per year.

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 CHIP. 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 would 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(s) and for its contractor(s) to give beneficiaries access. We estimate that it will take a token hour for each State to comply with this requirement. We estimate that it will take each contractor 1 hour to include this assurance in its contracts, however the number of contractors that will be affected cannot be known, as States have flexibility to use contractors as they deem appropriate.

Section 457.1005—Waiver for 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 HCFA 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 HCFA 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 HCFA approval. We estimate that 10 States/territories will submit a request for a total burden of 240 hours.

Section 457.1015—Cost Effectiveness

In summary, § 457.1015 requires a State to report to HCFA 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 associated 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 benefits may continue pending review.

The burden associated with this requirement is the time and effort for a State to prepare and give out the notice. We estimate that it will take each State four hours (216 hours nationally) to develop a standardized form into which enrollee-specific information may be inserted and a half hour per enrollee to prepare and give out the notice. We estimate that approximately 10 percent of enrollees will receive a notice under this provision, or 130,000 hours nationally [(2.6 million × 30 minutes × 10 percent) ÷ 60 minutes].

We have submitted a copy of this final rule to OMB for its review of the information collection requirements in §§ 457.50, 457.60, 457.70, 457.350, 457.360, 457.361, 457.431, 457.440, 457.525, 457.740, 457.750, 457.760, 457.810, 457.940, 457.965, 457.985, 457.1005, 457.1015, and 457.1140. These requirements are not effective until they have been approved by OMB.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and 3 copies directly to the following: Health Care Financing Administration, Office of Information Services, Standards and Security Group, Division of HCFA Enterprise Standards, Room N2-14-26, 7500 Security Boulevard, Baltimore, MD 21244-1850. Attn: Julie Brown HCFA-2006-P.

And, Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, HCFA Medicaid Desk Officer.

List of Subjects

42 CFR Part 431

Grant programs-health, Health facilities, Medicaid, Privacy, Reporting and record keeping requirements.

42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs-health, Medicaid, Reporting and record keeping requirements.

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs-health, Medicaid, Reporting and record keeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 436

Aid to Families with Dependent Children, Grant programs-health, Guam, Medicaid, Puerto Rico, Supplemental Security Income (SSI), Virgin Islands.

42 CFR Part 457

Administrative practice and procedure, Grant programs-health, Children's Health Insurance Program, Reporting and record keeping requirements.

42 CFR chapter IV is amended as set forth below:

A. Part 431 is amended as follows:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

1. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

2. A new § 431.636 is added to read as follows:

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

(a) *Statutory basis.* This section implements—

(1) Section 2102(b)(3)(B) of the Act, which provides that children who apply for coverage under a separate child health plan under title XXI, but are found to be eligible for medical assistance under the State Medicaid plan, must be enrolled in the State Medicaid plan; and

(2) Section 2102(c)(2) of the Act, which requires coordination between a State child health program and other public health insurance programs.

(b) *Obligations of State Medicaid Agency.* The State Medicaid agency must adopt procedures to facilitate the Medicaid application process for, and the enrollment of children for whom the Medicaid application and enrollment process has been initiated in accordance with § 457.350(f) of this chapter. The procedures must ensure that—

(1) The applicant is not required to provide information or documentation that has been provided to the State agency responsible for determining eligibility under a separate child health program under title XXI and forwarded by such agency to the Medicaid agency on behalf of the child in accordance with § 457.350(f) of this chapter;

(2) Eligibility is determined in a timely manner in accordance with § 435.911 of this chapter;

(3) The Medicaid agency promptly notifies 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; and

(4) The Medicaid agency adopts a process that facilitates enrollment in a State child health program when a child is determined ineligible for Medicaid at initial application or redetermination.

3. In § 431.865(b), the definition of "erroneous payments" is revised to read as follows:

§ 431.865 Disallowance of Federal financial participation for erroneous State payments (for annual assessment periods ending after July 1, 1990).

* * * * *

(b) * * *

Erroneous payments means the Medicaid payment that was made for an individual or family under review who—

(1) Was ineligible for the review month or, if full month coverage is not provided, at the time services were received;

(2) Was ineligible to receive a service provided during the review month; or

(3) Had not properly met enrollee liability requirements prior to receiving Medicaid services.

(4) The term does not include payments made for care and services covered under the State plan and furnished to children during a presumptive eligibility period as described in § 435.1102 of this chapter.

* * * * *

B. Part 433 is amended as follows:

PART 433—STATE FISCAL ADMINISTRATION

1. The authority citation for part 433 is revised to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

2. In § 433.10, the heading of paragraph (c) is republished and a new paragraph (c)(4) is added to read as follows:

§ 433.10 Rates of FFP for program services.

* * * * *

(c) *Special provisions.* * * *

(4) Under section 1905(b) of the Social Security Act, the Federal share of State expenditures described in § 433.11(a) for services provided to children, is the enhanced FMAP rate determined in accordance with § 457.622(b) of this chapter, subject to the conditions explained in § 433.11(b).

3. A new § 433.11 is added to read as follows:

§ 433.11 Enhanced FMAP rate for children.

(a) Subject to the conditions in paragraph (b) of this section, the enhanced FMAP determined in

accordance with § 457.622 of this chapter will be used to determine the Federal share of State expenditures, except any expenditures pursuant to section 1923 of the Act for payments to disproportionate share hospitals for—

(1) Services provided to optional targeted low-income children described in § 435.4 or § 436.3 of this chapter; and

(2) Services provided to children born before October 1, 1983, with or without group health coverage or other health insurance coverage, who would be described in section 1902(l)(1)(D) of the Act (poverty-level-related children's groups) if—

(i) They had been born on or after that date; and

(ii) They would not qualify for medical assistance under the State plan in effect on March 31, 1997.

(b) Enhanced FMAP is not available if—

(1) A State adopts income and resource standards and methodologies for purposes of determining a child's eligibility under the Medicaid State plan that are more restrictive than those applied under policies of the State plan (as described in the definition of optional targeted low-income children at § 435.4 of this chapter) in effect on June 1, 1997; or

(2) No funds are available in the State's title XXI allotment, as determined under part 457, subpart F of this chapter for the quarter enhanced FMAP is claimed; or

(3) The State fails to maintain a valid method of identifying services provided on behalf of children listed in paragraph (a) of this section.

C. Part 435 is amended as set forth below:

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

1. The authority citation for part 435 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 435.4 is amended by adding a definition of "optional targeted low-income child," in alphabetical order, to read as follows:

§ 435.4 Definitions and use of terms.

* * * * *

Optional targeted low-income child means a child under age 19 who meets the financial and categorical standards described below.

(1) *Financial need.* An optional targeted low-income child:

(i) Has a family income at or below 200 percent of the Federal poverty line for a family of the size involved; and

(ii) Resides in a State with no Medicaid applicable income level (as defined at § 457.10 of this chapter); or
 (iii) Resides in a State that has a Medicaid applicable income level (as defined at § 457.10 of this chapter) and has family income that either:

(A) Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points; or

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under the policies of the State plan under title XIX on June 1, 1997.

(2) *No other coverage and State maintenance of effort.* An optional targeted low-income child is not covered under a group health plan or health insurance coverage, or would not be eligible for Medicaid under the policies of the State plan in effect on March 31, 1997; except that, for purposes of this standard—

(i) A child shall not be considered to be covered by health insurance coverage based on coverage offered by the State under a program in operation prior to July 1, 1997 if that program received no Federal financial participation;

(ii) A child shall not be considered to be covered under a group health plan or health insurance coverage if the child did not have reasonable geographic access to care under that coverage.

(3) For purposes of this section, policies of the State plan under title XIX plan include policies under a Statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an expanded group of eligible children but that either—

(i) Did not provide inpatient hospital coverage; or

(ii) Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility.

* * * * *

3. A new § 435.229 is added to read as follows:

§ 435.229 Optional targeted low-income children.

The agency may provide Medicaid to—

(a) All individuals under age 19 who are optional targeted low-income children as defined in § 435.4; or
 (b) Reasonable categories of these individuals.

4. In § 435.910, paragraph (h) is added to read as follows:

§ 435.910 Use of social security number.

* * * * *

(h) *Exception.* (1) A State may give a Medicaid identification number to an

applicant who, because of well established religious objections, refuses to obtain a Social Security Number (SSN). The identification number may be either an SSN obtained by the State on the applicant's behalf or another unique identifier.

(2) The term *well established religious objections* means that the applicant—

(i) Is a member of a recognized religious sect or division of the sect; and

(ii) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

(3) A State may use the Medicaid identification number established by the State to the same extent as an SSN is used for purposes described in paragraph (b)(3) of this section.

5. In § 435.1001, paragraph (a) is revised to read as follows:

§ 435.1001 FFP for administration.

(a) FFP is available in the necessary administrative costs the State incurs in—

(1) Determining and redetermining Medicaid eligibility and in providing Medicaid to eligible individuals; and

(2) Determining presumptive eligibility for children and providing services to presumptively eligible children.

* * * * *

6. Section 435.1002 is amended by adding a new paragraph (c) to read as follows:

§ 435.1002 FFP for services.

* * * * *

(c) FFP is available in expenditures for services covered under the plan that are furnished—

(1) To children who are determined by a qualified entity to be presumptively eligible;

(2) During a period of presumptive eligibility;

(3) By a provider that is eligible for payment under the plan; and

(4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

§ 435.1007 [Amended]

7. In § 435.1007, in paragraph (a), the second sentence is amended by adding “and section 1905(u)” between “(X)”, and “of the Act;”.

8. A new subpart L is added to part 435 to read as follows:

Subpart L—Option for Coverage of Special Groups

Sec.

435.1100 Basis and scope.

Presumptive Eligibility for Children

435.1101 Definitions related to presumptive eligibility for children.

435.1102 General rules.

Subpart L—Option for Coverage of Special Groups

§ 435.1100 Basis and scope.

(a) *Statutory basis.* Section 1920A of the Act allows States to provide Medicaid services to children under age 19 during a period of presumptive eligibility, prior to a formal determination of Medicaid eligibility.

(b) *Scope.* This subpart prescribes the requirements for providing medical assistance to special groups who are not eligible for Medicaid as categorically or medically needy.

Presumptive Eligibility for Children

§ 435.1101 Definitions related to presumptive eligibility for children.

Application form means at a minimum the form used to apply for Medicaid under the poverty-level-related eligibility groups described in section 1902(l) of the Act or a joint form for children to apply for the State Children's Health Insurance Program and Medicaid.

Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of—

(1) In the case of a child on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application; or

(2) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

Presumptive income standard means the highest income eligibility standard established under the plan that is most likely to be used to establish the regular Medicaid eligibility of a child of the age involved.

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

(1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;

(2) Is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act;

(3) Is authorized to determine eligibility of a child to receive child care

services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;

(4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;

(5) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);

(6) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;

(7) Is a State or Tribal child support enforcement agency;

(8) Is an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(9) Is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or

(10) Is an entity that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*); or

(11) Any other entity the State so deems, as approved by the Secretary.

Services means all services covered under the plan including EPSDT (see part 440 of this chapter).

§ 435.1102 General rules.

(a) The agency may provide services to children under age 19 during one or more periods of presumptive eligibility following a determination by a qualified entity that the child's estimated gross family income or, at the State's option, the child's estimated family income after applying simple disregards, does not exceed the applicable income standard.

(b) If the agency elects to provide services to children during a period of presumptive eligibility, the agency must—

(1) Provide qualified entities with application forms for Medicaid and information on how to assist parents, caretakers and other persons in completing and filing such forms;

(2) Establish procedures to ensure that qualified entities—

(i) Notify the parent or caretaker of the child at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of such determination;

(ii) Provide the parent or caretaker of the child with a regular Medicaid application form;

(iii) Within five working days after the date that the determination is made, notify the agency that a child is presumptively eligible;

(iv) For children determined to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate, that—

(A) If a Medicaid application on behalf of the child is not filed by the last day of the following month, the child's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the child is filed by the last day of the following month, the child's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(v) For children determined not to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate—

(A) Of the reason for the determination; and

(B) That he or she may file an application for Medicaid on the child's behalf with the Medicaid agency;

(3) Provide all services covered under the plan, including EPSDT; and

(4) Allow determinations of presumptive eligibility to be made by qualified entities on a Statewide basis.

(c) The agency must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

D. Part 436 is amended as set forth below:

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

1. The authority citation for part 436 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 436.3 is amended by adding a definition of "optional targeted low-income child," in alphabetical order, to read as follows:

§ 436.3 Definitions and use of terms.

* * * * *

Optional targeted low-income child means a child under age 19 who meets the financial and categorical standards described below.

(1) *Financial need.* An optional targeted low-income child:

(i) Has a family income at or below 200 percent of the Federal poverty line for a family of the size involved;

(ii) Resides in a State with no Medicaid applicable income level (as defined in § 457.10 of this chapter); or,

(iii) Resides in a State that has a Medicaid applicable income level (as defined in § 457.10) and has family income that either:

(A) Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points (expressed as a percentage of the Federal poverty line); or

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under the policies of the State plan under title XIX on June 1, 1997.

