SUBCHAPTER D—STATE CHILDREN'S HEALTH INSURANCE PROGRAMS (SCHIPs)

PART 457—ALLOTMENTS AND GRANTS TO STATES

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 CMS review of State plan material.
457.160 Notice and timing of CMS action on State plan material.
457.170 Withdrawal process.

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

457.200 Program reviews.
457.202 Audits.
457.203 Administrative and judicial review of action on State plan material.
457.204 Withholding of payment for failure to comply with Federal requirements.
457.206 Administrative appeals under CHIP.
457.208 Judicial review.
457.216 Treatment of uncashed or canceled (voided) CHIP checks.
457.220 Funds from units of government as the State share of financial participation.
457.222 FFP for equipment.
457.224 FFP: Conditions relating to cost sharing.
457.226 Fiscal policies and accountability.
457.228 Cost allocation.
457.230 FFP for State ADP expenditures.
457.232 Refunding of Federal share of CHIP overpayments to providers and referral of allegations of waste, fraud or abuse of the Office of Inspector General.
457.236 Audit of records.
457.238 Documentation of payment rates.

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

457.300 Basis, scope, and applicability.
457.301 Definitions and use of terms.
457.305 State plan provisions.
457.310 Targeted low-income child.
457.315 Application of modified adjusted gross income and household
457.320 Other eligibility standards.
457.330 Application.
457.340 Application for and enrollment in CHIP.
457.342 Continuous eligibility for children.
457.343 Periodic renewal of CHIP eligibility.
457.348 Determinations of Children's Health Insurance Program eligibility by other insurance affordability programs.
457.350 Eligibility screening and enrollment in other insurance affordability programs.
457.351 Coordination involving appeals entities for different insurance affordability programs.
457.353 Monitoring and evaluation of screening process.
457.355 Presumptive eligibility for children.
457.360 Deemed newborn children.
457.370 Alignment with Exchange initial open enrollment period.
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 Prohibited coverage limitations, 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.
457.496 Parity in mental health and substance use disorder benefits.

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 F—Payment to States

457.600 Purpose and basis of this subpart.
457.602 Applicability.
457.606 Conditions for State allotments and Federal payments for a fiscal year.
457.608 Process and calculation of State allotments prior to FY 2009.
457.609 Process and calculation of State allotments for a fiscal year after FY 2008.
457.610 Period of availability for State allotments prior to FY 2009.
457.611 Period of availability for State allotments for a fiscal year after FY 2008.
457.614 General payment process.
457.616 Application and tracking of payments against the fiscal year allotments.
457.618 Ten percent limit on certain Children's Health Insurance Program expenditures.
457.622 Rate of FFP for State expenditures.
457.626 Prevention of duplicate payments.
457.628 Other applicable Federal regulations.
457.630 Grants procedures.

Subpart G—Strategic Planning, Reporting, and Evaluation

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.
457.730 Beneficiary access to and exchange of data.
457.731 Access to and exchange of health data for providers and payers.
457.732 Prior authorization requirements.
457.740 State expenditures and statistical reports.
457.750 Annual report.
457.760 Access to published provider directory information.
457.770 Reporting on Health Care Quality Measures.

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.
457.910 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.
457.965 Documentation.
457.980 Verification of enrollment and provider services received.
457.985 Integrity of professional advice to enrollees.

Subpart J—Allowable Waivers: General Provisions

457.990 Provider and supplier screening, oversight, and reporting requirements.
457.1000 Basis, scope, and applicability.
457.1003 CMS review of waiver requests.
457.1005 Cost-effective coverage through a community-based health delivery system.
457.1010 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 Program specific review process: Matters subject to review.

457.1140 Program specific review process: Core elements of review.
457.1150 Program specific review process: Impartial review.
457.1160 Program specific review process: Time frames.
457.1170 Program specific review process: Continuation of enrollment.
457.1180 Program specific review process: Notice.
457.1190 Application of review procedures when States offer premium assistance for group health plans.

Subpart L—Managed Care

GENERAL PROVISIONS

457.1200 Basis, scope, and applicability.
457.1201 Standard contract requirements.
457.1203 Rate development standards and medical loss ratio.
457.1206 Non-emergency medical transportation PAHPs.
457.1207 Information requirements.
457.1208 Provider discrimination prohibited.
457.1209 Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care provider (IHCP), and Indian managed care entities (IMCE).

STATE RESPONSIBILITIES

457.1210 Enrollment process.
457.1212 Disenrollment.
457.1214 Conflict of interest safeguards.
457.1216 Continued services to enrollees.
457.1218 Network adequacy standards.

ENROLLEE RIGHTS AND PROTECTIONS

457.1220 Enrollee rights.
457.1222 Provider-enrollee communication.
457.1224 Marketing activities.
457.1226 Liability for payment.
457.1228 Emergency and poststabilization services.

MCO, PIHP, AND PAHP STANDARDS

457.1230 Access standards.
457.1233 Structure and operation standards.

QUALITY MEASUREMENT AND IMPROVEMENT; EXTERNAL QUALITY REVIEW

457.1240 Quality measurement and improvement.
457.1250 External quality review.

GRIEVANCE SYSTEM

457.1260 Grievance system.

SANCTIONS

457.1270 Sanctions.
457.1280 Conditions necessary to contract as an MCO, PAHP, or PIHP.
457.1285 Program integrity safeguards.

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

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§ 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:

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.

Advanced payments of the premium tax credit (APTC) has the meaning given the term in 45 CFR 155.20.

Affordable Insurance Exchange (Exchange) has the meaning given the term ''Exchange'' in 45 CFR 155.20.

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 Children's Health Insurance Program. A child is an applicant until the child receives coverage through CHIP.

Application means the single, streamlined application form that is used by the State in accordance with § 435.907(b) of this chapter and 45 CFR 155.405 for individuals to apply for coverage for all insurance affordability programs.

Child means an individual under the age of 19 including the period from conception to birth.

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.

Children's Health Insurance Program (CHIP) 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.

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

Combined eligibility notice means an eligibility notice that informs an individual, or multiple family members of a household of eligibility for each of the insurance affordability programs and enrollment in a qualified health plan through the Exchange, for which a determination or denial of eligibility was made, as well as any right to request a review, fair hearing or appeal related to the determination made for each program. A combined notice must meet the requirements of § 457.340(e) and contain the content described in § 457.340(e)(1), except that information described in § 457.340(e)(1)(i)(C) may be provided in a combined notice issued by another insurance affordability program or in a supplemental notice provided by the State. A combined eligibility notice must be issued in accordance with the agreement(s) consummated by the State in accordance with § 457.348(a).

Comprehensive risk contract means a risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

(1) Outpatient hospital services.

(2) Rural health clinic services.

(3) Federally Qualified Health Center (FQHC) services.

(4) Other laboratory and X-ray services.

(5) Nursing facility (NF) services.

(6) Early and periodic screening, diagnostic, and treatment (EPSDT) services.

(7) Family planning services.

(8) Physician services.

(9) Home health services.

Coordinated content means information included in an eligibility notice regarding, if applicable—

(1) The transfer of an individual's or household's electronic account to another insurance affordability program;

(2) Any notice sent by the State to another insurance affordability program regarding an individual's eligibility for CHIP;

(3) The potential impact, if any, of—

(i) The State's determination of eligibility or ineligibility for CHIP on eligibility for another insurance affordability program; or

(ii) A determination of eligibility for, or enrollment in, another insurance affordability program on an individual's eligibility for CHIP; and

(iii) [Reserved]

(4) The status of household members on the same application or renewal

form whose eligibility is not yet determined.

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.

Electronic account means an electronic file that includes all information collected and generated by the State regarding each individual's CHIP eligibility and enrollment, including all documentation required under § 457.380 and including any information collected or generated as part of a review process conducted in accordance with subpart K of this part, the Exchange appeals process conducted under 45 CFR part 155, subpart F or other insurance affordability program appeals process.

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 CHIP.

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.

Exchange appeals entity has the meaning given to the term ''appeals entity,'' as defined in 45 CFR 155.500.

External quality review (EQR) means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO, PIHP, or PAHP, or their contractors furnish to CHIP beneficiaries.

External quality review organization (EQRO) means an organization that meets the competence and independence requirements set forth in § 438.354 of this chapter, and holds a contract with a State to perform external quality review, other EQR-related activities as set forth in § 438.358 of this chapter, or both.

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

Federally qualified HMO means an HMO that CMS has determined is a qualified HMO under section 2791(b)(3) of the Public Health Service Act.

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.

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).

Household income is defined as provided in § 435.603(d) of this chapter.

In lieu of service or setting (ILOS) is defined as provided in § 438.2 of this chapter.

Insurance affordability program is defined as provided in § 435.4 of this chapter.

Joint application has the meaning assigned at § 457.301.

Joint review request means a request for a review under subpart K of this part which is included in an appeal request submitted to an Exchange or Exchange appeals entity or other insurance affordability program or appeals entity, in accordance with the signed agreement between the State and an Exchange or Exchange appeals entity or other program or appeals entity in accordance with § 457.348(b).

Low-income child means a child whose household 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.

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is—

(1) A Federally qualified HMO that meets the requirements of subpart I of part 489 of this chapter; or

(2) Makes the services it provides to its CHIP enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other CHIP beneficiaries within the area served by the entity and

(3) Meets the solvency standards of § 438.116 of this chapter.

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 CHIP enrollee or enrollees' group health insurance coverage or coverage under a group health plan.

Premium Lock-Out is defined as a State-specified period of time not to exceed 90 days that a CHIP eligible child who has an unpaid premium or enrollment fee (as applicable) will not be permitted to reenroll for coverage in CHIP. Premium lock-out periods are not applicable to children who have paid outstanding premiums or enrollment fees.

Prepaid ambulatory health plan (PAHP) means an entity that—

(1) Provides services to enrollees under contract with the State, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates.

(2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees.

(3) Does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP) means an entity that—

(1) Provides services to enrollees under contract with the State, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates.

(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees.

(3) Does not have a comprehensive risk contract.

Presumptive income standard has the meaning assigned at § 457.301.

Primary care case management means a system under which:

(1) A PCCM contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to CHIP beneficiaries; or

(2) A PCCM entity contracts with the State to provide a defined set of functions to CHIP beneficiaries.

Primary care case management entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the State:

(1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.

(2) Development of enrollee care plans.

(3) Execution of contracts with and/or oversight responsibilities for the activities of fee-for-service providers in the fee-for-service program.

(4) Provision of payments to fee-for-service providers on behalf of the State.

(5) Provision of enrollee outreach and education activities.

(6) Operation of a customer service call center.

(7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.

(8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.

(9) Coordination with behavioral health systems/providers.

(10) Coordination with long-term services and supports systems/providers.

Primary care case manager (PCCM) means a physician, a physician group practice or, at State option, any of the following in addition to primary care case management services:

(1) A physician assistant.

(2) A nurse practitioner.

(3) A certified nurse-midwife.

Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.

Public agency has the meaning assigned in § 457.301.

Qualified entity has the meaning assigned at § 457.301.

Risk contract means a contract under which the contractor—

(1) Assumes risk for the cost of the services covered under the contract.

(2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Secure electronic interface is defined as provided in § 435.4 of this chapter.

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.

Shared eligibility service is defined as provided in § 435.4 of this chapter.

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 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.

[66 FR 2670, Jan. 11, 2001, as amended at 67 FR 61974, Oct. 2, 2002; 75 FR 48852, Aug. 11, 2010; 77 FR 17213, Mar. 23, 2012; 78 FR 42312, July 15, 2013; 81 FR 27896, May 6, 2016; 81 FR 47046, July 20, 2016; 81 FR 86463, Nov. 30, 2016; 89 FR 41284, May 10, 2024]

§ 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 CHIP, 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. CMS 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 CMS.

§ 457.50 State plan.

The State plan is a comprehensive written statement, submitted by the State to CMS for approval, that describes the purpose, nature, and scope of the State's CHIP 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 CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program. The Secretary will periodically specify updated requirements on the format of State plan through a process consistent with the requirements of the Paperwork Reduction Act.

[81 FR 86463, Nov. 30, 2016]

§ 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 CMS. The Secretary will periodically specify updated requirements on the format of State plan amendments through a process consistent with the requirements of the Paperwork Reduction Act. 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 as described in § 457.805, and in § 457.810 for premium assistance programs.

(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.

(8) Review procedures as described in § 457.1120.

(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.

[66 FR 2670, Jan. 11, 2001, as amended at 66 FR 33822, June 25, 2001; 81 FR 86463, Nov. 30, 2016]

§ 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 CMS 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 CMS 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 CMS 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 institutes or extends the use of waiting lists, enrollment 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.

[66 FR 2670, Jan. 11, 2001, as amended at 89 FR 22873, Apr. 2, 2024]

§ 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 CHIP 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 CHIP of children determined ineligible for Medicaid; and

(3) Ensure coordination with other insurance affordability programs in the determination of eligibility and enrollment in coverage to ensure that all eligible individuals are enrolled in the appropriate program, including through use of the procedures described in §§ 457.305, 457.348 and 457.350 of this part.

[65 FR 33622, May 24, 2000, as amended at 77 FR 17214, Mar. 23, 2012]

§ 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, 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. This information must be provided in plain language and is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.

(1) The State must provide individuals with a choice to receive notices and information required under this subpart and subpart K of this part, in electronic format or by regular mail, provided that the State establish safeguards in accordance with § 435.918 of this chapter.

(2) [Reserved]

(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.

[65 FR 33622, May 24, 2000, as amended at 78 FR 42312, July 15, 2013; 81 FR 86463, Nov. 30, 2016]

§ 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 CMS review of State plan material.

(a) *Basis for action.* CMS 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 CMS to assist in the interpretation of these regulations.

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

(c) *Authority.* The CMS 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 CMS's review for each State that submits a State plan.

(2) CMS 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 CMS 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 CMS, within 90 calendar days after receipt of the State plan or plan amendment in the CMS 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 CMS requests additional information, the 90-day review period for CMS action on the State plan or plan amendment—

(i) Stops on the day CMS 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 CMS 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 or any time on 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, CMS will consider the 90th day to be the next business day.

(5) CMS 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 CMS 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 CMS 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

§ 457.200 Program reviews.

(a) *Review of State and local administration of the CHIP plan.* In order to determine whether the State is complying with the Federal requirements and the provisions of its plan, CMS reviews State and local administration of the CHIP plan through analysis of the State's policies and procedures, on-site reviews of selected aspects of agency operation, and examination of samples of individual case records.

(b) *Action on review findings.* If Federal or State reviews reveal serious problems with respect to compliance with any Federal or State plan requirement, the State must correct its practice accordingly.

§ 457.202 Audits.

(a) *Purpose.* The Department's Office of Inspector General (OIG) periodically audits State operations in order to determine whether—

(1) The program is being operated in a cost-efficient manner; and

(2) Funds are being properly expended for the purposes for which they were appropriated under Federal and State law and regulations.

(b) *Reports.* (1) The OIG releases audit reports simultaneously to State officials and the Department's program officials.

(2) The reports set forth OIG opinion and recommendations regarding the practices it reviewed, and the allowability of the costs it audited.

(3) Cognizant officials of the Department make final determinations on all audit findings.

(c) *Action on audit exceptions*—(1) *Concurrence or clearance.* The State agency has the opportunity of concurring in the exceptions or submitting additional facts that support clearance of the exceptions.

(2) *Appeal.* Any exceptions that are not disposed of under paragraph (c)(1) of this section are included in a disallowance letter that constitutes the Department's final decision unless the State requests reconsideration by the Appeals Board. (Specific rules are set forth in § 457.212.)

(3) *Adjustment.* If the decision by the Board requires an adjustment of FFP, either upward or downward, a subsequent grant award promptly reflects the amount of increase or decrease.

§ 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.* CMS 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, CMS will pay the State a lump sum equal to any funds incorrectly denied.

[66 FR 2674, Jan. 11, 2001]

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

(a) *Basis for withholding.* CMS withholds payments to the State, in whole or in part, only if, after giving the State notice, a reasonable opportunity for correction, and an opportunity for a hearing, the Administrator finds—

(1) That the State plan is in substantial noncompliance with the requirements of Title XXI of the Act or the regulations in this part; or

(2) That the State is conducting its program in substantial noncompliance with either the State plan or the requirements of Title XXI of the Act or the regulations in this part. (Hearings are generally not called until a reasonable effort has been made to resolve the issues through conferences and discussions. These efforts may be continued even if a date and place have been set for the hearing.)