(2) *No other coverage and State maintenance of effort.* An optional targeted low-income child is not covered under a group health plan or health insurance coverage, or would not be eligible for Medicaid under the policies of the State plan in effect on March 31, 1997; except that, for purposes of this standard—

(i) A child shall not be considered to be covered by health insurance coverage based on coverage offered by the State under a program in operation prior to July 1, 1997 if that program received no Federal financial participation;

(ii) A child shall not be considered to be covered under a group health plan or health insurance coverage if the child did not have reasonable geographic access to care under that coverage.

(3) For purposes of this section, policies of the State plan under title XIX plan include policies under a Statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an expanded group of eligible children but that either—

(i) Did not provide inpatient hospital coverage; or

(ii) Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility.

3. A new § 436.229 is added to read as follows:

§ 436.229 Optional targeted low-income children.

The agency may provide Medicaid to—

(a) All individuals under age 19 who are optional targeted low-income children as defined in § 436.3; or

(b) Reasonable categories of these individuals.

4. In § 436.1001 paragraph (a) is revised to read as follows:

§ 436.1001 FFP for administration.

(a) FFP is available in the necessary administrative costs the State incurs in—

- (1) Determining and redetermining Medicaid eligibility and in providing Medicaid to eligible individuals; and
- (2) Determining presumptive eligibility for children and providing services to presumptively eligible children.

* * * * *

5. Section 436.1002 is amended by adding a new paragraph (c) to read as follows:

§ 436.1002 FFP for services.

* * * * *

(c) FFP is available in expenditures for services covered under the plan that are furnished—

- (1) To children who are determined by a qualified entity to be presumptively eligible;
- (2) During a period of presumptive eligibility;
- (3) By a provider that is eligible for payment under the plan; and
- (4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

6. A new subpart L is added to part 436 to read as follows:

Subpart L—Option for Coverage of Special Groups

Sec.

436.1100 Basis and scope.

Presumptive Eligibility for Children

436.1101 Definitions related to presumptive eligibility for children.

436.1102 General rules.

Subpart L—Option for Coverage of Special Groups**§ 436.1100 Basis and scope.**

(a) *Statutory basis.* Section 1920A of the Act allows States to provide Medicaid services to children under age 19 during a period of presumptive eligibility, prior to a formal determination of Medicaid eligibility.

(b) *Scope.* This subpart prescribes the requirements for providing medical assistance to special groups who are not eligible for Medicaid as categorically or medically needy.

Presumptive Eligibility for Children**§ 436.1101 Definitions related to presumptive eligibility period for children.**

Application form means at a minimum the form used to apply for Medicaid under the poverty-level-related eligibility groups described in section 1902(l) of the Act or a joint form for children to apply for the State

Children's Health Insurance Program and Medicaid.

Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of—

- (1) In the case of a child on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application; or
- (2) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

Presumptive income standard means the highest income eligibility standard established under the plan that is most likely to be used to establish the regular Medicaid eligibility of a child of the age involved.

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

- (1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;
- (2) Is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act;
- (3) Is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;
- (4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;
- (5) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);
- (6) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;
- (7) Is a State or Tribal child support enforcement agency;
- (8) Is an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;
- (9) Is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or
- (10) Is an entity that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under

section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*); or

(11) Any other entity the State so deems, as approved by the Secretary.

Services means all services covered under the plan including EPSDT (see part 440 of this chapter.)

§ 436.1102 General rules.

(a) The agency may provide services to children under age 19 during one or more periods of presumptive eligibility following a determination made by a qualified entity that the child's estimated gross family income or, at the State's option, the child's estimated family income after applying simple disregards, does not exceed the applicable income standard.

(b) If the agency elects to provide services to children during a period of presumptive eligibility, the agency must—

- (1) Provide qualified entities with application forms for Medicaid and information on how to assist parents, caretakers and other persons in completing and filing such forms;
- (2) Establish procedures to ensure that qualified entities—

- (i) Notify the parent or caretaker of the child at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of such determination;

- (ii) Provide the parent or caretaker of the child with a Medicaid application form;

- (iii) Within 5 working days after the date that the determination is made, notify the agency that a child is presumptively eligible;

- (iv) For children determined to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate, that—

- (A) If a Medicaid application on behalf of the child is not filed by the last day of the following month, the child's presumptive eligibility will end on that last day; and

- (B) If a Medicaid application on behalf of the child is filed by the last day of the following month, the child's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

- (v) For children determined not to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate—

- (A) Of the reason for the determination; and

(B) That he or she may file an application for Medicaid on the child's behalf with the Medicaid agency; and
 (3) Provide all services covered under the plan, including EPSDT.

(4) Allow determinations of presumptive eligibility to be made by qualified entities on a Statewide basis.

(c) The agency must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

E. Part 457 is amended as follows:

PART 457—ALLOTMENTS AND GRANTS TO STATES

1. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

2. A new subpart A is added to read as follows:

Subpart A—Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

Sec.

- 457.1 Program description.
- 457.2 Basis and scope of subchapter D.
- 457.10 Definitions and use of terms.
- 457.30 Basis, scope, and applicability of subpart A.
- 457.40 State program administration.
- 457.50 State plan.
- 457.60 Amendments.
- 457.65 Effective date and duration of State plans and plan amendments.
- 457.70 Program options.
- 457.80 Current State child health insurance coverage and coordination.
- 457.90 Outreach.
- 457.110 Enrollment assistance and information requirements.
- 457.120 Public involvement in program development.
- 457.125 Provision of child health assistance to American Indian and Alaska Native children.
- 457.130 Civil rights assurance.
- 457.135 Assurance of compliance with other provisions.
- 457.140 Budget.
- 457.150 HCFA review of State plan material.
- 457.160 Notice and timing of HCFA action on State plan material.
- 457.170 Withdrawal process.

Subpart A—Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

§ 457.1 Program description.

Title XXI of the Social Security Act, enacted in 1997 by the Balanced Budget Act, 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.

§ 457.2 Basis and scope of subchapter D.

(a) *Basis.* This subchapter implements title XXI of the Act, which authorizes Federal grants to States for the provision of child health assistance to uninsured, low-income children.

(b) *Scope.* The regulations in subchapter D set forth State plan requirements, standards, procedures, and conditions for obtaining Federal financial participation (FFP) to enable States to provide health benefits coverage to targeted low-income children, as defined at § 457.310.

§ 457.10 Definitions and use of terms.

For purposes of this part the following definitions apply:

American Indian/Alaska Native (AI/AN) means—

- (1) A member of a Federally recognized Indian tribe, band, or group;
- (2) An Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601 et. seq.; or

(3) A person who is considered by the Secretary of the Interior to be an Indian for any purpose.

Applicant means a child who has filed an application (or who has an application filed on their behalf) for health benefits coverage through the State Children's Health Insurance Program. A child is an applicant until the child receives coverage through SCHIP.

Child means an individual under the age of 19.

Child health assistance means payment for part or all of the cost of health benefits coverage provided to targeted low-income children for the services listed at § 457.402.

Combination program means a program under which a State implements both a Medicaid expansion program and a separate child health program.

Cost sharing means premium charges, enrollment fees, deductibles, coinsurance, copayments, or other similar fees that the enrollee has responsibility for paying.

Creditable health coverage has the meaning given the term "creditable coverage" at 45 CFR 146.113 and includes coverage that meets the requirements of § 457.410 and is provided to a targeted low-income child.

Emergency medical condition means a medical condition manifesting itself by

acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(1) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of a woman or her unborn child;

(2) Serious impairment of bodily function; or

(3) Serious dysfunction of any bodily organ or part.

Emergency services means health care services that are—

- (1) Furnished by any provider qualified to furnish such services; and
- (2) Needed to evaluate, treat, or stabilize an emergency medical condition.

Enrollee means a child who receives health benefits coverage through SCHIP.

Enrollment cap means a limit, established by the State in its State plan, on the total number of children permitted to enroll in a State's separate child health program.

Family income means income as determined by the State for a family as defined by the State.

Federal fiscal year starts on the first day of October each year and ends on the last day of the following September.

Fee-for-service entity has the meaning assigned in § 457.902.

Group health insurance coverage has the meaning assigned at 45 CFR 144.103.

Group health plan has the meaning assigned at 45 CFR 144.103.

Health benefits coverage means an arrangement under which enrolled individuals are protected from some or all liability for the cost of specified health care services.

Health care services means any of the services, devices, supplies, therapies, or other items listed in § 457.402.

Health insurance coverage has the meaning assigned at 45 CFR 144.103.

Health insurance issuer has the meaning assigned at 45 CFR 144.103.

Health maintenance organization (HMO) plan has the meaning assigned at § 457.420.

Health services initiatives means activities that protect the public health, protect the health of individuals, improve or promote a State's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children (including targeted low-income children and other low-income children).

Joint application has the meaning assigned at § 457.301.

Low-income child means a child whose family income is at or below 200 percent of the poverty line for the size of the family involved.

Managed care entity (MCE) means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, and primary care case managers.

Medicaid applicable income level means, with respect to a child, the effective income level (expressed as a percentage of the poverty line) specified under the policies of the State plan under title XIX of the Act (including for these purposes, a section 1115 waiver authorized by the Secretary or under the authority of section 1902(r)(2) of the Act) as of March 31, 1997 for the child to be eligible for medical assistance under either section 1902(l)(2) or 1905(n)(2) of the Act.

Medicaid expansion program means a program under which a State receives Federal funding to expand Medicaid eligibility to optional targeted low-income children.

Optional targeted low-income child has the meaning assigned at § 435.4 (for States) and § 436.3 (for Territories) of this chapter.

Period of presumptive eligibility has the meaning assigned at § 457.301.

Poverty line/Federal poverty level means the poverty guidelines updated annually in the **Federal Register** by the U.S. Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

Preexisting condition exclusion has the meaning assigned at 45 CFR 144.103.

Premium assistance program means a component of a separate child health program, approved under the State plan, under which a State pays part or all of the premiums for a SCHIP enrollee or enrollees' group health insurance coverage or coverage under a group health plan.

Presumptive income standard has the meaning assigned at § 457.301.

Public agency has the meaning assigned in § 457.301.

Qualified entity has the meaning assigned at § 457.301.

Separate child health program means a program under which a State receives Federal funding from its title XXI allotment to provide child health assistance through obtaining coverage that meets the requirements of section 2103 of the Act and § 457.402.

State means all States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands. The

Territories are excluded from this definition for purposes of § 457.740.

State Children's Health Insurance Program (SCHIP) means a program established and administered by a State, jointly funded with the Federal government, to provide child health assistance to uninsured, low-income children through a separate child health program, a Medicaid expansion program, or a combination program.

State health benefits plan has the meaning assigned in § 457.301.

State plan means the title XXI State child health plan.

Targeted low-income child has the meaning assigned in § 457.310.

Uncovered or uninsured child means a child who does not have creditable health coverage.

Well-baby and well-child care services means regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children and adolescents as defined by the State. For purposes of cost sharing, the term has the meaning assigned at § 457.520.

§ 457.30 Basis, scope, and applicability of subpart A.

(a) *Statutory basis.* This subpart implements the following sections of the Act:

(1) Section 2101(b), which requires that the State submit a State plan.

(2) Section 2102(a), which sets forth requirements regarding the contents of the State plan.

(3) Section 2102(b), which relates to eligibility standards and methodologies.

(4) Section 2102(c), which requires that the State plan include a description of the procedures to be used by the State to accomplish outreach and coordination with other health insurance programs.

(5) Section 2106, which specifies the process for submission, approval, and amendment of State plans.

(6) Section 2107(c), which requires that the State plan include a description of the process used to involve the public in the design and implementation of the plan.

(7) Section 2107(d), which requires that the State plan include a description of the budget for the plan.

(8) Section 2107(e), which provides that certain provisions of title XIX and title XI of the Act apply under title XXI in the same manner that they apply under title XIX.

(b) *Scope.* This subpart sets forth provisions governing the administration of SCHIP, the general requirements for a State plan, and a description of the process for review of a State plan or plan amendment.

(c) *Applicability.* This subpart applies to all States that request Federal

financial participation to provide child health assistance under title XXI.

§ 457.40 State program administration.

(a) *Program operation.* The State must implement its program in accordance with the approved State plan, any approved State plan amendments, the requirements of title XXI and title XIX (as appropriate), and the requirements in this chapter. HCFA monitors the operation of the approved State plan and plan amendments to ensure compliance with the requirements of title XXI, title XIX (as appropriate) and this chapter.

(b) *State authority to submit State plan.* A State plan or plan amendment must be signed by the State Governor, or signed by an individual who has been delegated authority by the Governor to submit it.

(c) *State program officials.* The State must identify in the State plan or State plan amendment, by position or title, the State officials who are responsible for program administration and financial oversight.

(d) *State legislative authority.* The State plan must include an assurance that the State will not claim expenditures for child health assistance prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by HCFA.

§ 457.50 State plan.

The State plan is a comprehensive written statement, submitted by the State to HCFA for approval, that describes the purpose, nature, and scope of the State's SCHIP and gives an assurance that the program is 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 HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

§ 457.60 Amendments.

A State may seek to amend its approved State plan in whole or in part at any time through the submission of an amendment to HCFA. When the State plan amendment has a significant impact on the approved budget, the amendment must include an amended budget that describes the State's planned expenditures for a 1-year period. A State must amend its State plan whenever necessary to reflect—

(a) Changes in Federal law, regulations, policy interpretations, or

court decisions that affect provisions in the approved State plan;

(b) Changes in State law, organization, policy, or operation of the program that affect the following program elements described in the State plan:

(1) Eligibility standards, enrollment caps, and disenrollment policies as described in § 457.305.

(2) Procedures to prevent substitution of private coverage, including exemptions or exceptions to required eligibility waiting periods without coverage under a group health plan as described in § 457.810.

(3) The type of health benefits coverage offered, consistent with the options described in § 457.410.

(4) Addition or deletion of specific categories of benefits covered under the State plan.

(5) Basic delivery system approach as described in § 457.490.

(6) Cost-sharing as described in § 457.505.

(7) Screen and enroll procedures, and other Medicaid coordination procedures as described in §§ 457.350 and 457.353.

(8) Review procedures as described in §§ 457.1130, 457.1160, 457.1170, 457.1180 and 457.1190.

(9) Other comparable required program elements.

(c) Changes in the source of the State share of funding, except for changes in the type of non-health care related revenues used to generate general revenue.

§ 457.65 Effective date and duration of State plans and plan amendments.

(a) *Effective date in general.* Except as otherwise limited by this section—

(1) A State plan or plan amendment takes effect on the day specified in the plan or plan amendment, but no earlier than October 1, 1997.

(2) The effective date may be no earlier than the date on which the State begins to incur costs to implement its State plan or plan amendment.

(3) A State plan amendment that takes effect prior to submission of the amendment to HCFA may remain in effect only until the end of the State fiscal year in which the State makes it effective, or, if later, the end of the 90-day period following the date on which the State makes it effective, unless the State submits the amendment to HCFA for approval before the end of that State fiscal year or that 90-day period.

(b) *Amendments relating to eligibility or benefits.* A State plan amendment that eliminates or restricts eligibility or benefits may not be in effect for longer than a 60-day period, unless the amendment is submitted to HCFA before the end of that 60-day period.

The amendment may not take effect unless—

(1) The State certifies that it has provided prior public notice of the proposed change in a form and manner provided under applicable State law; and

(2) The public notice was published before the requested effective date of the change.

(c) *Amendments relating to cost sharing.* A State plan amendment that implements cost-sharing charges, increases existing cost-sharing charges, or increases the cumulative cost-sharing maximum as set forth at § 457.560 is considered an amendment that restricts benefits and must meet the requirements in paragraph (b) of this section.

(d) *Amendments relating to enrollment procedures.* A State plan amendment that implements a required period of uninsurance, increases the length of existing required periods of uninsurance, or institutes or extends the use of waiting lists, enrollments caps or closed enrollment periods is considered an amendment that restricts eligibility and must meet the requirements in paragraph (b) of this section.

(e) *Amendments relating to the source of State funding.* A State plan amendment that changes the source of the State share of funding can take effect no earlier than the date of submission of the amendment.

(f) *Continued approval.* An approved State plan continues in effect unless—

(1) The State adopts a new plan by obtaining approval under § 457.60 of an amendment to the State plan;

(2) Withdraws its plan in accordance with § 457.170(b); or

(3) The Secretary finds substantial noncompliance of the plan with the requirements of the statute or regulations.

§ 457.70 Program options.

(a) *Health benefits coverage options.* A State may elect to obtain health benefits coverage under its plan through—

(1) A separate child health program;

(2) A Medicaid expansion program; or

(3) A combination program.

(b) *State plan requirement.* A State must include in the State plan or plan amendment a description of the State's chosen program option.

(c) *Medicaid expansion program requirements.* A State plan under title XXI for a State that elects to obtain health benefits coverage through its Medicaid plan must—

(1) Meet the requirements of—

(i) Subpart A;

(ii) Subpart B (to the extent that the State claims administrative costs under title XXI);

(iii) Subpart F (with respect to determination of the allotment for purposes of the enhanced matching rate, determination of the enhanced matching rate, and payment of any claims for administrative costs under title XXI only);

(iv) Subpart G; and

(v) Subpart J (if the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims based on a community based health delivery system).

(2) Be consistent with the State's Medicaid State plan, or an approvable amendment to that plan, as required under title XIX.

(d) *Separate child health program requirements.* A State that elects to obtain health benefits coverage under its plan through a separate child health program must meet all the requirements of part 457.

(e) *Combination program requirements.* A State that elects to obtain health benefits coverage through both a separate child health program and a Medicaid expansion program must meet the requirements of paragraphs (c) and (d) of this section.

§ 457.80 Current State child health insurance coverage and coordination.

A State plan must include a description of—

(a) The extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children, by income level and other relevant factors, currently have creditable health coverage (as defined in § 457.10) and, if sufficient information is available, whether the creditable health coverage they have is under public health insurance programs or health insurance programs that involve public-private partnerships;

(b) Current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships; and

(c) Procedures the State uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children. Such procedures include those designed to—

(1) Increase the number of children with creditable health coverage;

(2) Assist in the enrollment in SCHIP of children determined ineligible for Medicaid; and

(3) Ensure that only eligible targeted low-income children are covered under SCHIP, such as those procedures required under §§ 457.350 and 457.353, as applicable.

§ 457.90 Outreach.

(a) *Procedures required.* A State plan must include a description of procedures used to inform families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs of the availability of the programs, and to assist them in enrolling their children in one of the programs.

(b) *Examples.* Outreach strategies may include but are not limited to the following:

(1) Education and awareness campaigns, including targeted mailings and information distribution through various organizations.

(2) Enrollment simplification, such as simplified or joint application forms.

(3) Application assistance, including opportunities to apply for child health assistance under the plan through community-based organizations and in combination with other benefits and services available to children.

§ 457.110 Enrollment assistance and information requirements.

(a) *Information disclosure.* The State must make accurate, easily understood, linguistically appropriate information available to families of potential applicants, applicants and enrollees, and provide assistance to these families in making informed decisions about their health plans, professionals, and facilities.

(b) *Required information.* The State must make available to potential applicants and provide applicants and enrollees the following information in a timely manner:

(1) Types of benefits, and amount, duration and scope of benefits available under the program.

(2) Cost-sharing requirements as described in § 457.525.

(3) Names and locations of current participating providers.

(4) If an enrollment cap is in effect or the State is using a waiting list, a description of the procedures relating to the cap or waiting list, including the process for deciding which children will be given priority for enrollment, how children will be informed of their status on a waiting list and the

circumstances under which enrollment will reopen.

(5) Information on physician incentive plans as required by § 457.985.

(6) Review processes available to applicants and enrollees as described in the State plan pursuant to § 457.1120.

§ 457.120 Public involvement in program development.

A State plan must include a description of the method the State uses to—

(a) Involve the public in both the design and initial implementation of the program;

(b) Ensure ongoing public involvement once the State plan has been implemented; and

(c) Ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required at § 457.125.

§ 457.125 Provision of child health assistance to American Indian and Alaska Native children.

(a) *Enrollment.* A State must include in its State plan a description of procedures used to ensure the provision of child health assistance to American Indian and Alaska Native children.

(b) *Exemption from cost sharing.* The procedures required by paragraph (a) of this section must include an exemption from cost sharing for American Indian and Alaska Native children in accordance with § 457.535.

§ 457.130 Civil rights assurance.

The State plan must include an assurance that the State will comply with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35.

§ 457.135 Assurance of compliance with other provisions.

The State plan must include an assurance that the State will comply, under title XXI, with the following provisions of titles XIX and XI of the Social Security Act:

(a) Section 1902(a)(4)(C) (relating to conflict of interest standards).

(b) Paragraphs (2), (16) and (17) of section 1903(i) (relating to limitations on payment).

(c) Section 1903(w) (relating to limitations on provider donations and taxes).

(d) Section 1132 (relating to periods within which claims must be filed).

§ 457.140 Budget.

The State plan, or plan amendment that has a significant impact on the approved budget, must include a budget that describes the State's planned expenditures for a 1-year period. The budget must describe—

(a) Planned use of funds, including—

(1) Projected amount to be spent on health services;

(2) Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and

(3) Assumptions on which the budget is based, including cost per child and expected enrollment; and

(b) Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

§ 457.150 HCFA review of State plan material.

(a) *Basis for action.* HCFA reviews each State plan and plan amendment to determine whether it meets or continues to meet the requirements for approval under relevant Federal statutes, regulations, and guidelines furnished by HCFA to assist in the interpretation of these regulations.

(b) *Action on complete plan.* HCFA approves or disapproves the State plan or plan amendment only in its entirety.

(c) *Authority.* The HCFA Administrator exercises delegated authority to review and then to approve or disapprove the State plan or plan amendment, or to determine that previously approved material no longer meets the requirements for approval. The Administrator does not make a final determination of disapproval without first consulting the Secretary.

(d) *Initial submission.* The Administrator designates an official to receive the initial submission of State plans.

(e) *Review process.* (1) The Administrator designates an individual to coordinate HCFA's review for each State that submits a State plan.

(2) HCFA notifies the State of the identity of the designated individual in the first correspondence relating to that plan, and at any time there is a change in the designated individual.

(3) In the temporary absence of the designated individual during regular business hours, an alternate individual will act in place of the designated individual.

§ 457.160 Notice and timing of HCFA action on State plan material.

(a) *Notice of final determination.* The Administrator provides written notification to the State of the approval

or disapproval of a State plan or plan amendment.

(b) *Timing.* (1) A State plan or plan amendment will be considered approved unless HCFA, within 90 calendar days after receipt of the State plan or plan amendment in the HCFA central office, sends the State—

- (i) Written notice of disapproval; or
- (ii) Written notice of additional information it needs in order to make a final determination.

(2) A State plan or plan amendment is considered received when the designated official or individual, as determined in § 457.150(d) and (e), receives an electronic, fax or paper copy of the complete material.

(3) If HCFA requests additional information, the 90-day review period for HCFA action on the State plan or plan amendment—

(i) Stops on the day HCFA sends a written request for additional information or the next business day if the request is sent on a Federal holiday or weekend; and

(ii) Resumes on the next calendar day after the HCFA designated individual receives an electronic, fax, or hard copy from the State of all the requested additional information, unless the information is received after 5 p.m. eastern standard time on a day prior to a non-business day, in which case the review period resumes on the following business day.

(4) The 90-day review period cannot stop or end on a non-business day. If the 90th calendar day falls on a non-business day, HCFA will consider the 90th day to be the next business day.

(5) HCFA may send written notice of its need for additional information as many times as necessary to obtain the complete information necessary to review the State plan or plan amendment.

§ 457.170 Withdrawal process.

(a) *Withdrawal of proposed State plans or plan amendments.* A State may withdraw a proposed State plan or plan amendment, or any portion of a proposed State plan or plan amendment, at any time during the review process by providing written notice to HCFA of the withdrawal.

(b) *Withdrawal of approved State plans.* A State may request withdrawal of an approved State plan by submitting a State plan amendment to HCFA in accordance with § 457.60.

Subpart B—General Administration—Reviews and Audits; Withholding for Failure to Comply; Deferral and Disallowance of Claims; Reduction of Federal Medical Payments

3. A new § 457.203 is added to read as follows:

§ 457.203 Administrative and judicial review of action on State plan material.

(a) *Request for reconsideration.* Any State dissatisfied with the Administrator's action on State plan material under § 457.150 may, within 60 days after receipt of the notice of final determination provided under § 457.160(a), request that the Administrator reconsider whether the State plan or plan amendment conforms with the requirements for approval.

(b) *Notice of hearing.* Within 30 days after receipt of the request, the Administrator notifies the State of the time and place of a hearing to be held for the purpose of reconsideration.

(c) *Hearing procedures.* The hearing procedures set forth in part 430, subpart D of this chapter govern a hearing requested under this section.

(d) *Effect of hearing decision.* HCFA does not delay the denial of Federal funds, if required by the Administrator's original determination, pending a hearing decision. If the Administrator determines that his or her original decision was incorrect, HCFA will pay the State a lump sum equal to any funds incorrectly denied.

4. Paragraph (d)(2) of § 457.204 is revised to read as follows:

§ 457.204 Withholding of payment for failure to comply with Federal requirements.

* * * * *

(2) *Opportunity for corrective action.* If enforcement actions are proposed, the State must submit evidence of corrective action related to the findings of noncompliance to the Administrator within 30 days from the date of the preliminary notification. Corrective action is action to ensure that the plan is, and will be, administered consistent with applicable law and regulations, to ameliorate past deficiencies in plan administration, or to ensure that enrollees will be treated equitably.

* * * * *

5. Paragraph (a) of § 457.208 is revised to read as follows:

§ 457.208 Judicial review.