(3) For purposes of this paragraph (a), substantial non-compliance includes, but is not limited to, failure to comply with requirements that significantly affect federal or state oversight or state reporting.

(b) *Noncompliance of the plan.* A question of noncompliance of a State plan may arise from an unapprovable change in the approved State plan or the failure of the State to change its approved plan to conform to a new Federal requirement for approval of State plans.

(c) *Noncompliance in practice.* A question of noncompliance in practice may arise from the State's failure to actually comply with a Federal requirement, regardless of whether the plan itself complies with that requirement.

(d) *Notice, reasonable opportunity for correction, and implementation of withholding.* If the Administrator makes a finding of noncompliance under paragraph (a) of this section, the following steps apply:

(1) *Preliminary notice.* The Administrator provides a preliminary notice to the State—

(i) Of the findings of noncompliance;

(ii) The proposed enforcement actions to withhold payments; and

(iii) If enforcement action is proposed, that the State has a reasonable opportunity for correction, described in paragraph (d)(2) of this section, before the Administrator takes final action.

(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.

(3) *Final notice.* Taking into account any evidence submitted by the State under paragraph (d)(2) of this section, the Administrator makes a final determination related to the findings of noncompliance, and provides a final notice to the State—

(i) Of the final determination on the findings of noncompliance;

(ii) If enforcement action is appropriate—

(A) No further payments will be made to the State (or that payments will be made only for those portions or aspects of the programs that are not affected by the noncompliance); and

(B) The total or partial withholding will continue until the Administrator is satisfied that the State's plan and practice are, and will continue to be, in compliance with Federal requirements.

(4) *Hearing.* An opportunity for a hearing will be provided to the State prior to withholding under paragraph (d)(5) of this section.

(5) Withholding. CMS withholds payments, in whole or in part, until the

Administrator is satisfied regarding the State's compliance.

[65 FR 33622, May 24, 2000, as amended at 66 FR 2674, Jan. 11, 2001; 81 FR 27897, May 6, 2016]

§ 457.206 Administrative appeals under CHIP.

Three distinct types of determinations are subject to Departmental reconsideration upon request by a State.

(a) *Compliance with Federal requirements.* A determination that a State's plan or proposed plan amendments, or its practice under the plan do not meet (or continue to meet) Federal requirements are subject to the hearing provisions of 42 CFR part 430, subpart D of this chapter.

(b) *FFP in State CHIP expenditures.* Disallowances of FFP in State CHIP expenditures (mandatory grants) are subject to Departmental reconsideration by the Departmental Appeals Board (the Board) in accordance with procedures set forth in 45 CFR part 16.

(c) *Discretionary grants disputes.* Determinations listed in 45 CFR part 16, appendix A, pertaining to discretionary grants, such as grants for special demonstration projects under Section 1115 of the Act, that may be awarded to an CHIP agency, are subject to reconsideration by the Departmental Grant Appeals Board.

§ 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.

(b) *Petition for review.* (1) The State must file a petition for review with the U.S. Court of Appeals for the circuit in which the State is located, within 60 days after it is notified of the determination.

(2) After the clerk of the court files a copy of the petition with the Administrator, the Administrator files in the court the record of the proceedings on which the determination was based.

(c) *Court action.* (1) The court is bound by the Administrator's findings of fact, if they are supported by substantial evidence.

(2) The court has jurisdiction to affirm the Administrator's decision, to set it aside in whole or in part, or, for good cause, to remand the case for additional evidence.

(d) *Response to remand.* (1) If the court remands the case, the Administrator may make new or modified findings of fact and may modify his or her previous determination.

(2) The Administrator certifies to the court the transcript and record of the further proceedings.

(e) *Review by the Supreme Court.* The judgment of the appeals court is subject to review by the U.S. Supreme Court upon certiorari or certification, as provided in 28 U.S.C. 1254.

[65 FR 33622, May 24, 2000, as amended at 66 FR 2674, Jan. 11, 2001]

§ 457.216 Treatment of uncashed or canceled (voided) CHIP checks.

(a) *Purpose.* This section provides rules to ensure that States refund the Federal portion of uncashed or canceled (voided) checks under title XXI.

(b) *Definitions.* As used in this section—

Canceled (voided) check means an CHIP check issued by a State or fiscal agent that prior to its being cashed is canceled (voided) by the State or fiscal agent, thus preventing disbursement of funds.

Fiscal agent means an entity that processes or pays vendor claims for the CHIP agency.

Uncashed check means an CHIP check issued by a State or fiscal agent that has not been cashed by the payee.

Warrant means an order by which the CHIP agency or local agency without the authority to issue checks recognizes a claim. Presentation of a warrant by the payee to a State officer with authority to issue checks will result in release of funds due.

(c) *Refund of Federal financial participation (FFP) for uncashed checks*—(1) *General provisions.* If a check remains uncashed beyond a period of 180 days from the date it was issued; that is, the date of the check, it is no longer regarded as an allowable program expenditure. If the State has claimed and received FFP for the amount of the uncashed check, it must refund the amount of FFP received.

(2) *Report of refund.* At the end of each calendar quarter, the State agency must identify those checks that remain uncashed beyond a period of 180 days after issuance. The CHIP agency must refund all FFP that it received for uncashed checks by adjusting the Quarterly Statement of Expenditures for that quarter. If an uncashed check is cashed after the refund is made, the State may file a claim. The claim will be considered to be an adjustment to the costs for the quarter in which the check was originally claimed. This claim will be paid if otherwise allowed by the Act and the regulations issued in accordance with the Act.

(3) If the State does not refund the appropriate amount as specified in paragraph (c)(2) of this section, the amount will be disallowed.

(d) *Refund of FFP for canceled (voided) checks*—(1) *General provisions.* If the State has claimed and received FFP for the amount of a canceled (voided) check, it must refund the amount of FFP received.

(2) *Report of refund.* At the end of each calendar quarter, the CHIP agency must identify those checks that were canceled (voided). The State must refund all FFP that it received for canceled (voided) checks by adjusting the Quarterly Statement of Expenditures for that quarter.

(3) If the State does not refund the appropriate amount as specified in paragraph (d)(2) of this section, the amount will be disallowed.

§ 457.220 Funds from units of government as the State share of financial participation.

(a) Public funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.

(b) The public funds are appropriated directly to the State or local CHIP agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and are under its administrative control, or are certified by the contributing public agency as representing expenditures eligible for FFP under this section.

(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

[75 FR 73976, Nov. 30, 2010]

§ 457.222 FFP for equipment.

Claims for Federal financial participation in the cost of equipment under CHIP are determined in accordance with subpart G of 45 CFR part 95. Requirements concerning the management and disposition of equipment under CHIP are also prescribed in subpart G of 45 CFR part 95.

§ 457.224 FFP: Conditions relating to cost sharing.

(a) No FFP is available for the following amounts, even when related to services or benefit coverage which is or could be provided under a State CHIP program—

(1) Any cost sharing amounts that beneficiaries should have paid as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charges.

(2) Any amounts paid by the agency for health benefits coverage or services furnished to individuals who would not be eligible for that coverage or those services under the approved State child health plan, whether or not the individual paid any required premium or enrollment fee.

(b) The amount of expenditures under the State child health plan must be reduced by the amount of any premiums and other cost-sharing received by the State.

§ 457.226 Fiscal policies and accountability.

A State plan must provide that the CHIP agency and, where applicable, local agencies administering the plan will—

(a) Maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements;

(b) Retain records for 3 years from date of submission of a final expenditure report;

(c) Retain records beyond the 3-year period if audit findings have not been resolved; and

(d) Retain records for nonexpendable property acquired under a Federal

grant for 3 years from the date of final disposition of that property.

§ 457.228 Cost allocation.

A State plan must provide that the single or appropriate CHIP Agency will have an approved cost allocation plan on file with the Department in accordance with the requirements contained in subpart E of 45 CFR part 95. Subpart E also sets forth the effect on FFP if the requirements contained in that subpart are not met.

§ 457.230 FFP for State ADP expenditures.

FFP is available for State ADP expenditures for the design, development, or installation of mechanized claims processing and information retrieval systems and for the operation of certain systems. Additional HHS regulations and CMS procedures regarding the availability of FFP for ADP expenditures are in 45 CFR part 75, 45 CFR part 95, subpart F, and part 11, State Medicaid Manual.

[65 FR 33622, May 24, 2000, as amended at 81 FR 3012, Jan. 20, 2016]

§ 457.232 Refunding of Federal Share of CHIP overpayments to providers and referral of allegations of waste, fraud or abuse to the Office of Inspector General.

(a) Quarterly Federal payments to the States under title XXI (CHIP) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.

(b) The Secretary will consider the pro rata Federal share of the net amount recovered by a State during any quarter to be an overpayment.

(c) Allegations or indications of waste fraud and abuse with respect to the CHIP program shall be referred promptly to the Office of Inspector General.

§ 457.236 Audits.

The CHIP agency must assure appropriate audit of records on costs of provider services.

§ 457.238 Documentation of payment rates.

The CHIP agency must maintain documentation of payment rates and make it available to HHS upon request.

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

SOURCE: 66 FR 2675, Jan. 11, 2001, unless otherwise noted.

§ 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.

(4) Section 2107(e)(1)(O) of the Affordable Care Act, which relates to coordination of CHIP with the Exchanges and the State Medicaid agency.

(5) Section 2107(e)(1)(F) of the Affordable Care Act, which relates to income determined based on modified adjusted gross income.

(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 §§ 435.4, 435.229, 435.905 through 435.908, 435.1102, 435.940 through

435.958, 435.1200, 436.3, 436.229, and 436.1102 of this chapter.

[65 FR 33622, May 24, 2000, as amended at 77 FR 17214, Mar. 23, 2012]

§ 457.301 Definitions and use of terms.

As used in this subpart—

Eligibility determination means an approval or denial of eligibility in accordance with § 457.340 as well as a renewal or termination of eligibility under § 457.343 of this subpart.

Family size is defined as provided in § 435.603(b) of this chapter.

Medicaid applicable income level means, for a child, the effective income level (expressed as a percentage of the Federal poverty level and converted to a modified adjusted gross income equivalent level in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act) specified under the policies of the State plan under title XIX of the Act as of March 31, 1997 for the child to be eligible for Medicaid under either section 1902(l)(2) or 1905(n)(2) of the Act, or under a section 1115 waiver authorized by the Secretary (taking into consideration any applicable income methodologies adopted under the authority of section 1902(r)(2) of the Act).

Non-applicant means an individual who is not seeking an eligibility determination for him or herself and is included in an applicant's or enrollee's household to determine eligibility for such applicant or enrollee.

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.

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.

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.

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 authorized to determine eligibility of a child for medical assistance under the Medicaid State plan, or eligibility of a child for child health assistance under the Children's Health Insurance Program;

(6) 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);

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

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

(9) Is an organization that—

(i) Provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

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

(iii) 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.*); and

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

State health benefits plan means a health insurance coverage plan that is offered or organized by the State government on behalf of State employees or other public agency employees within the State. The term does not include a plan in which the State provides no contribution toward the cost of coverage and in which no State employees participate, or a plan that provides coverage only for a specific type of care, such as dental or vision care.

[66 FR 2675, Jan. 11, 2001, as amended at 66 FR 33823, June 25, 2001; 75 FR 48852, Aug. 11, 2010; 77 FR 17214, Mar. 23, 2012]

§ 457.305 State plan provisions.

The State plan must include a description of—

(a) The standards, consistent with § 457.310 and § 457.320 of this subpart, and financial methodologies consistent with § 457.315 of this subpart 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 applicants for and, if eligible, facilitating their enrollment in other insurance affordability programs; and processes for implementing waiting lists and enrollment caps (if any).

[77 FR 17214, Mar. 23, 2012]

§ 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 household income, as determined in accordance with § 457.315 of this subpart, at or below 200 percent of the Federal poverty level for a family of the size involved;

(ii) Resides in a State with no Medicaid applicable income level;

(iii) Resides in a State that has a Medicaid applicable income level and has a household 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), except for eligibility under § 435.214 of this chapter (related to coverage for family planning services);

(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 § 435.1010 of this chapter; or

(ii) A patient in an institution for mental diseases, as defined at § 435.1010 of this chapter, at the time of initial application or any redetermination of eligibility.

(d) A targeted low-income child must also include any child enrolled in Medicaid on December 31, 2013 who is determined to be ineligible for Medicaid as a result of the elimination of income disregards as specified under § 435.603(g) of this chapter, regardless of any other standards set forth in this section except those in paragraph (c) of this section. Such a child shall continue to be a targeted low-income child under this paragraph until the date of the child's next renewal under § 457.343 of this subpart.

[66 FR 2675, Jan. 11, 2001, as amended at 71 FR 39229, July 12, 2006; 77 FR 17214, Mar. 23, 2012; 81 FR 86463, Nov. 30, 2016]

§ 457.315 Application of modified adjusted gross income and household definition.

(a) Effective January 1, 2014, the State must apply the financial methodologies set forth in paragraphs (b) through (i) of § 435.603 of this chapter in determining the financial eligibility of all individuals for CHIP. The exception to application of such methods for individuals for whom the State relies on a finding of income made by an Express Lane agency at § 435.603(j)(1) of this subpart also applies.

(b) In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under § 457.343, whichever is later.

[77 FR 17214, Mar. 23, 2012]

§ 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) Spenddowns;

(5) Residency, in accordance with paragraph (d) of this section;

(6) Disability status, provided that such standards do not restrict eligibility;

(7) Access to, or coverage under, other health coverage; and

(8) 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 household income without covering children with a lower household 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 any family member who is not requesting services to provide a social security number (including those family members 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) [Reserved]

(d) *Citizenship and immigration status.* All individuals seeking coverage under a separate child health plan must make a declaration of United States citizenship or satisfactory immigration status. Such declaration may be made by an adult member of the individual's household, an authorized representative, as defined in § 435.923 of this chapter (referenced at § 457.340), or if the individual is a minor or incapacitated, someone acting responsibly for the individual provided that such individual attests to having knowledge of the individual's status.

(e) *Residency.* (1) Residency for a noninstitutionalized child who is not a ward of the State must be determined in accordance with § 435.403(i) of this chapter.

(2) Residency for a targeted low-income pregnant woman defined at 2112 of the Act must be determined in accordance with § 435.403(h) of this chapter.

(3) A State may not—

(i) Impose a durational residency requirement;

(ii) Preclude the following individuals from declaring residence in a State—

(A) 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 or caretaker at the time of placement; or

(B) A child who is a ward of a State, regardless of where the child lives

(4) In cases of disputed residency, the State must follow the process described in § 435.403(m) of this chapter.

(f) *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) [Reserved]

[66 FR 2675, Jan. 11, 2001, as amended at 66 FR 33823, June 25, 2001, 77 FR 17214, Mar. 23, 2012; 81 FR 86463, Nov. 30, 2016]

EFFECTIVE DATE NOTE: At 89 FR 39436, May 8, 2024, § 457.320 was amended by removing all instances of the words ''qualified aliens'' and adding in its place the words ''qualified noncitizens'' and revising paragraphs (b)(6) and adding paragraph (c), effective Nov. 1, 2024. For the convenience of the user, the added and revised text is set forth as follows:

§ 457.320 Other eligibility standards.

* * * * *

(b) * * *

(6) Exclude individuals based on citizenship or nationality, to the extent that the children are U.S. citizens, U.S. nationals or qualified noncitizens (as defined at paragraph (c) of this section); or

* * * * *

(c) *Definitions.* As used in this subpart:

Qualified noncitizen has the meaning assigned at § 435.4 of this chapter.

§ 457.330 Application.

The State shall use the single, streamlined application used by the State in accordance with paragraph (b) of § 435.907 of this chapter, and otherwise comply with such section, except that the terms of § 435.907(c) of this chapter (relating to applicants seeking coverage on a basis other than modified adjusted gross income) do not apply.

[77 FR 17215, Mar. 23, 2012]

§ 457.340 Application for and enrollment in CHIP.

(a) *Application and renewal assistance, availability of program information, and Web site.* The terms of §§ 435.905, 435.906, 435.908, and 435.1200(f) of this chapter apply equally to the State in administering a separate CHIP.