(a) *Right to judicial review.* Any State dissatisfied with the Administrator's final determination on approvability of plan material (§ 457.203) or compliance

with Federal requirements (§ 457.204) has a right to judicial review.

* * * * *

§ 457.234 [Removed]

6. Section 457.234 is removed.
7. New subparts C, D, and E are added to read as follows:

Subpart C—State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

- Sec.
- 457.300 Basis, scope, and applicability.
 - 457.301 Definitions and use of terms.
 - 457.305 State plan provisions.
 - 457.310 Targeted low-income child.
 - 457.320 Other eligibility standards.
 - 457.340 Application for and enrollment in a separate child health program.
 - 457.350 Eligibility screening and facilitation of Medicaid enrollment.
 - 457.353 Monitoring and evaluation of screening process.
 - 457.355 Presumptive eligibility.
 - 457.380 Eligibility verification.

Subpart D—State Plan Requirements: Coverage and Benefits

- 457.401 Basis, scope, and applicability.
- 457.402 Definition of child health assistance.
- 457.410 Health benefits coverage options.
- 457.420 Benchmark health benefits coverage.
- 457.430 Benchmark-equivalent health benefits coverage.
- 457.431 Actuarial report for benchmark-equivalent coverage.
- 457.440 Existing comprehensive State-based coverage.
- 457.450 Secretary-approved coverage.
- 457.470 Prohibited coverage.
- 457.475 Limitations on coverage: Abortions.
- 457.480 Preexisting condition exclusions and relation to other laws.
- 457.490 Delivery and utilization control systems.
- 457.495 State assurance of access to care and procedures to assure quality and appropriateness of care.

Subpart E—State Plan Requirements: Enrollee Financial Responsibilities

- 457.500 Basis, scope, and applicability.
- 457.505 General State plan requirements.
- 457.510 Premiums, enrollment fees, or similar fees: State plan requirements.
- 457.515 Co-payments, coinsurance, deductibles, or similar cost-sharing charges: State plan requirements.
- 457.520 Cost sharing for well-baby and well-child care services.
- 457.525 Public schedule.
- 457.530 General cost-sharing protection for lower income children.
- 457.535 Cost-sharing protection to ensure enrollment of American Indians and Alaska Natives.
- 457.540 Cost-sharing charges for children in families with incomes at or below 150 percent of the FPL.
- 457.555 Maximum allowable cost-sharing charges on targeted low-income children in families with income from 101 to 150 percent of the FPL.

457.560 Cumulative cost-sharing maximum.
457.570 Disenrollment protections.

Subpart C—State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

§ 457.300 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements —

(1) Section 2102 of the Act, which relates to eligibility standards and methodologies, coordination with other health insurance programs, and outreach and enrollment efforts to identify and enroll children who are eligible to participate in other public health insurance programs;

(2) Section 2105(c)(6)(B) of the Act, which relates to the prohibition against expenditures for child health assistance provided to children eligible for coverage under other Federal health care programs other than programs operated or financed by the Indian Health Service; and

(3) Section 2110(b) of the Act, which provides a definition of targeted low-income child.

(b) *Scope.* This subpart sets forth the requirements relating to eligibility standards and to screening, application and enrollment procedures.

(c) *Applicability.* The requirements of this subpart apply to child health assistance provided under a separate child health program. Regulations relating to eligibility, screening, applications and enrollment that are applicable to a Medicaid expansion program are found at § 431.636, § 435.4, § 435.229, § 435.1102, § 436.3, § 436.229, and § 436.1102 of this chapter.

§ 457.301 Definitions and use of terms.

As used in this subpart—

Joint application means a form used to apply for the separate child health program that, when transmitted to the Medicaid agency following a screening that shows the child is potentially eligible for Medicaid, may also be used to apply for Medicaid.

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

(1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;

(2) Is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act;

(3) Is authorized to determine eligibility of a child to receive child care

services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;

(4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;

(5) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);

(6) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;

(7) Is a State or Tribal child support enforcement agency;

(8) Is an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(9) Is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or

(10) Is an entity that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*); or

(11) Any other entity the State so deems, as approved by the Secretary.

Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of—

(1) In the case of a child on whose behalf a separate child health program application has been filed, the day on which a decision is made on that application; or

(2) In the case of a child on whose behalf an application for the separate child health program has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

Public agency means a State, county, city or other type of municipal agency, including a public school district, transportation district, irrigation district, or any other type of public entity.

Presumptive income standard means the highest income eligibility standard established under the plan that is most likely to be used to establish eligibility of a child of the age involved.

§ 457.305 State plan provisions.

The State plan must include a description of—

(a) The standards, consistent with §§ 457.310 and 457.320, used to determine the eligibility of children for coverage under the State plan.

(b) The State's policies governing enrollment and disenrollment; processes for screening applicant children for and, if eligible, facilitating their enrollment in Medicaid; and processes for implementing waiting lists and enrollment caps (if any).

§ 457.310 Targeted low-income child.

(a) *Definition.* A targeted low-income child is a child who meets the standards set forth below and the eligibility standards established by the State under § 457.320.

(b) *Standards.* A targeted low-income child must meet the following standards:

(1) *Financial need standard.* A targeted low-income child:

(i) Has a family income at or below 200 percent of the Federal poverty line for a family of the size involved;

(ii) Resides in a State with no Medicaid applicable income level or;

(iii) Resides in a State that has a Medicaid applicable income level and has family income that either—

(A) Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points; or

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under policies of the State plan under title XIX on June 1, 1997.

(2) *No other coverage standard.* A targeted low-income child must not be—

(i) Found eligible or potentially eligible for Medicaid under policies of the State plan (determined through either the Medicaid application process or the screening process described at § 457.350); or

(ii) Covered under a group health plan or under health insurance coverage, as defined in section 2791 of the Public Health Service Act, unless the plan or health insurance coverage program has been in operation since before July 1, 1997 and is administered by a State that receives no Federal funds for the program's operation. A child is not considered covered under a group health plan or health insurance coverage if the child does not have reasonable geographic access to care under that plan.

(3) For purposes of this section, policies of the State plan under title XIX plan include policies under a Statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an

expanded group of eligible children but that either—

(i) Did not provide inpatient hospital coverage; or

(ii) Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility.

(c) *Exclusions.* Notwithstanding paragraph (a) of this section, the following groups are excluded from the definition of targeted low-income children:

(1) *Children eligible for certain State health benefits coverage.* (i) A targeted low-income child may not be eligible for health benefits coverage under a State health benefits plan in the State on the basis of a family member's employment with a public agency, even if the family declines to accept the coverage.

(ii) A child is considered eligible for health benefits coverage under a State health benefits plan if a more than nominal contribution to the cost of health benefits coverage under a State health benefits plan is available from the State or public agency with respect to the child or would have been available from those sources on November 8, 1999. A contribution is considered more than nominal if the State or public agency makes a contribution toward the cost of an employee's dependent(s) that is \$10 per family, per month, more than the State or public agency's contribution toward the cost of covering the employee only.

(2) *Residents of an institution.* A child must not be—

(i) An inmate of a public institution as defined at § 435.1009 of this chapter; or

(ii) A patient in an institution for mental diseases, as defined at § 435.1009 of this chapter, at the time of initial application or any redetermination of eligibility.

§ 457.320 Other eligibility standards.

(a) *Eligibility standards.* To the extent consistent with title XXI of the Act and except as provided in paragraph (b) of this section, the State plan may adopt eligibility standards for one or more groups of children related to—

(1) Geographic area(s) served by the plan;

(2) Age (up to, but not including, age 19);

(3) Income;

(4) Resources;

(5) Spenddowns;

(6) Disposition of resources;

(7) Residency, in accordance with paragraph (d) of this section;

(8) Disability status, provided that such standards do not restrict eligibility;

(9) Access to, or coverage under, other health coverage; and

(10) Duration of eligibility, in accordance with paragraph (e) of this section.

(b) *Prohibited eligibility standards.* In establishing eligibility standards and methodologies, a State may *not*—

(1) Cover children with a higher family income without covering children with a lower family income within any defined group of covered targeted low-income children;

(2) Deny eligibility based on a preexisting medical condition;

(3) Discriminate on the basis of diagnosis;

(4) Require that any individual provide a social security number (SSN), including the SSN of the applicant child or that of a family member whose income or resources might be used in making the child's eligibility determination;

(5) Exclude American Indian or Alaska Native children based on eligibility for, or access to, medical care funded by the Indian Health Service;

(6) Exclude individuals based on citizenship or nationality, to the extent that the children are U.S. citizens, U.S. nationals or qualified aliens, (as defined at section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, as amended by the BBA of 1997, except to the extent that section 403 of PRWORA precludes them from receiving Federal means-tested public benefits); or

(7) Violate any other Federal laws or regulations pertaining to eligibility for a separate child health program under title XXI.

(c) *Self-declaration of citizenship.* In establishing eligibility for coverage under a separate child health plan, a State may accept self-declaration of citizenship (including nationals of the U.S.), provided that the State has implemented effective, fair, and nondiscriminatory procedures for ensuring the integrity of its application process.

(d) *Residency.* The State may establish residency requirements, except that a State may not—

(1) Impose a durational residency requirement;

(2) Preclude the following individuals from declaring residence in a State—

(i) A non-institutionalized child who is not a ward of the State, if the child is physically located in that State, including as a result of the parent's or caretaker's employment in that State;

(ii) An institutionalized child who is not a ward of a State, if the State is the State of residence of the child's

custodial parent's or caretaker at the time of placement;

(iii) A child who is a ward of a State, regardless of the child's physical location; or

(iv) A child whose custodial parent or caretaker is involved in work of a transient nature, if the State is the parent's or caretaker's home State.

(e) *Duration of eligibility.* (1) The State may not impose a lifetime cap or other time limit on the eligibility of an individual applicant or enrollee, based on the length of time such applicant or enrollee has received benefits under the State's separate child health program.

(2) Eligibility must be redetermined at least every 12 months.

§ 457.340 Application for and enrollment in a separate child health program.

(a) *Application assistance.* A State must afford families an opportunity to apply for child health assistance without delay, provided that the State has not reached an approved enrollment cap, and offer assistance to families in understanding and completing applications and in obtaining any required documentation.

(b) *Notice of rights and responsibilities.* A State must inform applicants at the time of application, in writing and orally if appropriate, about the application and eligibility requirements, the time frame for determining eligibility, and the right to review of eligibility determinations as described in § 457.1130.

(c) *Timely determinations of eligibility.* (1) The agency must promptly determine eligibility and issue a notice of decision within the time standards established, except in circumstances that are beyond the agency's control.

(2) A State must establish time standards for determining eligibility. These standards may not exceed forty-five calendar days (excluding days during which the application has been suspended, pursuant to § 457.350(f)(1)).

(3) In applying the time standards, the State must define "date of application" and must count each calendar day from the date of application to the day the agency mails or otherwise provides notice of its eligibility decision.

(d) *Notice of decision concerning eligibility.* A State must provide each applicant or enrollee a written notice of any decision on the application or other determination concerning eligibility.

(1) If eligibility is approved, the notice must include information on the enrollee's rights and responsibilities under the program, including the opportunity for review of matters described in § 457.1130.

(2) If eligibility is denied, suspended or terminated, the State must provide

notice in accordance with § 457.1180. In the case of a suspension or termination of eligibility, the State must provide sufficient notice to enable the child's parent or caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption.

(e) *Effective date of eligibility.* A State must specify a method for determining the effective date of eligibility for its separate child health program, which can be determined based on the date of application or through any other reasonable method.

§ 457.350 Eligibility screening and facilitation of Medicaid enrollment.

(a) *State plan requirement.* The State plan must include a description of—

(1) The screening procedures that the State will use, at intake and any follow-up eligibility determination, including any periodic redetermination, to ensure that only targeted low-income children are furnished child health assistance under the plan; and

(2) The procedures that the State will use to ensure that the Medicaid application and enrollment process is initiated and that Medicaid enrollment is facilitated for children found, through the screening process, to be potentially eligible for Medicaid.

(b) *Screening objectives.* A State must use screening procedures to identify, at a minimum, any applicant or enrollee who is potentially eligible for Medicaid under one of the poverty-level-related groups described in section 1902(l) of the Act, section 1931 of the Act, or a Medicaid demonstration project approved under section 1115 of the Act, applying whichever standard and corresponding methodology generally results in a higher income eligibility level for the age group of the child being screened.

(c) *Income eligibility test.* To identify the children described in paragraph (b) of this section, a State must either initially apply the gross income test described in paragraph (c)(1) of this section and then use an adjusted income test described in paragraph (c)(2) of this section for applicants whose gross income is above the appropriate Medicaid income standard, or use only the adjusted income test.

(1) *Initial gross income test.* Under this test, a State initially screens for Medicaid eligibility by comparing gross family income to the appropriate Medicaid income standard.