(b) *Use of Social Security number.* The terms of §§ 435.910 and 435.907(e) of this chapter regarding the provision and use of Social Security Numbers and non-applicant information apply equally to the State in administering a separate CHIP.

(c) *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.

(d) *Timely determination and redetermination of eligibility.* (1) The terms in § 435.912 of this chapter apply equally to CHIP, except that—

(i) The terms of § 435.912(c)(4)(ii), (c)(5)(iii), and (c)(6)(ii) of this chapter (relating to timelines for completing renewals and redeterminations when States must consider other bases of eligibility) do not apply; and

(ii) The standards for transferring electronic accounts to other insurance affordability programs are pursuant to § 457.350 and the standards for receiving applications from other insurance affordability programs are pursuant to § 457.348.

(2) In applying timeliness standards, the State must define ''date of application'' and must count each calendar day from the date of application to the day the agency provides notice of its eligibility decision.

(3) In the case of individuals subject to a period of uninsurance under this part, the state must identify and implement processes to facilitate enrollment of CHIP-eligible children who have satisfied a period of uninsurance (as described under § 457.805). To minimize burden on individuals, a state may not require a new application or information already provided by a family immediately preceding the beginning of a waiting period. States must also ensure that the proper safeguards are in place to prevent a disruption in coverage for children transitioning from coverage under another insurance affordability program after the completion of a period of uninsurance.

(e) *Notice of eligibility determinations.* The State must provide each applicant or enrollee with timely and adequate written notice of any decision affecting his or her eligibility, including an approval, denial or termination, or suspension of eligibility, consistent with §§ 457.315, 457.348, and 457.350. The notice must be written in plain language; and accessible to persons who are limited English proficient and individuals with disabilities, consistent with § 435.905(b) of this chapter and § 457.110.

(1) *Content of eligibility notice.* (i) Any notice of an approval of CHIP eligibility must include, but is not limited to, the following—

(A) The basis and effective date of eligibility;

(B) The circumstances under which the individual must report and procedures for reporting, any changes that may affect the individual's eligibility;

(C) Basic information on benefits and services and if applicable, any premiums, enrollment fees, and cost sharing required, and an explanation of how to receive additional detailed information on benefits and financial responsibilities; and

(D) Information on the enrollees' right and responsibilities, including the opportunity to request a review of matters described in § 457.1130.

(ii) Any notice of denial, termination, or suspension of CHIP eligibility must include, but is not limited to the following—

(A) The basis supporting the action and the effective date,

(B) Information on the individual's right to a review process, in accordance with § 457.1180;

(iii) In the case of a suspension or termination of eligibility, the State must provide sufficient notice to enable the child's parent or other caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption.

(2) The State's responsibility to provide notice under this paragraph is satisfied by a combined eligibility notice,

as defined in § 457.10, provided by an Exchange or other insurance affordability program in accordance with paragraph (f) of this section, except that, if the information described in paragraph (e)(1)(i)(C) of this section is not included in such combined eligibility notice, the State must provide the individual with a supplemental notice of such information, consistent with this section.

(f) *Coordination of notices with other programs.* The State must—

(1) Include in the agreement into which the State has entered under § 457.348(a) that, a combined eligibility notice, as defined in § 457.10, will be provided:

(i) To an individual, by the State agency administering a separate CHIP or the Medicaid agency, when a determination of CHIP eligibility is completed for such individual by the State agency administering Medicaid in accordance with § 457.348(e), or a determination of Medicaid eligibility is completed by the State in accordance with § 457.350(b)(1);

(ii) To the maximum extent feasible, to an individual who is not described in paragraph (f)(1)(i) of this section but who is transferred between the State and another insurance affordability program in accordance with § 457.348 or § 457.350; and

(iii) To the maximum extent feasible, to multiple members of the same household included on the same application or renewal form.

(2) For individuals and other household members who will not receive a combined eligibility notice, include appropriate coordinated content, as defined in § 457.10, in any notice provided by the State in accordance with paragraph (e)(1) of this section.

(g) *Effective date of eligibility.* A State must specify a method for determining the effective date of eligibility for CHIP, which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between CHIP and other insurance affordability programs as family circumstances change and avoids gaps or overlaps in coverage.

[66 FR 2675, Jan. 11, 2001, as amended at 66 FR 33823, June 25, 2001; 77 FR 17215, Mar. 23, 2012; 78 FR 42312, July 15, 2013; 81 FR 86464, Nov. 30, 2016; 89 FR 22873, Apr. 2, 2024]

§ 457.342 Continuous eligibility for children.

(a) A State may provide continuous eligibility for children under a separate CHIP in accordance with the terms of § 435.926 of this chapter, and subject to a child remaining ineligible for Medicaid, as required by section 2110(b)(1) of the Act and § 457.310 (related to the definition and standards for being a targeted low-income child) and the requirements of section 2102(b)(3) of the Act and § 457.350 (related to eligibility screening and enrollment).

(b) In addition to the reasons provided at § 435.926(d) of this chapter, a child may be terminated during the continuous eligibility period for failure to pay required premiums or enrollment fees required under the State plan, subject to the disenrollment protections afforded under section 2103(e)(3)(C) of the Act (related to premium grace periods) and § 457.570 (related to disenrollment protections).

[81 FR 86464, Nov. 30, 2016]

§ 457.343 Periodic renewal of CHIP eligibility.

The renewal procedures described in § 435.916 of this chapter apply equally to the State in administering a separate CHIP, except that the State shall verify information needed to renew CHIP eligibility in accordance with § 457.380 of this subpart, shall provide notice regarding the State's determination of renewed eligibility or termination in accordance with § 457.340(e) of this subpart and shall comply with the requirements set forth in § 457.350 of this subpart for screening individuals for other insurance affordability programs and transmitting such individuals' electronic account and other relevant information to the appropriate program.

[77 FR 17215, Mar. 23, 2012]

§ 457.344 Changes in circumstances.

(a) *Procedures for reporting changes.* The State must:

(1) Have procedures designed to ensure that enrollees understand the importance of making timely and accurate reports of changes in circumstances that may affect their eligibility; and

(2) Accept reports made under paragraph (a)(1) of this section and any other enrollee reported information through any of the modes permitted for submission of applications under § 435.907(a) of this chapter, as cross-referenced at § 457.330.

(b) *State action on information about changes.* Consistent with the requirements of § 457.380(f), the State must promptly redetermine eligibility between regularly scheduled renewals of eligibility required under § 457.343, whenever it has reliable information about a change in an enrollee's circumstances that may impact the enrollee's eligibility for CHIP, the amount of child or pregnancy-related health assistance for which the enrollee is eligible, or the enrollee's premiums or cost sharing charges. Such redetermination must be completed in accordance with paragraph (e) of this section.

(1) The State must redetermine eligibility based on available information, if possible. When needed information is not available, the State must request such information from the enrollee in accordance with § 435.952(b) and (c) of this chapter as referenced in § 457.380(f).

(2) Prior to furnishing additional child or pregnancy-related assistance or lowering applicable premiums or cost sharing charges based on a reported change:

(i) If the change was reported by the enrollee, the State must verify the information in accordance with §§ 435.940 through 435.960 of this chapter and the State's verification plan as referenced in § 457.380.

(ii) If the change was provided by a third-party data source, the State may verify the information with the enrollee.

(3) If the State is unable to verify a reported change that would result in additional child or pregnancy-related health assistance or lower premiums or cost sharing, the State may not terminate the enrollee's coverage for failure to respond to the request to verify such change.

(4) Prior to taking an action subject to review, as defined in § 457.1130, based on information received from a third-party data source, the State must request information from the enrollee to verify or dispute the information received consistent with § 435.952(d) of this chapter as referenced in § 457.380(f).

(5) If the State determines that a reported change results in an action subject to review, the State must:

(i) Comply with the requirements at § 435.916(d)(2) of this chapter as referenced in § 457.343 (relating to determining potential eligibility for other insurance affordability programs), prior to terminating an enrollee's eligibility in accordance with this section.

(ii) Provide notice and State review rights, in accordance with the requirements of § 457.340(e), and subpart K of this part, prior to taking any action subject to review resulting from a change in an enrollee's circumstances.

(6) If the State has information about anticipated changes in an enrollee's circumstances that may affect his or her eligibility, it must initiate a determination of eligibility at the appropriate time based on such changes consistent with paragraphs (b)(1) through (5) of this section and the requirements at § 435.912(c)(6) of this chapter as referenced in § 457.340(d)(1).

(c) *Enrollee response times*—(1) *State requirements.* The State must—

(i) Provide enrollees with at least 30 calendar days from the date the State sends the notice requesting the enrollee to provide the State with any additional information needed for the State to redetermine eligibility.

(ii) Allow enrollees to provide any requested information through any of the modes of submission specified in § 435.907(a) of this chapter, as referenced in § 457.330.

(2) *Time standards for redetermining eligibility.* The State must redetermine eligibility within the time standards described in § 435.912(c)(5) and (6) of this chapter, except in unusual circumstances, such as those as described in § 435.912(e) of this chapter, as referenced in § 457.340(d)(1); States must

document the reason for delay in the individual's case record.

(d) *Ninety-day reconsideration period.* If an individual terminated for not returning requested information in accordance with this section subsequently submits the information within 90 calendar days after the date of termination, or a longer period elected by the State, the State must—

(1) Reconsider the individual's eligibility without requiring a new application in accordance with the timeliness standards described at § 435.912(c)(3) of this chapter as referenced in § 457.340(d)(1).

(2) Request additional information needed to determine eligibility and obtain a signature under penalty of perjury consistent with § 435.907(e) and (f) of this chapter respectively as referenced in § 457.330 if such information or signature is not available to the State or included in the information described in this paragraph (d).

(e) *Scope of redeterminations following a change in circumstances.* For redeterminations of eligibility for CHIP enrollees completed in accordance with this section—

(1) The State must limit any requests for additional information under this section to information relating to change in circumstances which may impact the enrollee's eligibility.

(2) If the State has enough information available to it to renew eligibility with respect to all eligibility criteria, the State may begin a new eligibility period under § 457.343.

(f) *State action on updated address information*—(1) *Updated address information received from a third party.* (i) The State must have a process in place to regularly obtain updated address information from reliable data sources and to act on such updated address information in accordance with paragraphs (f)(2) and (3) of this section.

(ii) The State may establish a process to obtain updated address information from other third-party data sources and to act on such updated address information in accordance with paragraphs (f)(2) and (3) of this section.

(iii) For purposes of paragraph (f)(1)(i) of this section, reliable data sources include:

(A) Mail returned to the State by the United States Postal Service (USPS) with a forwarding address;

(B) The USPS National Change of Address (NCOA) database;

(C) The State's contracted MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities as defined in § 457.10, provided the MCO, PIHP, PAHP, PCCM, or PCCM entity received the information directly from or verified it with the enrollee; and

(D) Other data sources identified by the State and approved by the Secretary.

(2) *In-State address changes.* The following actions are required when the State receives updated in-State address information for an enrollee.

(i) If the information is provided by a reliable data source described in paragraph (f)(1)(iii) of this section, the State must—

(A) Accept the information as reliable;

(B) Update the enrollee's case record; and

(C) Notify the enrollee of the update.

(ii) If the information is provided by a data source not described in paragraph (f)(1)(iii) of this section, the State must check the State's Medicaid Enterprise System (MES) and the most recent address information received from reliable data sources described in paragraph (f)(1)(iii) of this section to confirm the accuracy of the information.

(A) If the updated address information is confirmed, the State must accept the information as reliable in accordance with paragraph (f)(2)(i) of this section.

(B) If the updated address information is not confirmed by the MES or a reliable data source, the State must make a good-faith effort, as described in paragraph (f)(5) of this section, to contact the enrollee to confirm the information.

(C) If the State is unable to confirm the updated address information, the State may not update the enrollee's address in the case record or terminate the enrollee's coverage for failure to respond to a request to confirm their address or State residency.

(3) *Out-of-State address changes.* The following actions are required when the

State receives updated out-of-State address information for an enrollee through the processes described in paragraph (f)(1) of this section.

(i) The State must make a good-faith effort, as described in paragraph (f)(5) of this section, to contact the enrollee to confirm the information or obtain information on whether the enrollee continues to meet the State's residency requirement.

(ii) If the State is unable to confirm that the enrollee continues to meet State residency requirements, the State must provide advance notice of termination and individual's rights to a CHIP review consistent with § 457.340(e)(1).

(4) *Whereabouts unknown.* The following actions are required when enrollee mail is returned to the State with no forwarding address.

(i) The State must check the State's MES and the most recently available information from reliable data sources described in paragraph (f)(1)(iii) of this section for additional contact information. If updated in-State address information is available from such a reliable data source, then accept the information as reliable in accordance with paragraph (f)(2)(i) of this section.

(ii) If updated address information cannot be obtained and confirmed as reliable in accordance with paragraph (f)(4)(i) of this section, the State must make a good-faith effort, as described in paragraph (f)(5) of this section, to contact the enrollee to obtain updated address information.

(iii) If the State is unable to identify and confirm the enrollee's address pursuant to paragraph (f)(4)(i) or (ii) of this section and the enrollee's whereabouts remain unknown, the State must take appropriate steps to move the enrollee to a fee-for-service delivery system, or to terminate or suspend the enrollee's coverage.

(A) If the State elects to terminate or suspend coverage in accordance with this paragraph (f)(4)(iii), the State must send notice to the enrollee's last known address or via electronic notification, in accordance with the enrollee's election under § 457.110, no later than the date of termination or suspension and provide notice of an individual's rights to a CHIP review in accordance with § 457.340(e).

(B) If whereabouts of an enrollee whose coverage was terminated or suspended in accordance with this paragraph (f)(4)(iii) become known within the enrollee's eligibility period, as defined in § 435.916(b) of this chapter as referenced in § 457.343, the State—

(*1*) Must reinstate coverage back to the date of termination without requiring the individual to provide additional information to verify their eligibility, unless the State has other information available to it that indicates the enrollee may not meet all eligibility requirements.

(*2*) May begin a new eligibility period consistent paragraph (e)(2) of this section, if the State has sufficient information available to it to renew eligibility with respect to all eligibility criteria without requiring additional information from the enrollee.

(5) *A good-faith effort to contact an enrollee.* (i) For purposes of this paragraph (f), a good-faith effort includes:

(A) At least two attempts to contact the enrollee;

(B) Use of two or more modalities (such as, mail, phone, email);

(C) A reasonable period of time between contact attempts; and

(D) At least 30 calendar days for the enrollee to respond to confirm updated address information, consistent with paragraph (c)(1) of this section.

(ii) If the State does not have the information necessary to make at least two attempts to contact an enrollee through two or more modalities in accordance with paragraph (f)(5)(i) of this section, the State must make a note of that fact in the enrollee's case record.

[89 FR 22873, Apr. 2, 2024]

§ 457.348 Determinations of Children's Health Insurance Program eligibility by other insurance affordability programs.

(a) *Agreements with other insurance affordability programs.* The State must enter into and, upon request, provide to the Secretary one or more agreements with an Exchange and the agencies administering other insurance affordability programs as are necessary to fulfill the requirements of this section, including a clear delineation of

the responsibilities of each program to—

(1) Minimize burden on individuals seeking to obtain or renew eligibility or to appeal a determination of eligibility for one or more insurance affordability program;

(2) Ensure compliance with paragraphs (b) and (c) of this section and § 457.350;

(3) Ensure prompt determination of eligibility and enrollment in the appropriate program without undue delay, consistent with the timeliness standards established under § 457.340(d), based on the date the application is submitted to any insurance affordability program, and

(4) Provide for a combined eligibility notice and coordination of notices with other insurance, consistent with § 457.340(f), and an opportunity for individuals to submit a joint review request, as defined in § 457.10, consistent with § 457.351.

(5) Provide for a combined appeals decision by an Exchange or Exchange appeals entity (or other insurance affordability program or appeals entity) for individuals who requested an appeal of an Exchange-related determination in accordance with 45 CFR part 155 subpart F (or of a determination related to another program) and an appeal of a denial of CHIP eligibility which is conducted by an Exchange or Exchange appeals entity (or other program or appeals entity) in accordance with the State plan.

(6) Seamlessly transition the enrollment of beneficiaries between CHIP and Medicaid when a beneficiary is determined eligible for one program by the agency administering the other.