(2) *Adjusted income test.* Under this test, a State screens for Medicaid eligibility by comparing adjusted family income to the appropriate Medicaid income standard. The State must apply

Medicaid standards and methodologies relating to income for the particular Medicaid eligibility group, including all income exclusions and disregards, except those that apply only in very limited circumstances.

(d) *Resource eligibility test.* (1) If a State applies a resource test for children under the Medicaid eligibility group used for screening purposes as described in paragraph (b) of this section and a child has been determined potentially income eligible for Medicaid, the State must also screen for Medicaid eligibility by comparing family resources to the appropriate Medicaid resource standard.

(2) In conducting the screening, the State must apply Medicaid standards and methodologies related to resources for the particular Medicaid eligibility group, including all resource exclusions and disregards, except those that apply only in very limited circumstances.

(e) *Children found potentially ineligible for Medicaid.* If a State 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.

(f) *Children found potentially eligible for Medicaid.* 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) Except as provided in § 457.355, find the child ineligible, provisionally ineligible, or suspend the child's application for the separate child health program unless and until a completed Medicaid application for that child is denied, or the child's circumstances change, and promptly transmit the separate child health application to the Medicaid agency as provided in paragraph (f)(3)(ii) of this section; and

(2) 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

(3) 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, if appropriate, orally 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

(4) 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; and

(5) Determine or redetermine eligibility for the separate child health program, if—

(i) The State is notified pursuant to § 431.636 of this chapter that the child has been found ineligible for Medicaid, consistent with the time standards established pursuant to § 457.340(c); or

(ii) The State is notified prior to the final Medicaid eligibility determination that the child's circumstances have changed and another screening shows that the child is not likely to be eligible for Medicaid.

(iii) For purposes of such determination or redetermination, the State must not require the child to complete a new application for the separate child health program, but may require supplemental information to account for any changes in the child's circumstances that may affect eligibility.

(g) *Informed application decisions.* To enable a family to make an informed decision about applying for Medicaid or completing the Medicaid application process, a State must provide the child's family with information, in writing, about—

(1) The State's Medicaid program, including the benefits covered, and restrictions on cost sharing; and

(2) 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.

(h) *Waiting lists, enrollment caps and closed enrollment.* The State must establish procedures to ensure that—

(1) The procedures developed in accordance with this section have been followed for each child applying for a separate child health program before placing the child on a waiting list or otherwise deferring action on the child's application for the separate child health program; and

(2) Families are informed that a child may be eligible for Medicaid if circumstances change while the child is on a waiting list for separate child health program.

§ 457.353 Monitoring and evaluation of screening process.

States must monitor and establish a mechanism to evaluate the screen and enroll process described at § 457.350 to ensure that children who are screened potentially eligible for Medicaid are enrolled in Medicaid, if eligible, and that children who are found ineligible for Medicaid are enrolled in the separate child health program, if eligible.

§ 457.355 Presumptive eligibility.

Consistent with subpart D of this part, the State may pay costs of coverage under a separate child health program, during a period of presumptive eligibility for children applying for coverage under the separate child health program, pending the screening process and a final determination of eligibility (including applicants found through screening to be potentially eligible for Medicaid)

(a) *Expenditures for coverage during a period of presumptive eligibility.* (1) Expenditures for coverage during a period of presumptive eligibility for a child ultimately determined eligible for the separate child health program, will be considered, for that period, as expenditures for child health assistance for targeted low-income children under the plan.

(2) Expenditures for coverage during a period of presumptive eligibility implemented in accordance with § 435.1101 of this part for a child ultimately determined ineligible for both the separate child health program and Medicaid for that period, and for a

child whose family does not complete the Medicaid application process, will be considered as expenditures for targeted low-income children under the plan.

(3) Expenditures for coverage during a period of presumptive eligibility for a child ultimately determined to be eligible for Medicaid may not be considered expenditures under the separate child health program.

§ 457.380 Eligibility verification.

(a) The State must establish procedures to ensure the integrity of the eligibility determination process.

(b) A State may establish reasonable eligibility verification mechanisms to promote enrollment of eligible children and may permit applicants and enrollees to demonstrate that they meet eligibility requirements through self-declaration or affirmation except that a State may permit self-declaration of citizenship only if the State has effective, fair and non-discriminatory procedures to ensure the integrity of the application process in accordance with § 457.320(c).

Subpart D—State Plan Requirements: Coverage and Benefits

§ 457.401 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements—

(1) Section 2102(a)(7) of the Act, which requires that States make assurances relating to, the quality and appropriateness of care, and access to covered services;

(2) Section 2103 of the Act, which outlines coverage requirements for children's health insurance;

(3) Section 2109 of the Act, which describes the relation of the SCHIP program to other laws;

(4) Section 2110(a) of the Act, which describes child health assistance; and

(5) Section 2110(c) of the Act, which contains definitions applicable to this subpart.

(b) *Scope.* This subpart sets forth requirements for health benefits coverage and child health assistance under a separate child health plan.

(c) *Applicability.* The requirements of this subpart apply to child health assistance provided under a separate child health program and do not apply to a Medicaid expansion program.

§ 457.402 Definition of child health assistance.

For the purpose of this subpart, the term "child health assistance" means payment for part or all of the cost of health benefits coverage provided to targeted low-income children for the following services:

(a) Inpatient hospital services.

(b) Outpatient hospital services.

(c) Physician services.

(d) Surgical services.

(e) Clinic services (including health center services) and other ambulatory health care services.

(f) Prescription drugs and biologicals and the administration of these drugs and biologicals, only if these drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

(g) Over-the-counter medications.

(h) Laboratory and radiological services.

(i) Prenatal care and pre-pregnancy family planning services and supplies.

(j) Inpatient mental health services, other than services described in paragraph (r) of this section but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

(k) Outpatient mental health services, other than services described in paragraph (s) of this section but including services furnished in a State-operated mental hospital and including community-based services.

(l) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices and adaptive devices).

(m) Disposable medical supplies.

(n) Home and community-based health care services and related supportive services (such as home health nursing services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members and minor modification to the home.)

(o) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing, pediatric nurse services and respiratory care services) in a home, school, or other setting.

(p) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.

(q) Dental services.

(r) Inpatient substance abuse treatment services and residential substance abuse treatment services.

(s) Outpatient substance abuse treatment services.

(t) Case management services.

(u) Care coordination services.

(v) Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.

(w) Hospice care.

(x) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—

(1) Prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law;

(2) Performed under the general supervision or at the direction of a physician; or

(3) Furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

(y) Premiums for private health care insurance coverage.

(z) Medical transportation.

(aa) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

(bb) Any other health care services or items specified by the Secretary and not excluded under this subchapter.

§ 457.410 Health benefits coverage options.

(a) *Types of health benefits coverage.* States may choose to obtain any of the following four types of health benefits coverage:

(1) Benchmark coverage in accordance with § 457.420.

(2) Benchmark-equivalent coverage in accordance with § 457.430.

(3) Existing comprehensive State-based coverage in accordance with § 457.440.

(4) Secretary-approved coverage in accordance with § 457.450.

(b) *Required coverage.* Regardless of the type of health benefits coverage, described at paragraph (a) of this section, that the State chooses to obtain, the State must obtain coverage for—

(1) Well-baby and well-child care services as defined by the State;

(2) Age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP); and

(3) Emergency services as defined in § 457.10.

§ 457.420 Benchmark health benefits coverage.

Benchmark coverage is health benefits coverage that is substantially equal to the health benefits coverage in one of the following benefit plans:

(a) *Federal Employees Health Benefit Plan (FEHBP).* The standard Blue Cross/

Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under, 5 U.S.C. 8903(1).

(b) *State employee plan.* A health benefits plan that is offered and generally available to State employees in the State.

(c) *Health maintenance organization (HMO) plan.* A health insurance coverage plan that is offered through an HMO (as defined in section 2791(b)(3) of the Public Health Service Act) and has the largest insured commercial, non-Medicaid enrollment in the State.

§ 457.430 Benchmark-equivalent health benefits coverage.

(a) *Aggregate actuarial value.* Benchmark-equivalent coverage is health benefits coverage that has an aggregate actuarial value determined in accordance with § 457.431 that is at least actuarially equivalent to the coverage under one of the benchmark packages specified in § 457.420.

(b) *Required coverage.* In addition to the coverage required under § 457.410(b), benchmark-equivalent health benefits coverage must include coverage for the following categories of services:

(1) Inpatient and outpatient hospital services.

(2) Physicians' surgical and medical services.

(3) Laboratory and x-ray services.

(c) *Additional coverage.* (1) In addition to the categories of services in paragraph (b) of this section, benchmark-equivalent coverage may include coverage for any additional services specified in § 457.402.

(2) If the benchmark coverage package used by the State for purposes of comparison in establishing the aggregate actuarial value of the benchmark-equivalent coverage package includes coverage for prescription drugs, mental health services, vision services or hearing services, then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the value of the coverage for such a category or service in the benchmark plan used for comparison by the State.

(3) If the benchmark coverage package does not cover one of the categories of services in paragraph (c)(2) of this section, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.

§ 457.431 Actuarial report for benchmark-equivalent coverage.

(a) To obtain approval for benchmark-equivalent health benefits coverage

described under § 457.430, the State must submit to HCFA an actuarial report that contains an actuarial opinion that the health benefits coverage meets the actuarial requirements under § 457.430. The report must also specify the benchmark coverage used for comparison.

(b) The actuarial report must state that it was prepared—

(1) By an individual who is a member of the American Academy of Actuaries;

(2) Using generally accepted actuarial principles and methodologies of the American Academy of Actuaries;

(3) Using a standardized set of utilization and price factors;

(4) Using a standardized population that is representative of privately insured children of the age of those expected to be covered under the State plan;

(5) Applying the same principles and factors in comparing the value of different coverage (or categories of services);

(6) Without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

(7) Taking into account the ability of a State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(c) The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of this section.

(d) The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by HCFA, to replicate the State's result.

§ 457.440 Existing comprehensive State-based coverage.

(a) *General requirements.* Existing comprehensive State-based health benefits is coverage that—

(1) Includes coverage of a range of benefits;

(2) Is administered or overseen by the State and receives funds from the State;

(3) Is offered in the State of New York, Florida or Pennsylvania; and

(4) Was offered as of August 5, 1997.

(b) *Modifications.* A State may modify an existing comprehensive State-based coverage program described in paragraph (a) of this section if—

(1) The program continues to include a range of benefits;

(2) The State submits an actuarial report demonstrating that the modification does not reduce the

actuarial value of the coverage under the program below the lower of either—

(i) The actuarial value of the coverage under the program as of August 5, 1997; or

(ii) The actuarial value of a benchmark benefit package as described in § 457.430 evaluated at the time the modification is requested.

§ 457.450 Secretary-approved coverage.

Secretary-approved coverage is health benefits coverage that, in the determination of the Secretary, provides appropriate coverage for the population of targeted low-income children covered under the program. Secretary-approved coverage, for which no actuarial analysis is required, may include—

(a) Coverage that is the same as the coverage provided to children under the Medicaid State plan;

(b) Comprehensive coverage offered by the State under a Medicaid demonstration project approved by the Secretary under section 1115 of the Act that either includes coverage for the full Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit or that the State has extended to the entire Medicaid population in the State;

(c) Coverage that includes benchmark health benefits coverage, as specified in § 457.420, plus any additional coverage; or

(d) Coverage, including coverage under a group health plan purchased by the State, that the State demonstrates to be substantially equivalent to or greater than coverage under a benchmark health benefits plan, as specified in § 457.420, through use of a benefit-by-benefit comparison of the coverage demonstrating that coverage for each benefit meets or exceeds the corresponding coverage under the benchmark health benefits plan.

§ 457.470 Prohibited coverage.

A State is not required to provide health benefits coverage under the plan for an item or service for which payment is prohibited under title XXI even if any benchmark health benefits plan includes coverage for that item or service.

§ 457.475 Limitations on coverage: Abortions.

(a) *General rule.* FFP under title XXI is not available in expenditures for an abortion, or in expenditures for the purchase of health benefits coverage that includes coverage of abortion services unless the abortion services meet the conditions specified in paragraph (b) of this section.

(b) *Exceptions.* (1) *Life of mother.* FFP is available in expenditures for abortion

services when a physician has found that the abortion is necessary to save the life of the mother.

(2) *Rape or incest.* FFP is available in expenditures for abortion services performed to terminate a pregnancy resulting from an act of rape or incest.

(c) *Partial Federal funding prohibited.*

(1) FFP is not available to a State for any amount expended under the title XXI plan to assist in the purchase, in whole or in part, of health benefits coverage that includes coverage of abortions other than those specified in paragraph (b) of this section.

(2) If a State wishes to have managed care entities provide abortions in addition to those specified in paragraph (b) of this section, those abortions must be provided under a separate contract using non-Federal funds. A State may not set aside a portion of the capitated rate paid to a managed care entity to be paid with State-only funds, or append riders, attachments or addenda to existing contracts with managed care entities to separate the additional abortion services from the other services covered by the contract.

(3) Nothing in this section affects the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than those expended under the State plan) for any abortion services or for health benefits coverage that includes coverage of abortion services.