(b) *Provision of CHIP for individuals found eligible for CHIP by another insurance affordability program.* (1) For each individual determined CHIP eligible in accordance with paragraph (b)(2) of this section, the State must—

(i) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of CHIP eligibility and notify such program of the receipt of the electronic account;

(ii) Comply with the provisions of § 457.340 to the same extent as if the application had been submitted to the State; and

(iii) Maintain proper oversight of the eligibility determinations made by the other program.

(2) For purposes of paragraph (b)(1) of this section, individuals determined eligible for CHIP in this paragraph (b) include:

(i) Individuals determined eligible for CHIP by another insurance affordability program, including the Exchange, pursuant to an agreement between the State and the other insurance affordability program (including as a result of a decision made by the program or the program's appeal entity in accordance with paragraph (a) of this section); and

(ii) Individuals determined eligible for CHIP by the State Medicaid agency (including as the result of a decision made by the Medicaid appeals entity) in accordance with paragraph (e) of this section.

(c) *Transfer from other insurance affordability programs to CHIP.* For individuals for whom another insurance affordability program has not made a determination of CHIP eligibility, but who have been screened as potentially CHIP eligible by such program (including as a result of a decision made by an Exchange or other program appeals entity), the State must—

(1) Accept, via secure electronic interface, the electronic account for the individual and notify such program of the receipt of the electronic account;

(2) Not request information or documentation from the individual in the individual's electronic account, or provided to the State by another insurance affordability program or appeals entity;

(3) Promptly and without undue delay, consistent with the timeliness standards established under § 457.340(g), determine the CHIP eligibility of the individual, in accordance with § 457.340, without requiring submission of another application and, for individuals determined not eligible for CHIP, comply with § 457.350(i) of this section;

(4) Accept any finding relating to a criterion of eligibility made by such program or appeals entity, without further verification, if such finding was

made in accordance with policies and procedures which are the same as those applied by the State in accordance with § 457.380 or approved by it in the agreement described in paragraph (a) of this section; and

(5) Notify such program of the final determination of the individual's eligibility or ineligibility for CHIP.

(d) *Certification of eligibility criteria.* The State must certify for the Exchange and other insurance affordability programs the criteria applied in determining CHIP eligibility.

(e) *CHIP determinations made by other insurance affordability programs.* The State must accept a determination of eligibility for CHIP from the Medicaid agency in the State. In order to comply with the requirement in this paragraph (e), the agency may:

(1) Apply the same modified adjusted gross income (MAGI)-based methodologies in accordance with § 457.315, and verification policies and procedures in accordance with § 457.380 as those used by the Medicaid agency in accordance with §§ 435.940 through 435.956 of this chapter, such that the agency will accept any finding relating to a criterion of eligibility made by a Medicaid agency without further verification;

(2) Enter into an agreement under which the State delegates authority to the Medicaid agency to make final determinations of CHIP eligibility; or

(3) Adopt other procedures approved by the Secretary.

[77 FR 17215, Mar. 23, 2012, as amended at 78 FR 42312, July 15, 2013; 81 FR 86464, Nov. 30, 2016; 89 FR 22875, Apr. 2, 2024]

§ 457.350 Eligibility screening and enrollment in other insurance affordability programs.

(a) *State plan requirement.* The State plan shall include a description of the coordinated eligibility and enrollment procedures used, at an initial and any follow-up eligibility determination, including any periodic redetermination, to ensure that:

(1) Only targeted low-income children are furnished CHIP coverage under the plan; and

(2) Enrollment is facilitated for applicants and enrollees found to be eligible or potentially eligible for other insurance affordability programs in accordance with this section.

(b) *Evaluation of eligibility for other insurance affordability programs.* (1) For individuals described in paragraph (b)(2) of this section, promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d), the State must:

(i) Determine eligibility for Medicaid on the basis of having household income at or below the applicable modified adjusted gross income standard, as defined in § 435.911(b) of this chapter (''MAGI-based Medicaid''); and

(ii) If unable to make a determination of eligibility for MAGI-based Medicaid, identify potential eligibility for other insurance affordability programs, including Medicaid on a basis other than MAGI, the Basic Health Program (BHP) in accordance with § 600.305(a) of this chapter, or insurance affordability programs available through the Exchange, as indicated by information provided on the application or renewal form provided by or on behalf of the beneficiary, including information obtained by the agency from other trusted electronic data sources.

(2) Individuals to whom paragraph (b)(1) of this section applies include:

(i) Any applicant who submits an application to the State which includes sufficient information to determine CHIP eligibility;

(ii) Any enrollee whose eligibility is being redetermined at renewal or due to a change in circumstance per § 457.343; and

(iii) Any enrollee whom the State determines is not eligible for CHIP, or who is determined not eligible for CHIP as a result of a review conducted in accordance with subpart K of this part.

(3) In determining eligibility for Medicaid as described in paragraph (b)(1) of this section, the State must utilize the option the Medicaid agency has elected at § 435.1200(b)(4) of this chapter to accept determinations of MAGI-based Medicaid eligibility made by a separate CHIP, and which must be detailed in the agreement described at § 457.348(a).

(c) *Income eligibility test.* To determine eligibility as described in paragraph (b)(1)(i) of this section and to identify the individuals described in paragraph

(b)(1)(ii) of this section who are potentially eligible for BHP or insurance affordability programs available through an Exchange, a State must apply the MAGI-based methodologies used to determine household income described in § 457.315 or such methodologies as are applied by such other programs.

(d) *Individuals found eligible for Medicaid based on MAGI.* For individuals identified in paragraph (b)(1) of this section, the State must—

(1) Promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d), transfer the individual's electronic account to the Medicaid agency via a secure electronic interface; and

(2) Except as provided in § 457.355, find the applicant ineligible for CHIP.

(e) *Individuals potentially eligible for Medicaid on a basis other than MAGI.* For individuals identified as potentially eligible for Medicaid on a non-MAGI basis, as described in paragraph (b)(1)(ii) of this section, the State must—

(1) Promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d), transfer the electronic account to the Medicaid agency via a secure electronic interface.

(2) Complete the determination of eligibility for CHIP in accordance with § 457.340 or evaluation for potential eligibility for other insurance affordability programs in accordance with paragraph (b) of this section.

(3) Include in the notice of CHIP eligibility or ineligibility provided under § 457.340(e), as appropriate, coordinated content relating to—

(i) The transfer of the individual's electronic account to the Medicaid agency per paragraph (e)(1) of this section;

(ii) The transfer of the individual's account to another insurance affordability program in accordance with paragraph (g) of this section, if applicable; and

(iii) The impact that an approval of Medicaid eligibility will have on the individual's eligibility for CHIP or another insurance affordability program, as appropriate.

(4) Disenroll the enrollee from CHIP if the State is notified in accordance with § 435.1200(d)(5) of this chapter that the applicant has been determined eligible for Medicaid.

(f) *Children found ineligible for Medicaid based on MAGI, and potentially ineligible for Medicaid on a basis other than MAGI.* 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 rules, covered benefits, and restrictions on cost sharing; and

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

(4) The State will determine the written format and timing of the information regarding Medicaid eligibility, benefits, and the application process required under this paragraph (f).

(g) *Individuals found potentially eligible for other insurance affordability programs.* For individuals identified in paragraph (b)(1)(ii) of this section who have been identified as potentially eligible for BHP or insurance affordability programs available through the Exchange, the State must promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d), transfer the electronic account to the other insurance affordability program via a secure electronic interface.

(h) *Evaluation of eligibility for Exchange coverage.* A State may enter into an arrangement with the Exchange for the entity that determines eligibility for CHIP to make determinations of eligibility for advance payments of the premium tax credit and cost sharing reductions, consistent with 45 CFR 155.110(a)(2).

(i) *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;

(2) Children placed on a waiting list or for whom action on their application is otherwise deferred are transferred to other insurance affordability programs in accordance with paragraph (h) of this section; and

(3) Families are informed that a child may be eligible for other insurance affordability programs, while the child is on a waiting list for a separate child health program or if circumstances change, for Medicaid.

[89 FR 22875, Apr. 2, 2024]

§ 457.351 Coordination involving appeals entities for different insurance affordability programs.

(a) The terms of § 435.1200(g) of this chapter apply equally to the State in administering a separate CHIP. References to a ''fair hearing'' and ''joint fair hearing request'' in § 435.1200(g) of this chapter are treated as references to a ''review'' under subpart K of this part and to a ''joint appeal request'' as defined in § 457.10. Reference to ''expedited review of a fair hearing request consistent with § 431.221(a)(1)(ii) of this chapter'' is considered a reference to ''expedited review of an eligibility or enrollment matter under § 457.1160(a)''. Reference to § 435.1200(b)(3), (c), (d) and (e) are treated as a reference to § 457.348(b), (c) and (d) and § 457.350(c), respectively.

(b) [Reserved]

[81 FR 86466, Nov. 30, 2016]

§ 457.353 Monitoring and evaluation of screening process.

States must establish a mechanism and monitor to evaluate the screen and enroll process described at § 457.350 of this subpart to ensure that children who are:

(a) Screened as potentially eligible for other insurance affordability programs are enrolled in such programs, if eligible; or

(b) Determined ineligible for other insurance affordability programs are enrolled in CHIP, if eligible.

[77 FR 17216, Mar. 23, 2012]

§ 457.355 Presumptive eligibility for children.

The State may provide coverage under a separate child health program for children determined by a qualified entity to be presumptively eligible for the State's separate CHIP in the same manner and to the same extent as permitted under Medicaid under § 435.1101 and § 435.1102 of this chapter.

[81 FR 86466, Nov. 30, 2016]

§ 457.360 Deemed newborn children.

(a) *Basis.* This section implements section 2112(e) of the Act.

(b) *Eligibility.* (1) The State must provide CHIP to children from birth until the child's first birthday without application if—

(i) The child's mother was eligible for and received covered services for the date of the child's birth under the State plan as a targeted low-income pregnant woman in accordance with section 2112 of the Act; and

(ii) The child is not eligible for Medicaid under § 435.117 of this chapter.

(2)(i) The State may provide coverage under this section to children who are not eligible for Medicaid under § 435.117 from birth until the child's first birthday without application if the requirement in paragraph (b)(2)(ii) of this section is met and if, for the date of the child's birth, the child's mother was eligible for and received covered services under—

(A) The State plan as a targeted low-income child;

(B) CHIP coverage in another State; or

(C) Coverage under the State's demonstration under section 1115 of the Act as a Medicaid or CHIP population.

(ii) For purposes of paragraph (b)(2)(i) of this section, the State may only elect the optional populations described if it elects to cover the corresponding optional populations in Medicaid under § 435.117(b)(2)(ii) of this chapter.

(3) The child is deemed to have applied and been determined eligible

under the State's separate CHIP State plan effective as of the date of birth, and remains eligible regardless of changes in circumstances (except if the child dies or ceases to be a resident of the State or the child's representative requests a voluntary termination of the child's eligibility) until the child's first birthday.

(c) *CHIP identification number.* (1) The CHIP identification number of the mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until the State issues a separate identification number for the child.

(2) The State must issue a separate CHIP identification number for the child prior to the effective date of any termination of the mother's eligibility or prior to the date of the child's first birthday, whichever is sooner, except that the State must issue a separate CHIP identification number for the child if the mother was covered in another State at the time of birth.

[81 FR 86466, Nov. 30, 2016]

§ 457.370 Alignment with Exchange initial open enrollment period.

The terms of § 435.1205 apply equally to the State in administering a separate CHIP, except that the State shall make available and accept the application described in § 457.330, shall accept electronic accounts as described in § 457.348, and furnish coverage in accordance with § 457.340.

[78 FR 42312, July 15, 2013]

§ 457.380 Eligibility verification.

(a) *General requirements.* Except where law requires other procedures (such as for citizenship and immigration status information), the State may accept attestation of information needed to determine the eligibility of an individual for CHIP (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f) of this subchapter, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or if the individual is a minor or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the individual.

(b) *Status as a citizen, national or a non-citizen.* (1) Except for newborns identified in § 435.406(a)(1)(iii)(E) of this chapter, who are exempt from any requirement to verify citizenship, the agency must—

(i) Verify citizenship or immigration status in accordance with § 435.956(a) of this chapter, except that the reference to § 435.945(k) is read as a reference to paragraph (i) of this section; and

(ii) Provide a reasonable opportunity period to verify such status in accordance with § 435.956(a)(5) and (b) of this chapter and provide benefits during such reasonable opportunity period to individuals determined to be otherwise eligible for CHIP.

(2) [Reserved]

(c) *State residents.* If the State does not accept self-attestation of residency, the State must verify residency in accordance with § 435.956(c) of this chapter.

(d) *Income.* If the State does not accept self-attestation of income, the State must verify the income of an individual by using the data sources and following standards and procedures for verification of financial eligibility consistent with § 435.945(a), § 435.948 and § 435.952 of this chapter.

(e) *Verification of other factors of eligibility.* For eligibility requirements not described in paragraphs (c) or (d) of this section, a State may adopt reasonable verification procedures, consistent with the requirements in § 435.952 of this chapter, except that the State must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation.

(f) *Requesting information.* The terms of § 435.952 of this chapter apply equally to the State in administering a separate CHIP.

(g) *Electronic service.* Except to the extent permitted under paragraph (i) of this section, to the extent that information sought under this section is available through the electronic service described in § 435.949 of this chapter, the State must obtain the information through that service.

(h) *Interaction with program integrity requirements.* Nothing in this section should be construed as limiting the State's program integrity measures or affecting the State's obligation to ensure that only eligible individuals receive benefits or its obligation to provide for methods of administration that are in the best interest of applicants and enrollees and are necessary for the proper and efficient operation of the plan.

(i) *Flexibility in information collection and verification.* Subject to approval by the Secretary, the State may modify the methods to be used for collection of information and verification of information as set forth in this section, provided that such alternative source will reduce the administrative costs and burdens on individuals and States while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance affordability programs.

(j) *Verification plan.* The State must develop, and update as modified, and submit to the Secretary, upon request, a verification plan describing the verification policies and procedures adopted by the State to implement the provisions set forth in this section in a format and manner prescribed by the Secretary.

[77 FR 17216, Mar. 23, 2012, as amended at 81 FR 86466, Nov. 30, 2016]

Subpart D—State Plan Requirements: Coverage and Benefits

SOURCE: 66 FR 2678, Jan. 11, 2001, unless otherwise noted.

§ 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 CHIP 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 CMS 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 CMS, 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, but is not limited to the following:

(a) Coverage that is the same as the coverage provided to children under the Medicaid State plan.

(b) Comprehensive coverage for children offered by the State under a Medicaid demonstration project approved by the Secretary under section 1115 of the Act.

(c) Coverage that either includes the full Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit or that the State has extended to the entire Medicaid population in the State.

(d) Coverage that includes benchmark health benefits coverage, as specified in § 457.420, plus any additional coverage.

(e) Coverage that is the same as the coverage provided under § 457.440.

(f) 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 which demonstrates that coverage for each benefit meets or exceeds the corresponding coverage under the benchmark health benefits plan.

[66 FR 33823, June 25, 2001]

§ 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 Prohibited coverage limitations, preexisting condition exclusions, and relation to other laws.

(a) *Prohibited coverage limitations.* The State may not impose any annual, lifetime or other aggregate dollar limitations on any medical or dental services which are covered under the State plan.

(b) *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.

(c) *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.

[66 FR 2678, Jan. 11, 2001, as amended at 89 FR 22876, Apr. 2, 2024]

§ 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 as follows:

(1) *Before January 1, 2026.* (i) 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; or

(ii) In accordance with existing State law regarding prior authorization of health services.

(2) *On or after January 1, 2026.* (i) In accordance with the medical needs of the enrollee, but no later than 7 calendar days after receiving the request for a standard determination and by no later than 72 hours after receiving the request for an expedited determination. 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 the additional information is needed; or

(ii) In accordance with existing State law regarding prior authorization of health services.

(3) *Enrollee notification.* Provide the enrollee with—

(i) Notice of the State's prior authorization decision; and

(ii) Information on the enrollee's right to a review process, in accordance with § 457.1180.

(e) Access to and delivery of services in a culturally competent manner to all beneficiaries, as described in 42 CFR 440.262.

[66 FR 2678, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001; 89 FR 8982, Feb. 4, 2024; 89 FR 37692, May 6, 2024]

§ 457.496 Parity in mental health and substance use disorder benefits.

(a) *Meaning of terms.* For purposes of this section, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a State plan or a Managed Care Entity (MCE) (as defined at § 457.10) that contracts with the State plan. State plans must meet the requirements of § 457.480.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a State plan or a MCE that contracts with a State plan. State plans must meet the requirements at § 457.480.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits has the meaning defined in section 1905(r) of the Act and must be provided in accordance with section 1902(a)(43) of the Act.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Medical/surgical benefits means benefits for items or services for medical conditions or surgical procedures, as defined under the terms of the State plan in accordance with applicable Federal and State law, but does not include mental health or substance use disorder benefits. Any condition defined by the State plan as being or not

being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or generally applicable State guidelines). Medical/surgical benefits include long term care services.

Mental health benefits means benefits for items or services that treat or otherwise address mental health conditions, as defined under the terms of the State plan in accordance with applicable Federal and State law, and consistent with generally recognized independent standards of current medical practice. Standards of current medical practice can be based on the most current version of the DSM, the most current version of the ICD, or generally applicable State guidelines. The term includes long term care services.

State Plan has the meaning assigned at §§457.10 and 457.50.

Substance use disorder benefits means benefits for items or services for substance use disorder, as defined under the terms of the State plan in accordance with applicable Federal and State law, and consistent with generally recognized independent standards of current medical practice. Standards of current medical practice can be based on the most current version of the DSM, the most current version of the ICD, or generally applicable State guidelines. The term includes long term care services.

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under the State plan. (*See* paragraph (d)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

(b) *State plan providing EPSDT benefits.* (1) A State child health plan is deemed to be in compliance with this section if—

(i) The State elects in the State child health plan to cover Secretary-approved coverage defined in §457.450(a) that includes all EPSDT benefits, as defined in section 1905(r) of the Act, in accordance with the requirement applied under section 1905(r)(5) of the Act to provide necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, as well as the informing and administrative requirements under 1902(a)(43) of the Act and the approved State Medicaid plan; and

(ii) The State child health plan does not exclude EPSDT benefits for any particular condition, disorder, or diagnosis.

(2) The child health plan must include a description of how the State will comply with paragraph (b)(1)(i) of this section.

(3) If a State has elected in its state plan to cover EPSDT benefits only for certain populations enrolled in the state child health plan, the State is deemed compliant with this section only with respect to such children.

(c) *Parity requirements for aggregate lifetime and annual dollar limits.* This paragraph (c) details the application of the parity requirements for aggregate lifetime and annual dollar limits. A State plan that provides both medical/surgical benefits and mental health or substance use disorder benefits must comply with paragraph (c)(1), (2), or (4) of this section.

(1) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a State plan does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(2) *State plans with a limit on at least two-thirds of all medical/surgical benefits.*

If a State plan includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or

(ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits. (For cumulative limits other than aggregate lifetime or annual dollar limits, see paragraph (d)(3)(iii) of this section prohibiting separately accumulating cumulative financial requirements.)

(3) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (c), the determination of whether the portion of medical/surgical benefits subject to an aggregate lifetime or annual dollar limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the State plan for the State plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual dollar limits). Any reasonable method may be used to determine whether the dollar amount expected to be paid under the State plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(4) *Plan not described in this section*—(i) *In general.* A State plan that is not described in paragraph (c)(1) or (2) of this section for aggregate lifetime or annual dollar limits on medical/surgical benefits, must either—

(A) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance use disorder benefits; or

(B) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (c)(4)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated dollar limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur for such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (c)(4), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (c)(3) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(d) *Parity requirements for financial requirements and treatment limitations*—(1) *Clarification of terms*—(i) *Classification of benefits.* When reference is made in this paragraph (d) to a classification of benefits, the term ''classification'' means a classification as described in paragraph (d)(2)(ii) of this section.

(ii) *Type of financial requirement or treatment limitation.* When reference is made in this paragraph (d) to a type of financial requirement or treatment limitation, the reference to type means its nature. Different types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. Different types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits. *See* paragraph (d)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.

(iii) *Level of a type of financial requirement or treatment limitation.* When reference is made in this paragraph (d) to

a level of a type of financial requirement or treatment limitation, level refers to the magnitude of the type of financial requirement or treatment limitation.

(2) *General parity requirement*—(i) *General rule.* A State plan or a MCE that contracts with CHIP through its State plan that provides both medical/surgical benefits and mental health or substance use disorder benefits, including when such benefits are delivered through an MCE, may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. The application of the rules of this paragraph (d)(2) to financial requirements and quantitative treatment limitations is addressed in paragraph (d)(3) of this section; the application of the rules of this paragraph (d)(2) to nonquantitative treatment limitations is addressed in paragraph (d)(4) of this section.

(ii) *Classifications of benefits used for applying rules.* If a State plan provides mental health or substance use disorder benefits in any classification of benefits described in this paragraph (d)(2)(ii), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. In determining the classification in which a particular benefit belongs, the same reasonable standards must apply to medical/surgical benefits and to mental health or substance use disorder benefits. To the extent that a State plan provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification, the rules of this paragraph (d) apply separately for that classification for all financial requirements or treatment limitations. The following classifications of benefits are the only classifications used in applying the rules of this paragraph (d):

(A) *Inpatient.* Benefits furnished on an inpatient basis.

(B) *Outpatient.* Benefits furnished on an outpatient basis. See special rules for office visits in paragraph (d)(3)(iii) of this section.

(C) *Emergency care.* Benefits for emergency care.

(D) *Prescription drugs.* Benefits for prescription drugs. See special rules for multi-tiered prescription drug benefits in paragraph (d)(3)(iii) of this section.

(3) *Financial requirements and quantitative treatment limitations*—(i) *Determining ''substantially all'' and ''predominant''*—(A) *Substantially all.* For purposes of this paragraph (d), a type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification. If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

(B) *Predominant.* (*1*) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under paragraph (d)(3)(i)(A) of this section, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

(*2*) If, for a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of

medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the State plan (or health insurance issuer) may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a State plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(C) *Portion based on plan payments.* For purposes of this paragraph (d), the determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all State plan payments and combinations of MCE payments for medical/surgical benefits in the classification expected to be paid under the plan or MCE or combination that contracts with the State plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation).

(D) *Clarifications for certain threshold requirements.* For any deductible, the dollar amount of a State plan payments includes all plan payments for claims that would be subject to the deductible if it had not been satisfied. In accordance with the cumulative cost-sharing maximum in § 457.560, or any other out-of-pocket maximum in the State plan, the dollar amount of plan payments includes all State plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Similar rules apply for any other thresholds at which the rate of health plan payment changes.

(E) *Determining the dollar amount of State plan payments.* Subject to paragraph (d)(3)(i)(D) of this section, any reasonable method may be used to determine the dollar amount expected to be paid under a State plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation).

(ii) *Special rules*—(A) *Multi-tiered prescription drug benefits.* If a State plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in paragraph (d)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations) and without regard to whether a drug is generally prescribed for medical/surgical benefits or for mental health or substance use disorder benefits, the health plan satisfies the parity requirements of this paragraph (d) for prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up/delivery.

(B) *Sub-classifications permitted for office visits, separate from other outpatient services.* For purposes of applying the financial requirement and treatment limitation rules of this paragraph (d), a State plan may divide its benefits furnished on an outpatient basis into the two sub-classifications described in this paragraph (d)(3)(ii)(B). After the sub-classifications are established, the State plan may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in paragraph (d)(3)(i) of this section. Sub-classifications other than these special rules, such as separate sub-classifications for generalists and specialists, are not permitted. The two

sub-classifications permitted under this paragraph (d)(3)(ii)(B) are:

(*1*) Office visits (such as physician visits); and

(*2*) All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

(iii) *No separate cumulative financial requirements.* A State plan may not apply any cumulative financial requirement for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.

(4) *Nonquantitative treatment limitations*—(i) *General rule.* A State plan may not impose a nonquantitative treatment limitation for mental health or substance use disorder benefits in any classification unless, under the terms of the CHIP State plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

(ii) *Illustrative list of nonquantitative treatment limitations.* Nonquantitative treatment limitations include—

(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(B) Formulary design for prescription drugs;

(C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(D) Standards for provider admission to participate in a network, including reimbursement rates;

(E) Plan methods for determining usual, customary, and reasonable charges;

(F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(G) Exclusions based on failure to complete a course of treatment;

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage; and

(I) Standards for providing access to out-of-network providers.

(5) *Application to out-of-network providers.* Any State plan providing access to out-of-network providers for medical/surgical benefits within a classification must use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits.

(e) *Availability of plan information*—(1) *Criteria for medical necessity determinations.* The criteria for medical necessity determinations made under a State plan including when benefits are furnished through a MCE contractor for mental health or substance use disorder benefits must be made available by the plan administrator (or the State offering the coverage) to any current enrollee or potential enrollee or contracting provider upon request. Health plans operating in compliance with § 438.236(c) of this chapter will be deemed compliant with the requirements in this paragraph (e).

(2) *Reason for any denial.* The reason for any denial under a health plan of reimbursement or payment for services for mental health or substance use disorder benefits in the case of any enrollee must be made available by the plan administrator or the State to the enrollee.

(3) *Provisions of other law.* Compliance with the disclosure requirements in paragraphs (e)(1) and (2) of this section is not determinative of compliance

with any other provision of applicable Federal or State law.

(f) *Applicability*—(1) *State plans.* The requirements of this section apply to State plans offering medical/surgical benefits and mental health or substance use disorder benefits to their enrollees including when benefits are furnished under a contract with MCEs. If, under an arrangement or arrangements to provide State plan benefits any enrollee can simultaneously receive coverage for medical/surgical benefits and coverage for mental health or substance use disorder benefits, then the requirements of this section apply separately for each combination of medical/surgical benefits and of mental health or substance use disorder benefits that any enrollee can simultaneously receive from the State.

(i) *Standard for defining benefits.* States must indicate the standard used for defining the following benefits in the State plan:

(A) Medical/surgical benefits.

(B) Mental health benefits.

(C) Substance use disorder benefits.

(ii) [Reserved]

(2) *Scope.* This section does not—

(i) Require a State plan or a MCE that contracts with a State plan to provide any mental health benefits or substance use disorder benefits, and the provision of benefits by a State plan or a MCE that contracts with a State plan for one or more mental health conditions or substance use disorders does not require the plan or health insurance coverage under this section to provide benefits for any other mental health condition or substance use disorder;

(ii) Affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the State plan or a MCE that contracts with a CHIP State plan except as specifically provided in paragraphs (c) and (d) of this section.

(g) *Compliance dates*—(1) *In general.* State plans (including those that contract with a MCE) must comply with the requirements of this section no later than October 2, 2017.

(2) [Reserved]

[81 FR 18842, Mar. 30, 2016]

Subpart E—State Plan Requirements: Enrollee Financial Responsibilities

SOURCE: 66 FR 2681, Jan. 11, 2001, unless otherwise noted.

§ 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 eligible children 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 eligible children 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 on behalf of an eligible child to ensure compliance with this subpart.

[66 FR 2681, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

§ 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 household 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 household 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, § 447.53, or § 447.54 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 household 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 household 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(a).

[66 FR 2681, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001; 78 FR 42312, July 15, 2013]

§ 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 household income is from 101 to 150 percent of the FPL, the State plan must provide that for non-institutional services, including emergency services, the following requirements must be met:

(1)(i) For Federal FY 2009, any copayment or similar charge the State imposes under a fee-for-service delivery system may not exceed the amounts shown in the following table:

State payment for the service	Maximum Copayment
$15 or less	$1.15
$15.01 to $40	$2.30
$40.01 to $80	$3.40
$80.01 or more	$5.70

(ii) Thereafter, any copayments may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(2) For Federal FY 2009, any co-payment that the State imposes for services provided by a managed care organization may not exceed $5.70 per visit. In succeeding years, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(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) For Federal FY 2009, any deductible the State imposes may not exceed $3.40 per month, per family for each period of eligibility. Thereafter, any deductible may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(b) *Institutional services.* For targeted low-income children whose household 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.* For Federal FY 2009, any copayment that the State imposes on emergency services provided by an institution may not exceed $5.70. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(d) *Non-emergency use of the emergency room.* For Federal FY 2009, for targeted low-income children whose household 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 $11.35 for services furnished in a hospital emergency room if those services are not emergency services as defined in § 457.10. Thereafter, any charge may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(e) *Standard copayment amount.* For targeted low-income children whose household 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.

[66 FR 2681, Jan. 11, 2001, as amended at 73 FR 71854, Nov. 25, 2008; 75 FR 30265, May 28, 2010]

§ 457.560 Cumulative cost-sharing maximum.

(a) A State may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate, exceed 5 percent of a family's total income for the length of a child's eligibility period in the State.

(b) 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.

[66 FR 2681, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

§ 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 household 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 ensure that disenrollment policies, such as policies related to non-payment of premiums, do not present barriers to the timely determination of eligibility and enrollment in coverage of an eligible child in the appropriate insurance affordability program. A State may not—

(1) Impose a specified period of time that a CHIP eligible targeted low-income child or targeted low-income pregnant woman who has an unpaid premium or enrollment fee will not be permitted to reenroll for coverage in CHIP.

(2) Require the collection of past due premiums or enrollment fees as a condition of eligibility for reenrollment if an individual was terminated for failure to pay premiums.

(d) 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).

[66 FR 2681, Jan. 11, 2001, as amended at 78 FR 42312, July 15, 2013; 89 FR 22876, Apr. 2, 2024]

Subpart F—Payments to States

§ 457.600 Purpose and basis of this subpart.

This subpart interprets and implements—

(a) Section 2104 of the Act which specifies the total allotment amount available for allotment to each State for child health assistance for fiscal years 1998 through 2015, the formula for determining each State allotment for a fiscal year, including the Commonwealth and Territories, and the amounts of payments for expenditures that are applied to reduce the State allotments.

(b) Section 2105 of the Act which specifies the provisions for making payment to States, the limitations and conditions on such payments, and the calculation of the enhanced Federal medical assistance percentage.

[66 FR 2670, Jan. 11, 2001, as amended at 76 FR 9246, Feb. 17, 2011]

§ 457.602 Applicability.

The provisions of this subpart apply to the 50 States and the District of Columbia, and the Commonwealths and Territories.

§ 457.606 Conditions for State allotments and Federal payments for a fiscal year.

(a) *Basic conditions.* In order to receive a State allotment for a fiscal year, a State must have a State child health plan submitted in accordance with section 2106 of the Act, and

(1) For fiscal years 1998 and 1999, the State child health plan must be approved before October 1, 1999;

(2) For fiscal years after 1999, the State child health plan must be approved by the end of the fiscal year;

(3) An allotment for a fiscal year is not available to a State prior to the beginning of the fiscal year; and

(4) Federal payments out of an allotment are based on State expenditures which are allowable under the approved State child health plan.

(b) Federal payments for Children's Health Insurance Program (CHIP) expenditures under an approved State child health plan are—

(1) Limited to the amount of available funds remaining in State allotments calculated in accordance with the allotment process and formula specified in §§ 457.608 and 457.610, and payment process in §§ 457.614 and 457.616.

(2) Available based on a percentage of State CHIP expenditures, at a rate equal to the enhanced Federal medical assistance percentage (FMAP) for each

fiscal year, calculated in accordance with § 457.622.

(3) Available through the grants process specified in § 457.630.

[65 FR 33622, May 24, 2000, as amended at 75 FR 48852, Aug. 11, 2010]

§ 457.608 Process and calculation of State allotments prior to FY 2009.

(a) *General*—(1) State allotments for a fiscal year are determined by CMS for each State and the District of Columbia with an approved State child health plan, as described in paragraph (e) of this section, and for each Commonwealth and Territory, as described in paragraph (f) of this section.

(2) In order to determine each State allotment, CMS determines the national total allotment amount for each fiscal year available to the 50 States and the District of Columbia, as described in paragraph (c) of this section, and the total allotment amount available for each fiscal year for allotment to the Commonwealths and Territories, as described in paragraph (d) of this section.

(3) The amount of allotments redistributed under section 2104(f) of the Act will not be applied or taken into account in determining the amounts of a fiscal year allotment for a State and the District of Columbia under this section.