§ 457.480 Preexisting condition exclusions and relation to other laws.

(a) *Preexisting condition exclusions.*

(1) Except as permitted under paragraph (a)(2) of this section, the State may not permit the imposition of any pre-existing condition exclusion for covered services under the State plan.

(2) If the State obtains health benefits coverage through payment or a contract for health benefits coverage under a group health plan or group health insurance coverage, the State may permit the imposition of a pre-existing condition exclusion but only to the extent that the exclusion is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (ERISA) and title XXVII of the Public Health Service Act.

(b) *Relation of title XXI to other laws.* (1) ERISA. Nothing in this title affects or modifies section 514 of ERISA with respect to a group health plan as defined by section 2791(a)(1) of the Public Health Service Act.

(2) *Health Insurance Portability and Accountability Act (HIPAA).* Health benefits coverage provided under a State plan and coverage provided as a cost-

effective alternative, as described in subpart J of this part, is creditable coverage for purposes of part 7 of subtitle B of title II of ERISA, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

(3) *Mental Health Parity Act (MHPA).* Health benefits coverage under a group health plan provided under a State plan must comply with the requirements of the MHPA of 1996 regarding parity in the application of annual and lifetime dollar limits to mental health benefits in accordance with 45 CFR 146.136.

(4) *Newborns and Mothers Health Protection Act (NMHPA).* Health benefits coverage under a group health plan provided under a State plan must comply with the requirements of the NMHPA of 1996 regarding requirements for minimum hospital stays for mothers and newborns in accordance with 45 CFR 146.130 and 148.170.

§ 457.490 Delivery and utilization control systems.

A State that elects to obtain health benefits coverage through a separate child health program must include in its State plan a description of the child health assistance provided under the plan for targeted low-income children, including a description of the proposed methods of delivery and utilization control systems. A State must—

(a) Describe the methods of delivery of child health assistance including the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations; and

(b) Describe utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan.

§ 457.495 State assurance of access to care and procedures to assure quality and appropriateness of care.

A State plan must include a description of the methods that a State uses for assuring the quality and appropriateness of care provided under the plan, including how the State will assure:

(a) Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations.

(b) Access to covered services, including emergency services as defined at § 457.10.

(c) Appropriate and timely procedures to monitor and treat enrollees with

chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition.

(d) That decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days after receipt of a request for services. A possible extension of up to 14 days may be permitted if the enrollee requests the extension or if the physician or health plan determines that additional information is needed.

Subpart E—State Plan Requirements: Enrollee Financial Responsibilities

§ 457.500 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart implements—

(1) Section 2101(a) of the Act, which provides that the purpose of title XXI is to provide 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; and

(2) Section 2103(e) of the Act, which sets forth provisions regarding State plan requirements and options for cost sharing.

(b) *Scope.* This subpart consists of provisions relating to the imposition under a separate child health program of cost-sharing charges including enrollment fees, premiums, deductibles, coinsurance, copayments, and similar cost-sharing charges.

(c) *Applicability.* The requirements of this subpart apply to separate child health programs.

§ 457.505 General State plan requirements.

The State plan must include a description of—

(a) The amount of premiums, deductibles, coinsurance, copayments, and other cost sharing imposed;

(b) The methods, including the public schedule, the State uses to inform enrollees, applicants, providers and the general public of the cost-sharing charges, the cumulative cost-sharing maximum, and any changes to these amounts;

(c) The disenrollment protections as required under § 457.570;

(d) In the case of coverage obtained through premium assistance for group health plans—

(1) The procedures the State uses to ensure that enrollees are not charged copayments, coinsurance, deductibles or similar fees on well-baby and well-

child care services described at § 457.520, and that any cost sharing complies with the requirements of this subpart;

(2) The procedures to ensure that American Indian and Alaska Native children are not charged premiums, copayments, coinsurance, deductibles, or similar fees in accordance with § 457.535;

(3) The procedures to ensure that enrollees are not charged cost sharing in excess of the cumulative cost-sharing maximum specified in § 457.560.

(e) Procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee to ensure compliance with this subpart.

§ 457.510 Premiums, enrollment fees, or similar fees: State plan requirements.

When a State imposes premiums, enrollment fees, or similar fees on enrollees, the State plan must describe—

(a) The amount of the premium, enrollment fee or similar fee imposed on enrollees;

(b) The time period for which the charge is imposed;

(c) The group or groups that are subject to the premiums, enrollment fees, or similar charges;

(d) The consequences for an enrollee or applicant who does not pay a charge, and the disenrollment protections adopted by the State in accordance with § 457.570; and

(e) The methodology used to ensure that total cost-sharing liability for a family does not exceed the cumulative cost-sharing maximum specified in § 457.560.

§ 457.515 Co-payments, coinsurance, deductibles, or similar cost-sharing charges: State plan requirements.

To impose copayments, coinsurance, deductibles or similar charges on enrollees, the State plan must describe—

(a) The service for which the charge is imposed;

(b) The amount of the charge;

(c) The group or groups of enrollees that may be subject to the cost-sharing charge;

(d) The consequences for an enrollee who does not pay a charge, and the disenrollment protections adopted by the State in accordance with § 457.570;

(e) The methodology used to ensure that total cost-sharing liability for a family does not exceed the cumulative cost-sharing maximum specified in § 457.560; and

(f) An assurance that enrollees will not be held liable for cost-sharing amounts for emergency services that are

provided at a facility that does not participate in the enrollee's managed care network beyond the copayment amounts specified in the State plan for emergency services as defined in § 457.10.

§ 457.520 Cost sharing for well-baby and well-child care services.

(a) A State may not impose copayments, deductibles, coinsurance or other cost sharing with respect to the well-baby and well-child care services covered under the State plan in either the managed care delivery setting or the fee-for-service delivery setting.

(b) For the purposes of this subpart, at a minimum, any of the following services covered under the State plan will be considered well-baby and well-child care services:

(1) All healthy newborn physician visits, including routine screening, whether provided on an inpatient or outpatient basis.

(2) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents."

(3) Laboratory tests associated with the well-baby and well-child routine physical examinations as described in paragraph (b)(2) of this section.

(4) Immunizations and related office visits as recommended and updated by the Advisory Committee on Immunization Practices (ACIP).

(5) Routine preventive and diagnostic dental services (such as oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described in the most recent guidelines issued by the American Academy of Pediatric Dentistry (AAPD).

§ 457.525 Public schedule.

(a) The State must make available to the groups in paragraph (b) of this section a public schedule that contains the following information:

(1) Current cost-sharing charges.

(2) Enrollee groups subject to the charges.

(3) Cumulative cost-sharing maximums.

(4) Mechanisms for making payments for required charges.

(5) The consequences for an applicant or an enrollee who does not pay a charge, including the disenrollment protections required by § 457.570.

(b) The State must make the public schedule available to the following groups:

(1) Enrollees, at the time of enrollment and reenrollment after a

redetermination 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.

§ 457.530 General cost-sharing protection for lower income children.

The State may vary premiums, deductibles, coinsurance, copayments or any other cost sharing based on family income only in a manner that does not favor children from families with higher income over children from families with lower income.

§ 457.535 Cost-sharing protection to ensure enrollment of American Indians and Alaska Natives.

States may not impose premiums, deductibles, coinsurance, copayments or any other cost-sharing charges on children who are American Indians or Alaska Natives, as defined in § 457.10.

§ 457.540 Cost-sharing charges for children in families with incomes at or below 150 percent of the FPL.

The State may impose premiums, enrollment fees, deductibles, copayments, coinsurance, cost sharing and other similar charges for children whose family income is at or below 150 percent of the FPL as long as—

(a) Aggregate monthly enrollment fees, premiums, or similar charges imposed on a family are less than or equal to the maximum amounts permitted under § 447.52 of this chapter for a Medicaid eligible family of the same size and income;

(b) Any copayments, coinsurance, deductibles or similar charges for children whose family income is at or below 100 percent of the FPL are equal to or less than the amounts permitted under § 447.54 of this chapter;

(c) For children whose family income is from 101 percent to 150 percent of the FPL, any copayments, coinsurance, deductibles or similar charges are equal to or less than the maximum amounts permitted under § 457.555;

(d) The State does not impose more than one type of cost-sharing charge (deductible, copayment, or coinsurance) on a service;

(e) The State only imposes one copayment based on the total cost of services furnished during one office visit; and

(f) Aggregate annual cost sharing of all types, with respect to all targeted low-income children in a family, does not exceed the maximum permitted under § 457.560(b).

§ 457.555 Maximum allowable cost-sharing charges on targeted low-income children in families with income from 101 to 150 percent of the FPL.

(a) *Non-institutional services.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State plan must provide that for non-institutional services, including emergency services—

(1) Any copayment or similar charge the State imposes under a fee-for-service delivery system does not exceed the following amounts:

Total cost of services provided during a visit	Maximum amount chargeable to enrollee
\$15.00 or less	\$1.00
\$15.01 to \$40	2.00
\$40.01 to \$80	3.00
\$80.01 or more	5.00

(2) Any copayment that the State imposes for services provided by a managed care organization may not exceed \$5.00 per visit;

(3) Any coinsurance rate the State imposes may not exceed 5 percent of the payment the State directly or through contract makes for the service; and

(4) Any deductible the State imposes may not exceed \$3.00 per month, per family for each period of eligibility.

(b) *Institutional services.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the maximum deductible, coinsurance or copayment charge for each institutional admission may not exceed 50 percent of the payment the State would make under the Medicaid fee-for-service system for the first day of care in the institution.

(c) *Institutional emergency services.* Any copayment that the State imposes on emergency services provided by an institution may not exceed \$5.00.

(d) *Nonemergency use of the emergency room.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State may charge up to twice the charge for non-institutional services, up to a maximum amount of \$10.00, for services furnished in a hospital emergency room if those services are not emergency services as defined in § 457.10.

(e) *Standard copayment amount.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, a standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in paragraphs (a), (b), and (c) of this

section to the State's average or typical payment for that service.

§ 457.560 Cumulative cost-sharing maximum.

(a) *Computation.* A State must count cost-sharing amounts that the family has a legal obligation to pay in computing whether a family has met the cumulative cost-sharing maximum. A family will be considered to have a legal obligation to pay amounts a provider actually charges the family for covered services furnished to enrollees, and any other amounts for which payment is required under applicable State law for covered services furnished to eligible children, even if the family never pays those amounts.

(b) *Children with family incomes at or below 150 percent of the FPL.* For targeted low-income children with family income at or below 150 percent of the FPL, the State may not impose premiums, deductibles, copayments, coinsurance, enrollment fees, or similar cost-sharing charges that, in the aggregate, exceed 2.5 percent of total family income for the length of the child's eligibility period in the State.

(c) *Children with family incomes above 150 percent of the FPL.* For targeted low-income children with family income above 150 percent of the FPL, the State may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate, exceed 5 percent of total family income for the length of the child's eligibility period in the State.

(d) The 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.

§ 457.570 Disenrollment protections.

(a) The State must give enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

(b) The disenrollment process must afford the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges, and in the event that such a showing indicates that the enrollee may have become eligible for Medicaid or for a lower level of cost sharing, the State must facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate.

(c) The State must provide the enrollee with an opportunity for an impartial review to address

disenrollment from the program in accordance with § 457.1130(a)(3).

Subpart F—Payments to States

§ 457.624 [Removed]

8. Section 457.624 is removed.
9. New subparts G, H, I, J, and K are added to read as follows:

Subpart G—Strategic Planning, Reporting, and Evaluation

Sec.
457.700 Basis, scope, and applicability.
457.710 State plan requirements: Strategic objectives and performance goals.
457.720 State plan requirement: State assurance regarding data collection, records, and reports.
457.740 State expenditures and statistical reports.
457.750 Annual report.

Subpart H—Substitution of Coverage

457.800 Basis, scope, and applicability.
457.805 State plan requirements: Procedures to address substitution under group health plans.
457.810 Premium assistance programs: Required protections against substitution.

Subpart I—Program Integrity

457.900 Basis, scope, and applicability.
457.902 Definitions.
457.910 State program administration.
457.915 Fraud detection and investigation.
457.925 Preliminary investigation.
457.930 Full investigation, resolution, and reporting requirements.
457.935 Sanctions and related penalties.
457.940 Procurement standards.
457.945 Certification for contracts and proposals.
457.950 Contract and payment requirements including certification of payment-related information.
457.955 Conditions necessary to contract as a managed care entity (MCE).
457.960 Reporting changes in eligibility and redetermining eligibility.
457.965 Documentation.
457.980 Verification of enrollment and provider services received.
457.985 Integrity of professional advice to enrollees.

Subpart J—Allowable Waivers: General Provisions

457.1000 Basis, scope, and applicability.
457.1003 HCFA review of waiver requests.
457.1005 Waiver for cost-effective coverage through a community-based health delivery system.
457.1010 Waiver for purchase of family coverage.
457.1015 Cost-effectiveness.

Subpart K—State Plan Requirements: Applicant and Enrollee Protections

457.1100 Basis, scope and applicability.
457.1110 Privacy protections.
457.1120 State plan requirement: Description of review process.
457.1130 Matters subject to review.
457.1140 Core elements of review.

457.1150 Impartial review.
457.1160 Time frames.
457.1170 Continuation of enrollment.
457.1180 Notice.
457.1190 Application of review procedures when States offer premium assistance for group health plans.

Subpart G—Strategic Planning, Reporting, and Evaluation

§ 457.700 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart implements—
(1) Sections 2107(a), (b) and (d) of the Act, which set forth requirements for strategic planning, reports, and program budgets; and
(2) Section 2108 of the Act, which sets forth provisions regarding annual reports and evaluation.

(b) *Scope.* This subpart sets forth requirements for strategic planning, monitoring, reporting and evaluation under title XXI.

(c) *Applicability.* The requirements of this subpart apply to separate child health programs and Medicaid expansion programs.

§ 457.710 State plan requirements: Strategic objectives and performance goals.

(a) *Plan description.* A State plan must include a description of—

(1) The strategic objectives as described in paragraph (b) of this section;
(2) The performance goals as described in paragraph (c) of this section; and
(3) The performance measurements, as described in paragraph (d) of this section, that the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health benefits coverage for other low-income children and children generally in the State.

(b) *Strategic objectives.* The State plan must identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children.
(c) *Performance goals.* The State plan must specify one or more performance goals for each strategic objective identified.
(d) *Performance measurements.* The State plan must describe how performance under the plan is—

(1) Measured through objective, independently verifiable means; and
(2) Compared against performance goals.
(e) *Core elements.* The State's strategic objectives, performance goals and performance measures must include a common core of national performance

goals and measures consistent with the data collection, standard methodology, and verification requirements, as developed by the Secretary.

§ 457.720 State plan requirement: State assurance regarding data collection, records, and reports.

A State plan must include an assurance that the State collects data, maintains records, and furnishes reports to the Secretary, at the times and in the standardized format the Secretary may require to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under title XXI.

§ 457.740 State expenditures and statistical reports.

(a) *Required quarterly reports.* A State must submit reports to HCFA that contain quarterly program expenditures and statistical data no later than 30 days after the end of each quarter of the Federal fiscal year. A State must collect required data beginning on the date of implementation of the approved State plan. Territories are exempt from the definition of "State" for purposes of the required quarterly reporting under this section. The quarterly reports must include data on—

(1) Program expenditures;
(2) The number of children enrolled in the title XIX Medicaid program, the separate child health program, and the Medicaid expansion program, as applicable, as of the last day of each quarter of the Federal fiscal year; and
(3) 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) Gender, race, and ethnicity.
(iii) Service delivery system (managed care, fee-for-service, and primary care case management).
(iv) Family income as a percentage of the Federal poverty level as described in paragraph (b) of this section.

(b) *Reportable family income categories.* (1) A State that does not impose cost sharing or a State that imposes cost sharing based on a fixed percentage of income must report by two family income categories:
(i) At or below 150 percent of FPL.
(ii) Over 150 percent of FPL.

(2) A State that imposes a different level or percentage of cost sharing at different poverty levels must report by poverty level categories that match the

poverty level categories used for purposes of cost sharing.

(c) *Required unduplicated counts.* Thirty days after the end of the Federal fiscal year, the State must submit an unduplicated count for the Federal fiscal year of children who were enrolled in the Medicaid program, the separate child health program, and the Medicaid expansion program, as appropriate, by age, gender, race, ethnicity, service delivery system, and poverty level categories described in paragraphs (a) and (b) of this section.

§ 457.750 Annual report.

(a) *Report required for each Federal fiscal year.* A State must report to HCFA by January 1 following the end of each Federal fiscal year, on the results of the State's assessment of the operation of the State plan.

(b) *Contents of annual report.* In the annual report required under paragraph (a) of this section, a State must—

(1) Describe the State's progress in reducing the number of uncovered, low-income children and; in meeting other strategic objectives and performance goals identified in the State plan; and provide information related to a core set of national performance goals and measures as developed by the Secretary;

(2) Report on the effectiveness of the State's policies for discouraging the substitution of public coverage for private coverage;

(3) Identify successes and barriers in State plan design and implementation, and the approaches the State is considering to overcome these barriers;

(4) Describe the State's progress in addressing any specific issues (such as outreach) that the State plan proposed to periodically monitor and assess;

(5) Provide an updated budget for a 3-year period that describes those elements required in § 457.140, including any changes in the sources of the non-Federal share of State plan expenditures;

(6) Identify the total State expenditures for family coverage and total number of children and adults, respectively, covered by family coverage during the preceding Federal fiscal year;

(7) Collect and provide data regarding the primary language of SCHIP enrollees; and

(8) Describe the State's current income standards and methodologies for its Medicaid expansion program, separate child health program, and title XIX Medicaid program, as appropriate.

(c) *Methodology for estimate of number of uninsured, low-income children.* (1) To report on the progress made in reducing the number of uninsured, low-income children as

required in paragraph (b) of this section, a State must choose a methodology to establish an initial baseline estimate of the number of low-income children who are uninsured in the State.

(i) A State may base the estimate on data from—

(A) The March supplement to the Current Population Survey (CPS);

(B) A State-specific survey;

(C) A statistically adjusted CPS; or

(D) Another appropriate source.

(ii) If the State does not base the estimate on data from the March supplement to the CPS, the State must submit a description of the methodology used to develop the initial baseline estimate and the rationale for its use.

(2) The State must provide an annual estimate of changes in the number of uninsured in the State using—

(i) The same methodology used in establishing the initial baseline; or

(ii) Another methodology based on new information that enables the State to establish a new baseline.

(3) If a new methodology is used, the State must also provide annual estimates based on either the March supplement to the CPS or the methodology used to develop the initial baseline.

Subpart H—Substitution of Coverage

§ 457.800 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements section 2102(b)(3)(C) of the Act, which provides that the State plan must include a description of procedures the State uses to ensure that health benefits coverage provided under the State plan does not substitute for coverage under group health plans.

(b) *Scope.* This subpart sets forth State plan requirements relating to substitution of coverage in general and specific requirements relating to substitution of coverage under premium assistance programs.

(c) *Applicability.* The requirements of this subpart apply to separate child health programs.

§ 457.805 State plan requirement: Procedures to address substitution under group health plans.

The State plan must include a description of reasonable procedures to ensure that health benefits coverage provided under the State plan does not substitute for coverage provided under group health plans as defined at § 457.10.

§ 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.

(a) *Minimum period without coverage under a group health plan.* For health benefits coverage provided through premium assistance for group health plans, the following rules apply:

(1) An enrollee must not have had coverage under a group health plan for a period of at least 6 months prior to enrollment in a premium assistance program. A State may not require a minimum period without coverage under a group health plan that exceeds 12 months.

(2) States may permit reasonable exceptions to the requirement for a minimum period without coverage under a group health plan for—

(i) Involuntary loss of coverage under a group health plan, due to employer termination of coverage for all employees and dependents;

(ii) Economic hardship;

(iii) Change to employment that does not offer dependent coverage; or

(iv) Other reasons proposed by the State and approved as part of the State plan.

(3) The requirement for a minimum period without coverage under a group health plan does not apply to a child who, within the previous 6 months, has received coverage under a group health plan through Medicaid under section 1906 of the Act.

(4) The Secretary may waive the 6-month waiting period requirement described in this section at her discretion.

(b) *Employer contribution.* For health benefits coverage obtained through premium assistance for group health plans, the employee who is eligible for the coverage must apply for the full premium contribution available from the employer.

(c) *Cost effectiveness.* In establishing cost effectiveness—

(1) The State's cost for coverage for children under premium assistance programs must not be greater than the cost of other SCHIP coverage for these children; and

(2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage for children under premium assistance programs to the cost of other SCHIP coverage for these children, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

(d) *State evaluation.* The State must evaluate and report in the annual report (in accordance with § 457.750(b)(2)) the amount of substitution that occurs as a result of premium assistance programs and the effect of those programs on access to coverage.

Subpart I—Program Integrity

§ 457.900 Basis, scope and applicability.

(a) *Statutory basis.* This subpart implements—

(1) Section 2101(a) of the Act, which provides that the purpose of title XXI is to provide 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; and

(2) Section 2107(e) of the Act, which provides that certain title XIX and title XI provisions, including the following, apply to States under title XXI in the same manner as they apply to a State under title XIX:

(i) Section 1902(a)(4)(C) of the Act, relating to conflict of interest standards.

(ii) Paragraphs (2), (16), and (17), of section 1903(i) of the Act, relating to limitations on payment.

(iii) Section 1903(w) of the Act, relating to limitations on provider taxes and donations.

(iv) Section 1124 of the Act, relating to disclosure of ownership and related information.

(v) Section 1126 of the Act, relating to disclosure of information about certain convicted individuals.

(vi) Section 1128 of the Act, relating to exclusions.

(vii) Section 1128A of the Act, relating to civil monetary penalties.

(viii) Section 1128B(d) of the Act, relating to criminal penalties for certain additional charges.

(ix) Section 1132 of the Act, relating to periods within which claims must be filed.

(b) *Scope.* This subpart sets forth requirements, options, and standards for program integrity assurances that must be included in the approved State plan.

(c) *Applicability.* This subpart applies to separate child health programs. Medicaid expansion programs are subject to the program integrity rules and requirements specified under title XIX.

§ 457.902 Definitions

As used in this subpart—

Actuarially sound principles means generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the population and services to be covered, and have been

certified by actuaries who meet the qualification standards established by the Actuarial Standards Board.

Fee-for-service entity means any individual or entity that furnishes services under the program on a fee-for-service basis, including health insurance services.

§ 457.910 State program administration.

The State's child health program must include—

(a) Methods of administration that the Secretary finds necessary for the proper and efficient operation of the separate child health program; and

(b) Safeguards necessary to ensure that—

(1) Eligibility will be determined appropriately in accordance with subpart C of this part; and

(2) Services will be provided in a manner consistent with administrative simplification and with the provisions of subpart D of this part.

§ 457.915 Fraud detection and investigation.

(a) *State program requirements.* The State must establish procedures for ensuring program integrity and detecting fraudulent or abusive activity. These procedures must include the following:

(1) Methods and criteria for identifying suspected fraud and abuse cases.

(2) Methods for investigating fraud and abuse cases that—

(i) Do not infringe on legal rights of persons involved; and

(ii) Afford due process of law.

(b) *State program integrity unit.* The State may establish an administrative agency responsible for monitoring and maintaining the integrity of the separate child health program.

(c) *Program coordination.* The State must develop and implement procedures for referring suspected fraud and abuse cases to the State program integrity unit (if such a unit is established) and to appropriate law enforcement officials. Law enforcement officials include the—

(1) U.S. Department of Health and Human Services Office of Inspector General (OIG);

(2) U.S. Attorney's Office, Department of Justice (DOJ);

(3) Federal Bureau of Investigation (FBI); and

(4) State Attorney General's office.

§ 457.925 Preliminary investigation.

If the State agency receives a complaint of fraud or abuse from any source or identifies questionable practices, the State agency must conduct

a preliminary investigation or take otherwise appropriate action within a reasonable period of time to determine whether there is sufficient basis to warrant a full investigation.

§ 457.930 Full investigation, resolution, and reporting requirements.

The State must establish and implement effective procedures for investigating and resolving suspected and apparent instances of fraud and abuse. Once the State determines that a full investigation is warranted, the State must implement procedures including, but not limited to the following:

(a) Cooperate with and refer potential fraud and abuse cases to the State program integrity unit, if such a unit exists.

(b) Conduct a full investigation.

(c) Refer the fraud and abuse case to appropriate law enforcement officials.

§ 457.935 Sanctions and related penalties.

(a) A State may not make payments for any item or service furnished, ordered, or prescribed under a separate child health program to any provider who has been excluded from participating in the Medicare and Medicaid programs.

(b) The following provisions and their corresponding regulations apply to a State under title XXI, in the same manner as these provisions and regulations apply to a State under title XIX:

(1) Part 455, subpart B of this chapter.

(2) Section 1124 of the Act pertaining to disclosure of ownership and related information.

(3) Section 1126 of the Act pertaining to disclosure by institutions, organizations, and agencies of owners and certain other individuals who have been convicted of certain offenses.

(4) Section 1128 of the Act pertaining to exclusions.

(5) Section 1128A of the Act pertaining to civil monetary penalties.

(6) Section 1128B of the Act pertaining to criminal penalties for acts involving Federal health care programs.

(7) Section 1128E of the Act pertaining to the reporting of final adverse actions on liability findings made against health care providers, suppliers, and practitioners under the health care fraud and abuse data collection program.

§ 457.940 Procurement standards.

(a) A State must submit to HCFA a written assurance that title XXI services will be provided in an effective and efficient manner. The State must submit the assurance—

(1) With the initial State plan; or

(2) For States with approved plans, with the first request to amend the approved plan.