(b) *Definition of Proportion.* As used in this section, *proportion* means the amount of the allotment for a State or the District of Columbia for a fiscal year, divided by the national total allotment amount available for allotment to all States and the District of Columbia, as specified in paragraph (c) of this section, for that fiscal year.

(c) *National total allotment amount for the 50 States and the District of Columbia.* (1) The national total allotment amount available for allotment to the 50 States and the District of Columbia is determined by subtracting the following amounts in the following order from the total appropriation specified in section 2104(a) of the Act for the fiscal year—

(i) The total allotment amount available for allotment for each fiscal year to the Commonwealths and Territories, as determined in paragraph (d)(1) of this section;

(ii) The total amount of the grant for the fiscal year for children with Type I Diabetes under Section 4921 of Public Law 105–33. This is $30,000,000 for each of the fiscal years 1998 through 2002; and

(iii) The total amount of the grant for the fiscal year for diabetes programs for Indians under Section 4922 of Public Law 105–33. This is $30,000,000 for each of the fiscal years 1998 through 2002.

(2) The following formula illustrates the calculation of the national total allotment amount available for allotment to the 50 States and the District of Columbia for a fiscal year:

$$A_{TA} = S_{2104(a)} - T_{2104(c)} - D_{4921} - D_{4922}$$

A_{TA} = National total allotment amount available for allotment to the 50 States and the District of Columbia for the fiscal year.

$S_{2104(a)}$ = Total appropriation for the fiscal year indicated in Section 2104(a) of the Act.

$T_{2104(c)}$ = Total allotment amount for a fiscal year available for allotment to the Commonwealths and Territories; as determined under paragraph (d)(1) of this section.

D_{4921} = Amount of total grant for children with Type I Diabetes under Section 4921 of Public Law 105–33. This is $30,000,000 for each of the fiscal years 1998 through 2002.

(d) *Total allotment amount available to the Commonwealths and Territories*—(1) *General.* The total allotment amount available to all the Commonwealths and Territories for a fiscal year is equal to .25 percent of the total appropriation for the fiscal year indicated in section 2104(a) of the Act, plus the additional amount for the fiscal year specified in paragraph (d)(2) of this section.

(2) *Additional amounts for allotment to the Commonwealths and Territories.* The following amounts are available for allotment to the Commonwealths and Territories for the indicated fiscal years in addition to the amount specified in paragraph (d)(1) of this section: For FY 1999, $32 million; for each of FY 2000 and FY 2001, $34.2 million; for each fiscal year FY 2002 through 2004, $25.2 million; for each fiscal year FY 2005 and FY 2006, $32.4 million; and for FY 2007, $40 million. The additional amount for allotment for FY 1999 for

the Commonwealths and Territories was provided under Public Law 105–277. The additional amounts for allotment for FY 2000 through FY 2007 were provided for the Commonwealths and Territories under section 702 of Public Law 106–113.

(e) *Determination of State allotments for a fiscal year*—(1) *General.* The allotment for a State and the District of Columbia for a fiscal year is the product of:

(i) The proportion for the State or the District of Columbia for the fiscal year, as defined in paragraph (b) of this section, and determined after application of the provisions of paragraphs (e)(2) and (3), related to the preadjusted proportion, and the floors, ceilings, and reconciliation process, respectively; and

(ii)(A) The national total allotment amount available for allotment for the fiscal year, as specified in paragraph (c) of this section. The State and the District of Columbia's allotment for a fiscal year is determined in accordance with the following general formula:

$SA_i = P_i \times A_{TA}$

SA_i = Allotment for a State or District of Columbia for a fiscal year.
P_i = Proportion for a State or District of Columbia for a fiscal year.
A_{TA} = Total amount available for allotment to the 50 States and the District of Columbia for the fiscal year.

(B) There are two steps for determining the proportion for a State and the District of Columbia. The first step determines the preadjusted proportions, and is described under paragraph (e)(2) of this section. The first step applies in determining the proportion for all fiscal years. The second step applies floors and ceilings and, if necessary, applies a reconciliation to the preadjusted proportion. The second step is described in paragraph (e)(3) of this section. The second step applies in determining the proportion only for FY 2000 and subsequent fiscal years. For FY 1998 and FY 1999, the preadjusted proportion is the State or District of Columbia's proportion for the fiscal year.

(2) *Determination of the Preadjusted Proportions for a Fiscal Year.* (i)The methodology for determining the State preadjusted proportion, referring to the determination of the proportion before the application of floors and ceilings and reconciliation for a fiscal year is in accordance with the following formula:

$PP_i = (C_i \times SCF_i) / \Sigma(C_i \times x\ SCF_i)$

PP_i = Preadjusted proportion for a State or District of Columbia for a fiscal year.
C_i = *Number of children* in a State (section 2104(b)(1)(A)(I) of the Act) for a fiscal year. This number is based on the number of low-income children for a State for a fiscal year and the number of low-income children for a State for a fiscal year with no health insurance coverage for the fiscal year determined on the basis of the arithmetic average of the number of such children as reported and defined in the 3 most recent March supplements to the Current Population Survey (CPS) of the Bureau of the Census, and for FY 2000 and subsequent fiscal years, officially available before the beginning of the calendar year in which the fiscal year begins. For FY 1998 and FY 1999, the availability of the CPS data obtained from the Bureau of the Census is as specified in paragraphs (e)(4) and (5) of this section, respectively. (section 2104(b)(2)(B) of the Act).

(ii) For each of the fiscal years 1998 and 1999, the number of children is equal to the number of low-income children in the State for the fiscal year with no health insurance coverage. For fiscal year 2000, the number of children is equal to the sum of 75 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage and 25 percent of the number of low-income children in the State for the fiscal year. For fiscal years 2001 and thereafter, the number of children is equal to the sum of 50 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage and 50 percent of the number of low-income children in the State for the fiscal year. (section 2104(b)(2)(A) of the Act).

SCF_i = *State cost factor for a State* (section 2104(b)(1)(A)(ii) of the Act). For a fiscal year, this is equal to: $.15 + .85 \times (W_i/W_N)$ (section 2104(b)(3)(A) of the Act).

W_i = The annual average wages per employee for a State for such year (section 2104(b)(3)(A)(ii)(I) of the Act).
W_N = The annual average wages per employee for the 50 States and the District of Columbia (section 2104(b)(3)(A)(ii)(II)

of the Act). The annual average wages per employee for a State or for all States and the District of Columbia for a fiscal year is equal to the average of such wages for employees in the health services industry (SIC 80), as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years, and for FY 2000 and subsequent fiscal years, finally available before the beginning of the calendar year in which the fiscal year begins. For FY 1998 and FY 1999, the availability of the wage data obtained from the Bureau of Labor Statistics is as specified in paragraphs (e)(4) and (5), respectively. (section 2104(b)(3)(B) of the Act).

$\Sigma(C_i \times SCF_i)$ = The sum of the products of ($C_i \times SCF_i$) for each State (section 2104(b)(1)(B) of the Act).

A_{TA} = Total amount available for allotment to the 50 States and the District of Columbia for the fiscal year as determined under paragraph (c) of this section.

(3) *Application of floors and ceilings and reconciliation in determining proportion*—(i) *Floors and ceilings in proportions.* The preadjusted State proportions for a fiscal year are subject to the application of floors and ceilings in paragraphs (e)(3)(i)(A) and (B) of this section.

(A) The proportion floors, or minimum proportions, that apply in determining a State's proportion for the fiscal year are:

(*1*) $2,000,000 divided by the total of the amount available nationally;

(*2*) 90 percent of the State's proportion for the previous fiscal year; and

(*3*) 70 percent of the State's proportion for FY 1999.

(B) The proportion ceiling, or maximum proportion, for a fiscal year that applies in determining the State's fiscal year proportion is 145 percent of the State's proportion for FY 1999.

(ii) *Reconciliation of State proportions.* If, after the application of the floors and ceilings in paragraph (e)(3)(i), the sum of the States' proportions is not equal to one, the Secretary will reconcile the States' proportions by applying either paragraph (e)(3)(i)(A) or (B) of this paragraph, as appropriate, such that the sum of the proportions after reconciliation equals one. If, after the application of the floors and ceilings in paragraph (e)(3)(i), the sum of the States' proportions is equal to one, no reconciliation is necessary, and the States' proportions will be the same as the preadjusted proportions determined under paragraph (e)(2) of this section.

(A) If, after the application of the floors and ceilings under paragraphs (e)(3)(i)(A) and (B) of this section, the sum of the States' proportions is greater than one, the Secretary will establish a maximum percentage increase in States' proportions, such that when applied to the States' proportions, the sum of the proportions is exactly equal to one.

(B) If, after the application of the floors and ceilings under paragraphs (e)(3)(i)(A) and (B), the sum of the proportions is less than one, the Secretary will increase States' proportions (as computed before the application of the floors under paragraph (e)(3)(i)(A)) in a pro rata manner (but not to exceed the 145 percent ceiling computed under paragraph (e)(3)(i)(B)), such that when applied to the States' proportions, the sum of the proportions is exactly equal to one.

(4) *Data used for calculating the FY 1998 CHIP allotments.* The FY 1998 CHIP allotments were calculated in accordance with the methodology described in paragraphs (e)(1) and (2) of this section, using the most recent official and final data that were available from the Bureau of the Census and the Bureau of Labor Statistics, respectively, prior to the September 1 before the beginning of FY 1998 (that is, through August 31, 1997). In particular, through August 31, 1997, the only official data available on the numbers of children were data from the 3 March CPSs conducted in March 1994, 1995, and 1996 that reflected data for the 3 calendar years 1993, 1994, and 1995.

(5) *Data used for calculating the FY 1999 CHIP allotments.* In accordance with section 101(f) of Public Law 105–277, the FY 1999 allotments were calculated in accordance with the methodology described in paragraph (e)(2) of this section, using the same data as were used in calculating the FY 1998 CHIP allotments.

(f) *Methodology for determining the Commonwealth and Territory allotments for a fiscal year.* The total amount available for the Commonwealths and Territories for each fiscal year, as determined under paragraph (d) of this section, is allotted to each Territory

and Commonwealth below which has an approved State child health plan. These allotments are in the proportion that the following percentages for each Commonwealth Territory bear to the sum of such percentages, as specified in section 2104(c)(2) of the Act:

Puerto Rico—91.6%
Guam—3.5%
Virgin Islands—2.6%
American Samoa—1.2%
Northern Mariana Islands—1.1%

(g) *Reserved State allotments for a fiscal year.* (1) For FY 2000 and subsequent fiscal years, CMS determines and publishes the State reserved allotments for a fiscal year for each State, the District of Columbia, and Commonwealths and Territories in the FEDERAL REGISTER based on the most recent official and final data available before the beginning of the calendar year in which the fiscal year begins for the number of children and the State cost factor.

(2) For FY 1998 and FY 1999, CMS determined and published the State reserved allotments using the available data described in paragraphs (e)(4) and (e)(5) of this section, respectively, on the basis of the statutory allotment formula as it existed prior to the enactment of Public Law 106–113.

(3) If all States, the District of Columbia, and the Commonwealths and Territories have approved State child health plans in place prior to the beginning of the fiscal year, as appropriate, CMS may publish the allotments as final in the FEDERAL REGISTER, without the need for publication as reserved allotments.

(h) *Final allotments.* (1) Final State allotments for FY 1998 and FY 1999 for each State, the District of Columbia, and the Commonwealths and Territories are determined by CMS based only on those States, the District of Columbia, and the Commonwealths and Territories that have approved State child health plans by the end of fiscal year 1999, in accordance with the formula and methodology specified in paragraphs (a) through (g) of this section.

(2) Final State allotments for a fiscal year after FY 1999 for each State, the District of Columbia, and the Commonwealths and Territories are determined by CMS based only on those States, the District of Columbia, and the Commonwealths and Territories that have approved State child health plans by the end of the fiscal year, in accordance with the formula and methodology specified in paragraphs (a) through (g) of this section.

(3) CMS determines and publishes the States' final fiscal year allotments in the FEDERAL REGISTER based on the same data, with respect to the number of children and State cost factor, as were used in determining the reserved allotments for the fiscal year.

[66 FR 2670, Jan. 11, 2001, as amended at 76 FR 9246, Feb. 17, 2011]

§ 457.609 Process and calculation of State allotments for a fiscal year after FY 2008.

(a) *General.* For each of the 50 States and the District of Columbia and for each Commonwealth and Territory with an approved State child health plan, the State allotments for FY 2009 through FY 2015 are determined by CMS as described in paragraphs (b) through (g) of this section. Unless otherwise indicated in this section, the reference to ''State'' refers to the 50 States and the District of Columbia and the Commonwealths and Territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands).

(b) *Amounts available for allotment.* The total amounts available for allotment for each fiscal year are as follows:

(1) FY 2009: $10,562,000,000.
(2) FY 2010: $12,520,000,000.
(3) FY 2011: $13,459,000,000.
(4) FY 2012: $14,982,000,000.
(5) FY 2013: $17,406,000,000.
(6) FY 2014: $19,147,000,000.

(7) FY 2015, for the period beginning October 1, 2014 and ending March 31, 2015, the following amounts are available for allotment:

(i) $2,850,000,000.
(ii) 15,361,000,000.

(8) FY 2015, for the period beginning April 1, 2013 and ending on September 30, 2013, $2,850,000,000.

(c) *Determination of a State allotment for FY 2009*—(1) *For the 50 States and the District of Columbia.* From the amount in paragraph (b)(1) of this section as appropriated for the fiscal year under

section 2104(a) of the Act, subject to paragraph (e) related to proration, and paragraph (c)(3) of this section relating to coordination of funding, the allotment for FY 2009 is equal to 110 percent of the highest of the following amounts for each State and the District of Columbia:

(i) The total Federal payments to the State under title XXI of the Act for FY 2008 as reported by the State and certified to the Secretary through the November 2008 submission of the quarterly expenditure reports, Forms CMS–21 (OMB # 0938–0731) and CMS–64 (OMB # 0938–0067), multiplied by the allotment increase factor determined under paragraph (f) of this section.

(ii) The amount allotted to the State for FY 2008, multiplied by the allotment increase factor determined under paragraph (f) of this section;

(iii) The projected total Federal payments to the State under title XXI of the Act for FY 2009, subject to paragraph (c)(1)(iv) of this section, as determined based on the February 2009 projections certified by the State to CMS by no later than March 31, 2009.

(iv) In the case of a State described in section 2105(g) of the Act and electing the option under paragraph (4) of such section, for purposes of the projections described in paragraph (c)(1)(iii) of this section, such projections would include an amount equal to the difference between the following amounts:

(A) the amount of Federal payments for the expenditures described in section 2105(g)(4)(B) of the Act made after February 4, 2009 that would have been paid to the State if claimed at the enhanced Federal medical assistance percentage determined under section 2105(b) of the Act.

(B) the amount of Federal payments for the expenditures described in section 2105(g)(4)(B) of the Act made after February 4, 2009 that would have been paid to the State if claimed at the Federal medical assistance percentage defined in section 1905(b) of the Act; during the recession adjustment period described in section 5001(h) of the American Recovery and Reinvestment Act of 2009 (ARRA), as amended the Federal medical assistance percentage is as determined for the State under section 5001 of ARRA.

(2) *For the Commonwealths or Territories.* (i) From the amount in paragraph (b)(1) of this section, as appropriated for the FY 2009 under section 2104(a) of the Act, subject to paragraph (e) of this section related to proration, and paragraph (c)(3) of this section relating to coordination of funding, an amount equal to the highest amount of Federal payments made to the Commonwealth or Territory under title XXI of the Social Security Act for any fiscal year occurring during the period for FY 1999 through FY 2008, multiplied by the allotment increase factor determined under paragraph (f) of this section, plus the additional amount for the fiscal year specified in paragraph (c)(2)(ii) of this section.

(ii) *Additional Amounts for FY 2009.* From the amount appropriated for the fiscal year under section 2104(c)(4)(B) of the Act, the additional amount for each Commonwealth or Territory is equal to $40,000,000 multiplied by the following percentage as specified in section 2104(c)(2) of the Act:

(A) For Puerto Rico, 91.6 percent.

(B) For Guam, 3.5 percent.

(C) For the Virgin Islands, 2.6 percent.

(D) For American Samoa, 1.2 percent.

(E) For the Northern Mariana Islands, 1.1 percent.

(3) *Coordination of CHIP Funding for FY 2009.* The amount of the CHIP allotment for FY 2009 available for payment for a States' expenditures may be reduced by the amounts appropriated and obligated before April 1, 2009 for States' FY 2009 allotments, FY 2006 allotments redistributed to the State in FY 2009 determined under section 2104(k) of the Act, and the amounts of additional FY 2009 shortfall allotments determined under section 2104(l) of the Act.

(d) *Determination of a State allotment for FY 2010 through FY 2015*—(1) *General.* Subject to the provisions of paragraph (e) of this section relating to proration and paragraph (g) of the section relating to increases in a fiscal year allotment for approved program expansions, the State allotments for FY 2010 through FY 2015 are determined as follows.

(2) *Determination of a State Allotment for FY 2010.* (i) For the 50 States and the District of Columbia, and for the

Commonwealths and Territories subject to paragraph (d)(2)(ii) of this section, the State allotment for FY 2010 is equal to the product of the following:

(A) The sum of:

(*1*) The State Allotment for FY 2009, as determined under paragraph (c) of the section.

(*2*) The amount of any Federal payments made as redistributions of unexpended FY 2006 allotments under section 2104(k) of the Act.

(*3*) The amount of any Federal payments made as additional FY 2009 allotments under section 2104(l) of the Act.

(*4*) The amount of any Federal payments made as contingency fund payments for FY 2009 under section 2104(n) of the Act.

(B) The State allotment increase factor for FY 2010 as determined under paragraph (f) of the section.

(ii) In determining the amount of the FY 2010 allotment for each Commonwealth and Territory, for purposes of determining the amount of the FY 2009 allotment under paragraph (d)(2)(i)(A)(1) of this section, the amount of such FY 2009 allotment will not include the additional amount determined under paragraph (c)(2)(ii).

(3) *Determination of a State Allotment for FY 2011.* For the 50 States and the District of Columbia, and the Commonwealths and Territories, the State allotment for FY 2011 is equal to the product of:

(i) The amount of Federal payments attributable and countable toward the available State allotments in FY 2010, including:

(A) Any amount redistributed to the State in FY 2010, and

(B) Any Federal payments made as contingency fund payments for FY 2010 under section 2104(n) of the Act.

(ii) The State allotment increase factor for FY 2011 as determined under paragraph (f) of the section.

(4) *Determination of a State Allotment for FY 2012.* For the 50 States and the District of Columbia, and the Commonwealths and Territories, the State allotment for FY 2012 is equal to the product of:

(i) The sum of:

(A) The State Allotment for FY 2011, as determined under paragraph (d)(3) of this section.

(B) The amount of any Federal payments made as contingency fund payments for FY 2011 under section 2104(n) of the Act.

(ii) The State allotment increase factor for FY 2012 as determined under paragraph (f) of this section.

(5) *Determination of a State Allotment for FY 2013.* For the 50 States and the District of Columbia, and the Commonwealths and Territories, the State allotment for FY 2013 is equal to the product of:

(i) The amount of Federal payments attributable and countable toward the available State allotments in FY 2012, including:

(A) Any amount redistributed to the State in FY 2012, and

(B) Any Federal payments made as contingency fund payments for FY 2012 under section 2104(n) of the Act.

(ii) The State allotment increase factor for FY 2013 as determined under paragraph (f) of the section.

(6) *Determination of a State Allotment for FY 2014.* For the 50 States and the District of Columbia, and the Commonwealths and Territories, the State allotment for FY 2014 is equal to the product of:

(i) The sum of:

(A) The State Allotment for FY 2013, as determined under paragraph (d)(5) of this section.

(B) The amount of any Federal payments made as contingency fund payments for FY 2013 under section 2104(n) of the Act.

(ii) The State allotment increase factor for FY 2014 as determined under paragraph (f) of this section.

(7) *Determination of a State Allotment for FY 2015*—(i) *General.* There are two State allotments for FY 2015; one for the period beginning October 1, 2014 and ending March 31, 2015 and the second beginning April 1, 2015 and ending September 30, 2015. These State allotments are determined for each of the 50 States and the District of Columbia, and the Commonwealths and Territories.

(ii) The State allotment for FY 2015 for the period October 1, 2014 and ending March 31, 2015 is determined as the product of the following:

(A) The first half ratio determined as the amount in paragraph (d)(7)(ii)(A)(*1*) of this section divided by the amount in paragraph (d)(7)(ii)(A)(*2*) of this section as follows:

(*1*) $18,211,000,000 (calculated as the sum of the amount in paragraph (b)(7)(i) of this section, $2,850,000,000 (appropriated in section 2104(a)(18)(A) of the Act) and the amount in paragraph (b)(7)(ii) of this section, $15,361,000,000 (appropriated in section 108 of Pub. L. 111–3, as amended by section 10203 of Pub. L. 111–148)).

(*2*) $21,061,000,000, determined as the sum of the amount determined in paragraph (*1*) of this section, $18,211,000,000, and $2,850,000,000, the amount in paragraph (b)(8) of this section, as appropriated in section 2104(a)(18)(B) of the Act, as amended by section 10203 Of Public Law 111–148.

(B) The product of:

(*1*) The amount of Federal payments attributable and countable toward the total amount of available State allotments in FY 2014, to include:

(*i*) Any amount redistributed to the State in FY 2014; and

(*ii*) Any Federal payments made as contingency fund payments for FY 2014 under section 2104(n) of the Act.

(*2*) The State allotment increase factor for FY 2015 as determined under paragraph (f) of this section.

(iii) The State allotment for FY 2015 for the period April 1, 2015 and ending September 30, 2015 is determined as the product of the following:

(A) $2,850,000,000 the amount in paragraph (b)(8) of this section, as appropriated in section 2104(a)(18)(B) of the Act; and

(B) The ratio determined as the amount in paragraph (d)(7)(iii)(B)(*1*) of this section divided by the amount in paragraph (d)(7)(iii)(B)(*2*) of this section:

(*1*) The amount of the State allotment determined in paragraph (d)(7)(ii) of this section.

(*2*) The total of all the State allotments determined in paragraph (d)(7)(ii) of this section.

(e) *Proration.* (1) If for a fiscal year the sum of the State allotments for the 50 States and the District of Columbia, and the State allotments for the Commonwealths and Territories (not including the additional amount for FY 2009 determined under paragraph (c)(2)(ii) of this section), exceeds the total amount available for allotment for the fiscal year in paragraph (b) of this section, the amount of the allotment for each of the 50 States and the District of Columbia, and for each of the Commonwealths and Territories (not including the additional amount for FY 2009 determined under paragraph (c)(2)(ii) of this section) will be reduced on a proportional basis as indicated in paragraph (e)(2) of this section.

(2) The amount of the allotment for each of the 50 States and the District of Columbia, and for each of the Commonwealths and Territories (not including the additional amount for FY 2009 determined in paragraph (c)(2)(ii) of this section) is equal to the product of:

(i) The percentage determined by dividing the amount in paragraph (e)(2)(i)(A) by the amount in paragraph (e)(2)(i)(B) of this section.

(A) The amount of the State allotment for each of the 50 States and the District of Columbia, and for each of the Commonwealths and Territories (not including the additional amount for FY 2009 determined under paragraph (c)(2)(ii) of this section).

(B) The sum of the amounts for each of the 50 States and the District of Columbia, and the Commonwealths and Territories in paragraph (e)(2)(i) of this section.

(ii) The total amount available for allotment for the fiscal year under paragraph (b) of this section.

(f) *Allotment increase factor.* The allotment increase factor for a fiscal year is equal to the product of the following:

(1) Per capita health care growth factor. The per capita health care growth factor for a fiscal year is equal to 1 plus the percentage increase in the projected per capita amount of the National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as

most recently published by CMS before the beginning of the fiscal year involved.

(2) *Child Population Growth Factor* (CPGF). The CPGF for a fiscal year is equal to 1 plus the percentage increase (if any) in the population of children in the State from July 1 in the previous fiscal year to July 1 in the fiscal year involved, as determined by CMS based on the most recent published estimates of the Census Bureau available before the beginning of the fiscal year involved plus 1 percentage point. For purposes of determining the CPGF for FY 2009 for the Commonwealths and Territories only, in applying the previous sentence, ''United States'' is substituted for ''the State''.

(g) *Increase in State allotment for the 50 States and the District of Columbia for FY 2010 through FY 2015 to account for approved program expansions.* In the case of the 50 States and the District of Columbia, the State allotment for FY 2010 through FY 2015, as determined in accordance with the provisions of this section, may be increased under the following conditions and amounts:

(1) The State has submitted to the Secretary, and has approved by the Secretary a State plan amendment or waiver request relating to an expansion of eligibility for children or benefits under title XXI of the Act that becomes effective for a fiscal year (beginning with FY 2010 and ending with FY 2015).

(2) The State has submitted to the Secretary, before the August 31 preceding the beginning of the fiscal year, a request for an expansion allotment adjustment under this paragraph for such fiscal year that specifies.

(i) The additional expenditures that are attributable to the eligibility or benefit expansion provided under the amendment or waiver described in paragraph (g)(1) of this section, as certified by the State and submitted to the Secretary by not later than August 31 preceding the beginning of the fiscal year.

(ii) The extent to which such additional expenditures are projected to exceed the allotment of the State or District for the year.

(3) Subject to paragraph (e) of this section relating to proration, the amount of the allotment of the State or District under this section for such fiscal year shall be increased by the excess amount described in paragraph (g)(2)(i)of this section. A State or District may only obtain an increase under paragraph (g)(2)(ii) of this section for an allotment for FY 2010, FY 2012, or FY 2014.

(h) *CHIP fiscal year allotment process.* The national CHIP allotment and State CHIP allotments will be posted in the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System and at *Medicaid.gov* (or similar successor system or website) as soon as practicable after the allotments have been determined for each Federal fiscal year.

[76 FR 9246, Feb. 17, 2011, as amended at 89 FR 13947, Feb. 23, 2024]

§ 457.610 Period of availability for State allotments prior to FY 2009.

The amount of a final allotment prior to FY 2009, as determined under § 457.608(h) and reduced to reflect certain Medicaid expenditures in accordance with § 457.616, remains available until expended for Federal payments based on expenditures claimed during a 3-year period of availability, beginning with the fiscal year of the final allotment and ending with the end of the second fiscal year following the fiscal year.

[66 FR 2670, Jan. 11, 2001, as amended at 76 FR 9249, Feb. 17, 2011]

§ 457.611 Period of availability for State allotments for a fiscal year after FY 2008.

The amount of a final allotment for a fiscal year after FY 2008, as determined under § 457.609 and reduced to reflect certain Medicaid expenditures in accordance with § 457.616, remains available until expended for Federal payments based on expenditures claimed during a 2-year period of availability, beginning with the fiscal year of the final allotment and ending with the end of the succeeding fiscal year following the fiscal year.

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

[76 FR 9249, Feb. 17, 2011]

§457.614 General payment process.

(a) A State may make claims for Federal payment based on expenditures incurred by the State prior to or during the period of availability related to that fiscal year.

(b) In order to receive Federal financial participation (FFP) for a State's claims for payment for the State's expenditures, a State must—

(1) Submit budget estimates of quarterly funding requirements for Medicaid and the Children's Health Insurance Programs; and

(2) Submit an expenditure report.

(c) Based on the State's quarterly budget estimates, CMS—

(1) Issues an advance grant to a State as described in §457.630;

(2) Tracks and applies Federal payments claimed quarterly by each State, the District of Columbia, and each Commonwealth and Territory to ensure that payments do not exceed the applicable allotments for the fiscal year; and

(3) Track and apply relevant State, District of Columbia, Commonwealth and Territory expenditures reported each quarter against the 10 percent limit on expenditures other than child health assistance for standard benefit package, on a fiscal year basis as specified in §457.618.

[65 FR 33622, May 24, 2000, as amended at 75 FR 48852, Aug. 11, 2010]

§457.616 Application and tracking of payments against the fiscal year allotments.

(a) *Categories of payments applied to reduce the State allotments.* In accordance with the principles described in paragraph (c) of this section, the following categories of payments are applied to reduce the State allotments for a fiscal year:

(1) Payments made to the State for expenditures claimed during the fiscal year under its title XIX Medicaid program, to the extent the payments were made on the basis of the enhanced FMAP described in sections 1905(b) and 2105(b) of the Act for expenditures attributable to children described in section 1905(u)(2) of the Act.

(2) Payments made to the State for expenditures claimed during the fiscal year under its title XIX Medicaid program, to the extent the payments were made on the basis of the enhanced FMAP described in sections 1905(b) and 2105(b) of the Act for expenditures attributable to children described in section 1905(u)(3) of the Act.

(3) [Reserved]

(4) Payments made to a State under its title XXI State Children's Health Insurance Program with respect to section 2105(a) of the Act for expenditures claimed by the State during a fiscal year.

(b) *Application of principles.* CMS applies the principles in paragraph (c) of this section to—

(1) Coordinate the application of the payments made to a State for the State's expenditures claimed under the Medicaid and State Children's Health Insurance programs against the State allotment for a fiscal year;

(2) Determine the order of these payments in that application; and

(3) Determine the application of payments against multiple State Child Health Insurance Program fiscal year allotments.

(c) *Principles for applying Federal payments against the allotment.* CMS—

(1) Applies the payments attributable to Medicaid expenditures specified in paragraphs (a)(1) through (a)(3) of this section, against the State child health plan allotment for a fiscal year before State child health plan expenditures specified in paragraph (a)(4) of this section are applied.

(2) Applies the payments attributable to Medicaid and State child health plan expenditures specified in paragraph (a) of this section against the applicable allotments for a fiscal year based on the quarter in which the expenditures are claimed by the State.

(3) Applies payments against the State allotments for a fiscal year in a manner that is consistent for all States.

(4) Applies payments attributable to Medicaid expenditures specified in paragraphs (a)(1) through (a)(3) of this section, in an order that maximizes Federal reimbursement for States. Expenditures for which the enhanced FMAP is available are applied before expenditures for which the regular FMAP is available.

(5) Applies payments for expenditures against State Child Health Insurance Program fiscal year allotments in the least administratively burdensome, and most effective and efficient manner; payments are applied on a quarterly basis as they are claimed by the State, and are applied to reduce the earliest fiscal year State allotments before the payments are applied to reduce later fiscal year allotments.

(6) Subject to paragraphs (c)(6)(i) and (ii) of this section, applies payments for expenditures for a fiscal year's allotment against a subsequent fiscal year's allotment; however, the subsequent fiscal year's allotment must be available at the time of application. For example, if the allotment for fiscal year 1998 has been fully expended, payments for expenditures claimed in fiscal year 1998 are carried over for application against the fiscal year 1999 allotment when it becomes available.

(i) In accordance with § 457.618, the amount of non-primary expenditures that are within the 10 percent limit for the fiscal year for which they are claimed may be applied against a fiscal year allotment or allotments available in a subsequent fiscal year.

(ii) In accordance with § 457.618, the amounts of non-primary expenditures that exceed the 10 percent limit for the fiscal year for which they are claimed may not be applied against a fiscal year allotment or allotments available in a subsequent fiscal year.

(7) Carries over unexpended amounts of a State's allotment for a fiscal year for use in subsequent fiscal years through the end of the 3-year period of availability. For example, if the amounts of the fiscal year 1998 allotment are not fully expended by the end of fiscal year 1998, these amounts are carried over to fiscal year 1999 and are available to provide FFP for expenditures claimed by the State for that fiscal year.

(d) *Amount of Federal payment for expenditures claimed.* The amount of the Federal payment for expenditures claimed by a State, District of Columbia, or the Commonwealths and Territories is determined by the enhanced FMAP applicable to the fiscal year in which the State paid the expenditure. For example, Federal payment for an expenditure paid by a State in fiscal year 1998 that was carried over to fiscal year 1999 (in accordance with paragraph (c)(6) of this section), because the State exceeded its fiscal year 1998 allotment, is available at the fiscal year 1998 enhanced FMAP rate.

[65 FR 33622, May 24, 2000, as amended at 81 FR 86466, Nov. 30, 2016]

§ 457.618 Ten percent limit on certain Children's Health Insurance Program expenditures.