(b) A State must—

(1) Provide for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services in accordance with the procurement requirements of 45 CFR 74.43; or

(2) Use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with principles of actuarial soundness as defined at § 457.902.

(c) A State may establish higher rates than permitted under paragraph (b) of this section if 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.

(d) All contracts under this part must include provisions that define a sound and complete procurement contract, as required by 45 CFR part 74.

(e) The State must provide to HCFA, if requested, a description of the manner in which rates were developed in accordance with the requirements of paragraphs (b) or (c) of this 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.

§ 457.950 Contract and payment requirements including certification of payment-related information.

(a) *Managed care entity (MCE).* A State that makes payments to an MCE under a separate child health program, based on data submitted by the MCE, must ensure that its contract requires the MCE to provide—

(1) Enrollment information and other information required by the State;

(2) An attestation to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury;

(3) Access for the State, HCFA, and the HHS Office of the Inspector General to enrollee health claims data and payment data, in conformance with the appropriate privacy protections in the State; and

(4) A guarantee that the MCE will not avoid costs for services covered in its contract by referring enrollees to

publicly supported health care resources.

(b) *Fee-for-service entities.* A State that makes payments to fee-for-service entities under a separate child health program must—

(1) Establish procedures to ensure that the entity certifies and attests that information on claim forms is truthful, accurate, and complete;

(2) Ensure that fee-for-service entities understand that payment and satisfaction of the claims will be from Federal and State funds, and that any false claims may be prosecuted under applicable Federal or State laws; and

(3) Require, as a condition of participation, that fee-for-service entities provide the State, HCFA and/or the HHS Office of the Inspector General with access to enrollee health claims data, claims payment data and related records.

§ 457.955 Conditions necessary to contract as a managed care entity (MCE).

(a) The State must assure that any entity seeking to contract as an MCE under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse.

(b) The State must ensure that the arrangements or procedures required in paragraph (a) of this section—

(1) Enforce MCE compliance with all applicable Federal and State standards;

(2) Prohibit MCEs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of a managed care entity for the purpose of influencing the individual to enroll with the entity; and

(3) Include a mechanism for the MCE to report to the State, to HCFA, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors or enrollees of an MCE and other individuals.

(c) With respect to enrollees, the reporting requirement in paragraph (b)(3) of this section applies only to information on violations of law that pertain to enrollment in the plan, or the provision of, or payment for, health services.

(d) The State may inspect, evaluate, and audit MCEs at any time, as necessary, in instances where the State determines that there is a reasonable possibility of fraudulent and abusive activity.

§ 457.960 Reporting changes in eligibility and redetermining eligibility.

If the State requires reporting of changes in circumstances that may affect the enrollee's eligibility for child health assistance, the State must:

(a) Establish procedures to ensure that enrollees make timely and accurate reports of any such change; and

(b) Promptly redetermine eligibility when the State has information about these changes.

§ 457.965 Documentation.

The State must include in each applicant's record facts to support the State's determination of the applicant's eligibility for SCHIP.

§ 457.980 Verification of enrollment and provider services received.

(a) The State must establish methodologies to verify whether beneficiaries have received services for which providers have billed.

(b) The State must establish and maintain systems to identify, report, and verify the accuracy of claims for those enrolled children who meet requirements of section 2105(a) of the Act, where enhanced Federal medical assistance percentage computations apply.

§ 457.985 Integrity of professional advice to enrollees.

The State must ensure through its contracts for coverage and services that its contractors comply with—

(a) Section 422.206(a) of this chapter, which prohibits interference with health care professionals' advice to enrollees and requires that professionals provide information about treatment in an appropriate manner; and

(b) Sections 422.208 and 422.210 of this chapter, which place limitations on physician incentive plans, and information disclosure requirements related to those physician incentive plans, respectively.

Subpart J—Allowable Waivers: General Provisions

§ 457.1000 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements—

(1) Section 2105(c)(2)(B) of the Act, which sets forth the requirements for a waiver to permit a State to exceed the 10 percent cost limit on expenditures other than benefit expenditures; and

(2) Section 2105(c)(3) of the Act, which permits a waiver for the purchase of family coverage.

(b) *Scope.* This subpart sets forth requirements for obtaining a waiver under title XXI.

(c) *Applicability.* This subpart applies to separate child health programs; and applies to Medicaid expansion programs when the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims for use of a community-based health delivery

system. This subpart does not apply to demonstrations requested under section 1115 of the Act.

§ 457.1003 HCFA review of waiver requests.

HCFA will review the waiver requests under this subpart using the same time frames used for State plan amendments, as specified in § 457.160.

§ 457.1005 Waiver for cost-effective coverage through a community-based health delivery system.

(a) *Availability of waiver.* The Secretary may waive the requirements of § 457.618 (the 10 percent limit on expenditures not used for health benefits coverage for targeted low-income children, that meets the requirements of § 457.410) in order to provide child health assistance to targeted low-income children under the State plan through a cost-effective, community-based health care delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or section 1923 of the Act.

(b) *Requirements for obtaining a waiver.* To obtain a waiver for cost-effective coverage through a community-based health delivery system, a State must demonstrate that—

(1) The coverage meets all of the requirements of this part, including subpart D and subpart E.

(2) The cost of such coverage, on an average per child basis, does not exceed the cost of coverage under the State plan.

(c) *Three-year approval period.* An approved waiver remains in effect for no more than 3 years.

(d) *Application of cost savings.* If the cost of coverage of a child under a community-based health delivery system is equal to or less than the cost of coverage of a child under the State plan, the State may use the difference in the cost of coverage for each child enrolled in a community-based health delivery system for—

(1) Other child health assistance, health services initiatives, or outreach; or

(2) Any reasonable costs necessary to administer the State's program.

§ 457.1010 Waiver for purchase of family coverage.

A State may purchase family coverage that includes coverage for targeted low-income children if the State establishes that—

(a) Purchase of family coverage is cost-effective under the standards described in § 457.1015;

(b) The State does not purchase the coverage if it would otherwise substitute for health insurance coverage that would be provided to targeted, low-income children but for the purchase of family coverage; and

(c) The coverage for the family otherwise meets the requirements of this part.

§ 457.1015 Cost-effectiveness.

(a) *Definition.* For purposes of this subpart, "cost-effective" means that the State's cost of purchasing family coverage that includes coverage for targeted low-income children is equal to or less than the State's cost of obtaining coverage under the State plan only for the eligible targeted low-income children involved.

(b) *Cost comparisons.* A State may demonstrate cost-effectiveness by comparing the cost of coverage for the family to the cost of coverage only for the targeted low-income children under the health benefits package offered by the State under the State plan for which the child is eligible.

(c) *Individual or aggregate basis.* (1) The State may base its demonstration of the cost-effectiveness of family coverage on an assessment of the cost of family coverage for individual families, done on a case-by-case basis, or on the cost of family coverage in the aggregate.

(2) The State must assess cost-effectiveness in its initial request for a waiver and then annually.

(3) For any State that chooses the aggregate cost method, if an annual assessment of the cost-effectiveness of family coverage in the aggregate reveals that it is not cost-effective, the State must assess cost-effectiveness on a case-by-case basis.

(d) *Reports on family coverage.* A State with a waiver under this section must include in its annual report pursuant to § 457.750, the cost of family coverage purchased under the waiver, and the number of children and adults, respectively, covered under family coverage pursuant to the waiver.

Subpart K—State Plan Requirements: Applicant and Enrollee Protections

§ 457.1100 Basis, scope and applicability.

(a) *Statutory basis.* This subpart interprets and implements—

(1) Section 2101(a) of the Act, which states that the purpose of title XXI of the Act is to provide 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;

(2) Section 2102(a)(7)(B) of the Act, which requires that the State plan include a description of the methods used to assure access to covered services, including emergency services;

(3) Section 2102(b)(2) of the Act, which requires that the State plan include a description of methods of establishing and continuing eligibility and enrollment; and

(4) Section 2103 of the Act, which outlines coverage requirements for a State that provides child health assistance through a separate child health program.

(b) *Scope.* This subpart sets forth minimum standards for privacy protection and for procedures for review of matters relating to eligibility, enrollment, and health services.

(c) *Applicability.* This subpart only applies to a separate child health program.

§ 457.1110 Privacy protections.

The State must ensure that, for individual medical records and any other health and enrollment information maintained with respect to enrollees, that identifies particular enrollees (in any form), the State establishes and implements procedures to—

(a) Abide by all applicable Federal and State laws regarding confidentiality and disclosure, including those laws addressing the confidentiality of information about minors and the privacy of minors, and privacy of individually identifiable health information;

(b) Comply with subpart F of part 431 of this chapter;

(c) Maintain the records and information in a timely and accurate manner;

(d) Specify and make available to any enrollee requesting it—

(1) The purposes for which information is maintained or used; and

(2) To whom and for what purposes the information will be disclosed outside the State;

(e) Except as provided by Federal and State law, ensure that each enrollee may request and receive a copy of records and information pertaining to the enrollee in a timely manner and that an enrollee may request that such records or information be supplemented or corrected.

§ 457.1120 State plan requirement: Description of review process.

A State plan must include a description of the State's review process that meets the requirements of §§ 457.1130, 457.1140, 457.1150, 457.1160, 457.1170, 457.1180, and 457.1190.

§ 457.1130 Matters subject to review.

(a) *Eligibility or enrollment matter.* A State must ensure that an applicant or enrollee has an opportunity for review, consistent with §§ 457.1140 and 457.1150, of a—

- (1) Denial of eligibility;
- (2) Failure to make a timely determination of eligibility; and
- (3) Suspension or termination of enrollment, including disenrollment for failure to pay cost sharing.

(b) *Health services matter.* A State must ensure that an enrollee has an opportunity for external review of a—

- (1) Delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; and
- (2) Failure to approve, furnish, or provide payment for health services in a timely manner.

(c) *Exception.* A State is not required to provide an opportunity for review of a matter described in paragraph (a) or (b) of this section if the sole basis for the decision is a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

§ 457.1140 Core elements of review.

In adopting the procedures for review of matters described in § 457.1130, a State must ensure that—

(a) Reviews are conducted by an impartial person or entity in accordance with § 457.1150;

(b) Review decisions are timely in accordance with § 457.1160;

(c) Review decisions are written; and

(d) Applicants and enrollees have an opportunity to—

(1) Represent themselves or have representatives of their choosing in the review process;

(2) Timely review their files and other applicable information relevant to the review of the decision;

(3) Fully participate in the review process, whether the review is conducted in person or in writing,

including by presenting supplemental information during the review process; and

(4) Receive continued enrollment in accordance with § 457.1170.

§ 457.1150 Impartial review.

(a) *Eligibility or enrollment matter.* The review of a matter described in § 457.1130(a) must be conducted by a person or entity who has not been directly involved in the matter under review.

(b) *Health services matter.* The State must ensure that an enrollee has an opportunity for an independent external review of a matter described in § 457.1130(b). External review must be conducted by the State or a contractor other than the contractor responsible for the matter subject to external review.

§ 457.1160 Time frames.

(a) *Eligibility or enrollment matter.* A State must complete the review of a matter described in § 457.1130(a) within a reasonable amount of time. In setting time frames, the State must consider the need for expedited review when there is an immediate need for health services.

(b) *Health services matter.* The State must ensure that reviews are completed in accordance with the medical needs of the patient. If the medical needs of the patient do not dictate a shorter time frame, the review must be completed within the following time frames:

(1) *Standard timeframe.* A State must ensure that external review, as described in § 457.1150(b), is completed within 90 calendar days of the date an enrollee requests internal (if available) or external review. If both internal and external review are available to the enrollee, both types of review must be completed within the 90 calendar day period.

(2) *Expedited timeframe.* A State must ensure that external review, as described in § 457.1150(b), is completed within 72 hours of the time an enrollee requests external review, if the enrollee's physician or health plan determines that operating under the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. If the enrollee has

access to internal and external review, then each level of review may take no more than 72 hours. The State may extend the 72-hour time frame by up to 14 calendar days, if the enrollee requests an extension.

§ 457.1170 Continuation of enrollment.

A State must ensure the opportunity for continuation of enrollment pending the completion of review of a suspension or termination of enrollment, including a decision to disenroll for failure to pay cost sharing.

§ 457.1180 Notice.

A State must provide enrollees and applicants timely written notice of any determinations required to be subject to review under § 457.1130 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, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

§ 457.1190 Application of review procedures when States offer premium assistance for group health plans.

A State that has a premium assistance program through which it provides coverage under a group health plan that does not meet the requirements of §§ 457.1130(b), 457.1140, 457.1150(b), 457.1160(b), and 457.1180 must give applicants and enrollees the option to obtain health benefits coverage other than through that group health plan. The State must provide this option at initial enrollment and at each redetermination of eligibility.

(Catalog of Federal Domestic Assistance Program No. 00.000, State Children's Health Insurance Program)

Dated: January 4, 2001.

Robert A. Berenson,
Acting Deputy Administrator, Health Care Financing Administration.

Dated: January 4, 2001.

Donna E. Shalala,
Secretary.

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