(a) *Expenditures*—(1) *Primary expenditures* are expenditures under a State plan for child health assistance to targeted low-income children in the form of a standard benefit package, and Medicaid expenditures claimed during the fiscal year to the extent Federal payments made for these expenditures on the basis of the enhanced FMAP described in sections 1905(b) and 2105(b) of the Act that are used to calculate the 10 percent limit.

(2) *Non-primary expenditures* are other expenditures under a State plan. Subject to the 10 percent limit described in paragraph (c) of this section, a State may receive Federal funds at the enhanced FMAP for 4 categories of non-primary expenditures:

(i) Administrative expenditures;

(ii) Outreach;

(iii) Health initiatives; and

(iv) Certain other child health assistance.

(b) *Federal payment.* Federal payment will not be available based on a State's non-primary expenditures for a fiscal year which exceed the 10 percent limit of the total of expenditures under the plan, as specified in paragraph (c) of this section.

(c) *10 Percent Limit.* The 10 percent limit is—

(1) Applied on an annual fiscal year basis;

(2) Calculated based on the total computable expenditures claimed by the State on quarterly expenditure reports submitted for a fiscal year. Expenditures claimed on a quarterly report for a different fiscal year may not be used in the calculation; and

(3) Calculated using the following formula:

$$L10\% = (A1 + U2 + U3)/9;$$

L10% = 10 Percent Limit for a fiscal year
A1 = Total computable amount of expenditures for the fiscal year under section 2105(a)(1) of the Act for which Federal payments are available at the enhanced FMAP described in Section 2105(b) of the Act;
U2 = Total computable expenditures for medical assistance for which Federal payments are made during the fiscal year based on the enhanced FMAP described in sections 1905(b) and 2105(b) of the Act for individuals described in section 1905(u)(2) of the Act; and
U3 = Total computable expenditures for medical assistance for which Federal payments are made during the fiscal year based on the enhanced FMAP described in sections 1905(b) and 2105(b) of the Act for individuals described in section 1905(u)(3) of the Act.

(d) The expenditures under section 2105(a)(2) of the Act that are subject to the 10 percent limit are applied—

(1) On an annual fiscal year basis; and

(2) Against the 10 percent limit in the fiscal year for which the State submitted a quarterly expenditure report including the expenditures. Expenditures claimed on a quarterly report for one fiscal year may not be applied against the 10 percent limit for any other fiscal year.

(e)(1) The 10 percent limit for a fiscal year, as calculated under paragraph (c)(3) of this section, may be no greater than 10 percent of the total computable amount (determined under paragraph (e)(2) of this section) of the State allotment or allotments available in that fiscal year. Therefore, the 10 percent limit is the lower of the amount calculated under paragraph (c)(3) of this section, and 10 percent of the total computable amount of the State allotment available in that fiscal year.

(2) As used in paragraph (e)(1) of this section, the total computable amount of a State's allotment for a fiscal year is determined by dividing the State's allotment for the fiscal year by the State's enhanced FMAP for the year. For example, if a State allotment for a fiscal year is $65 million and the enhanced FMAP rate for the fiscal year is 65 percent, the total computable amount of the allotment for the fiscal year is $100 million ($65 million/.65). In this example, the 10 percent limit may be no greater than a total computable amount of $10 million (10 percent of $100 million).

[65 FR 33622, May 24, 2000, as amended at 75 FR 48852, Aug. 11, 2010]

§ 457.622 Rate of FFP for State expenditures.

(a) *Basis.* Sections 1905(b), 2105(a) and 2105(b) of the Act provides for payments to States from the States' allotments for a fiscal year, as determined under § 457.608, for part of the cost of expenditures for services and administration made under an approved State child health assistance plan. The rate of payment is generally the enhanced Federal medical assistance percentage described below.

(b) *Enhanced Federal medical assistance percentage (Enhanced FMAP)—Computations.* The enhanced FMAP is the lower of the following:

(1) 70 percent of the regular FMAP determined under section 1905(b) of the Act, plus 30 percentage points; or

(2) 85 percent.

(c) *Conditions for availability of enhanced FMAP based on a State's expenditures*—The enhanced FMAP is available for payments based on a State's expenditures claimed under the State's title XXI program from the State's fiscal year allotment only under the following conditions:

(1) The State has an approved title XXI State child health plan;

(2) The expenditures are allowable under the State's approved title XXI State child health plan;

(3) State allotment amounts are available in the fiscal year, that is, the State's allotment or allotments (as reduced in accordance with § 457.616) remain available for a fiscal year and have not been fully expended.

(4) Expenditures claimed against the 10 percent limit are within the State's 10 percent limit for the fiscal year.

(5) For States that elect to extend eligibility to unborn children under the approved Child Health Plan, the State does not adopt eligibility standards and methodologies for purposes of determining a child's eligibility under the Medicaid State plan that were more restrictive than those applied under policies of the State plan in effect on June 1, 1997. This limitation applies also to more restrictive standards

and methodologies for determining eligibility for services for a child based on the eligibility of a pregnant woman.

(d) *Categories of expenditures for which enhanced FMAP are available.* Except as otherwise provided below, the enhanced FMAP is available with respect to the following States' expenditures:

(1) Child health assistance under the plan for targeted low-income children in the form of providing health benefits coverage that meets the requirements of section 2103 of the Act; and

(2) Subject to the 10 percent limit provisions under §457.618(a)(2), the following expenditures:

(i) Payment for other child health assistance for targeted low-income children;

(ii) Expenditures for health services initiatives under the State child health assistance plan for improving the health of children (including targeted low-income children);

(iii) Expenditures for outreach activities; and

(iv) Other reasonable costs incurred by the State to administer the State child health assistance plan.

(e) *CHIP administrative expenditures and CHIP related title XIX administrative expenditures*—(1) *General rule.* Allowable title XXI administrative expenditures should support the operation of the State child health assistance plan. In general, FFP for administration under title XXI is not available for costs of activities related to the operation of other programs.

(2) *Exception.* FFP is available under title XXI, at the enhanced FFP rate, for Medicaid administrative expenditures attributable to the provision of medical assistance to children described in sections 1905(u)(2) and 1905(u)(3), and during the presumptive eligibility period described in section 1920A of the Act, to the extent that the State does not claim those costs under the Medicaid program.

(3) FFP is not available in expenditures for administrative activities for items or services included within the scope of another claimed expenditure.

(4) FFP is available in expenditures for activities defined in sections 2102(c)(1) and 2105(a)(2)(C) of the Act as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in such a program.

(5) FFP is available in administrative expenditures for activities specified in sections 2102(c)(2) of the Act as coordination of the administration of the Children's Health Insurance Program with other public and private health insurance programs. FFP would not be available for the costs of administering the other public and private health insurance programs. Coordination activities must be distinguished from other administrative activities common among different programs.

[65 FR 33622, May 24, 2000, as amended at 67 FR 61974, Oct. 2, 2002; 75 FR 48852, Aug. 11, 2010]

§ 457.626 Prevention of duplicate payments.

(a) *General rule.* No payment shall be made to a State for expenditures for child health assistance under its State child health plan to the extent that:

(1) A non-governmental health insurer would have been obligated to pay for those services but for a provision of its insurance contract that has the effect of limiting or excluding those obligations based on the actual or potential eligibility of the individual for child health assistance under the State child health insurance plan.

(2) Payment has been made or can reasonably be expected to be made promptly under any other Federally operated or financed health insurance or benefits program, other than a program operated or financed by the Indian Health Service.

(3) Services are for an unborn child and are payable under Medicaid as a service to an eligible pregnant woman under that program.

(b) *Definitions.* As used in paragraph (a) of this section—

Non-governmental health insurer includes any health insurance issuer, group health plan, or health maintenance organization, as those terms are defined in 45 CFR 144.103, which is not part of, or wholly owned by, a governmental entity.

Prompt payment can reasonably be expected when payment is required by applicable statute, or under an approved State plan.

Programs operated or financed by the Indian Health Service means health programs operated by the Indian Health Service, or Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement or compact with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450, *et seq.*), or by an urban Indian organization in accordance with a grant or contract with the Indian Health Service under the authority of title V of the Indian Health Care Improvement Act (25 U.S.C. 1601, *et seq.*).

[65 FR 33622, May 24, 2000, as amended at 67 FR 61974, Oct. 2, 2002]

§ 457.628 Other applicable Federal regulations.

Other regulations applicable to CHIP programs include the following:

(a) HHS regulations in §§ 431.800 through 431.1010 of this chapter (related to the PERM and MEQC programs); §§ 433.312 through 433.322 of this chapter (related to Overpayments); § 433.38 of this chapter (Interest charge on disallowed claims of FFP); §§ 430.40 through 430.42 of this chapter (Deferral of claims for FFP and Disallowance of claims for FFP); § 430.48 of this chapter (Repayment of Federal funds by installments); §§ 433.50 through 433.74 of this chapter (sources of non-Federal share and Health Care-Related Taxes and Provider Related Donations); and § 447.207 of this chapter (Retention of Payments) apply to State's CHIP programs in the same manner as they apply to State's Medicaid programs.

(b) HHS Regulations in 45 CFR subtitle A:

Part 16—Procedures of the Departmental Appeals Board.

45 CFR part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (except as specifically excepted).

Part 80—Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services: Effectuation of title VI of the Civil Rights Act of 1964.

Part 81—Practice and Procedure for Hearings Under 45 CFR part 80.

Part 84—Nondiscrimination on the Basis of Handicap in Programs and activities Receiving or Benefiting From Federal Financial Assistance.

Part 95—General Administration—grant programs (public assistance and medical assistance).

[66 FR 2670, Jan. 11, 2001, as amended at 72 FR 29836, May 29, 2007; 75 FR 73976, Nov. 30, 2010; 77 FR 31513, May 29, 2012; 81 FR 3012, Jan. 20, 2016; 82 FR 31187, July 5, 2017]

§ 457.630 Grants procedures.

(a) *General provisions.* Once CMS has approved a State child health plan, CMS makes quarterly grant awards to the State to cover the Federal share of expenditures for child health assistance, other child health assistance, special health initiatives, outreach and administration.

(1) For fiscal year 1998, a State must submit a budget request in an appropriate format for the 4 quarters of the fiscal year. CMS bases the grant awards for the 4 quarters of fiscal year 1998 based on the State's budget requests for those quarters.

(2) For fiscal years after 1998, a State must submit a budget request in an appropriate format for the first 3 quarters of the fiscal year. CMS bases the grant awards for the first 3 quarters of the fiscal year on the State's budget requests for those quarters.

(3) For fiscal years after 1998, a State must also submit a budget request for the fourth quarter of the fiscal year. The amount of this quarter's grant award is based on the difference between a State's final allotment for the fiscal year, and the total of the grants for the first 3 quarters that were already issued in order to ensure that the total of all grant awards for the fiscal year are equal to the State's final allotment for that fiscal year.

(4) The amount of the quarterly grant is determined on the basis of information submitted by the State (in quarterly estimate and quarterly expenditure reports) and other pertinent information. This information must be submitted by the State through the Medicaid Budget and Expenditure System (MBES) for the Medicaid program, and through the Child Health Budget

and Expenditure System (CBES) for the title XXI program.

(b) *Quarterly estimates.* The Children's Health Insurance Program agency must submit Form CMS–21B (State Children's Health Insurance Program Budget Report for State Children's Health Insurance Program State expenditures) to the CMS central office (with a copy to the CMS regional office) 45 days before the beginning of each quarter.

(c) *Expenditure reports.* (1) The State must submit Form CMS–64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) and Form CMS–21 (Quarterlye Children's Health Insurance Program Statement of Expenditures for title XXI), to central office (with a copy to the regional office) not later than 30 days after the end of the quarter.

(2) This report is the State's accounting of actual recorded expenditures. This disposition of Federal funds may not be reported on the basis of estimates.

(d) *Additional required information.* A State must provide CMS with the following information regarding the administration of the title XXI program:

(1) Name and address of the State Agency/organization administering the program;

(2) The employer identification number (EIN); and

(3) A State official contact name and telephone number.

(e) *Grant award*—(1) *Computation by CMS.* Regional office staff analyzes the State's estimates and sends a recommendation to the central office. Central office staff considers the State's estimates, the regional office recommendations and any other relevant information, including any adjustments to be made under paragraph (e)(2) of this section, and computes the grant.

(2) *Content of award.* The grant award computation form shows the estimate of expenditures for the ensuing quarter, and the amounts by which that estimate is increased or decreased because of an increase or overestimate for prior quarters, or for any of the following reasons:

(i) Penalty reductions imposed by law.

(ii) Deferrals or disallowances.

(iii) Interest assessments.

(iv) Mandated adjustments such as those required by Section 1914 of the Act.

(3) *Effect of award.* The grant award authorizes the State to draw Federal funds as needed to pay the Federal share of disbursements.

(4) *Draw procedure.* The draw is through a commercial bank and the Federal Reserve system against a continuing letter of credit certified to the Secretary of the Treasury in favor of the State payee. (The letter of credit payment system was established in accordance with Treasury Department regulations—Circular No.1075.)

(f) *General administrative requirements.* With the following exceptions, the provisions of 45 CFR part 75, that establish uniform administrative requirements and cost principles, apply to all grants made to States under this subpart:

(1) Cost sharing or matching, 45 CFR 75.306; and

(2) Financial reporting, 45 CFR 75.341.

[65 FR 33622, May 24, 2000, as amended at 75 FR 48852, Aug. 11, 2010; 81 FR 3012, Jan. 20, 2016]

Subpart G—Strategic Planning, Reporting, and Evaluation

SOURCE: 66 FR 2683, Jan. 11, 2001, unless otherwise noted.

§ 457.700 Basis, scope, and applicability.

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

(1) Section 2101(a) of the Act, which sets forth that the purpose of title XXI is to provide funds to States to provide child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage;

(2) Sections 2107(a), (b) and (d) of the Act, which set forth requirements for strategic planning, reports, and program budgets;

(3) Section 2108 of the Act, which sets forth provisions regarding annual reports and evaluation; and

(4) Section 1139A and 1139B of the Act, which set forth the requirements

for child and adult health quality measures and reporting.

(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, except that §§ 457.730, 457.731, and 457.732 do not apply to Medicaid expansion programs. Separate child health programs that provide benefits exclusively through managed care entities may meet the requirements of §§ 457.730, 457.731, and 457.732 by requiring the managed care entities to meet the requirements of § 457.1233(d).

[66 FR 2683, Jan. 11, 2001, as amended at 85 FR 25635, May 1, 2020; 88 FR 60315, Aug. 31, 2023; 89 FR 8982, Feb. 8, 2024]

§ 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 of the Act. This includes collection of data and reporting as required under § 431.970 of this chapter.

[71 FR 51084, Aug. 28, 2006]

§ 457.730 Beneficiary access to and exchange of data.

(a) *Application Programming Interface to support CHIP beneficiaries.* A State must implement and maintain a standards-based Application Programming Interface (API) that permits third-party applications to retrieve, with the approval and at the direction of the current individual beneficiary or the beneficiary's personal representative, data specified in paragraph (b) of this section through the use of common technologies and without special effort from the beneficiary.

(b) *Accessible content.* A State must make the following information accessible to its current beneficiaries or the beneficiary's personal representative through the API described in paragraph (a) of this section:

(1) Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and beneficiary cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;

(2) Encounter data no later than 1 business day after receiving the data from providers, other than MCOs,

PIHPs, or PAHPs, compensated on the basis of capitation payments;

(3) All data classes and data elements included in a content standard in 45 CFR 170.213 that are maintained by the State no later than 1 business day after the State receives the data; and

(4) Information, about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of the information or updates to such information.

(5) Beginning January 1, 2027, the information in paragraph (b)(5)(i) of this section about prior authorizations for items and services (excluding drugs as defined in paragraph (b)(6) of this section), according to the timelines in paragraph (b)(5)(ii) of this section.

(i) The prior authorization request and decision, including all of the following, as applicable:

(A) The prior authorization status.

(B) The date the prior authorization was approved or denied.

(C) The date or circumstance under which the prior authorization ends.

(D) The items and services approved.

(E) If denied, a specific reason why the request was denied.

(F) Related structured administrative and clinical documentation submitted by a provider.

(ii) The information in paragraph (b)(5)(i) of this section must—

(A) Be accessible no later than 1 business day after the State receives a prior authorization request;

(B) Be updated no later than 1 business day after any status change; and

(C) Continue to be accessible for the duration that the authorization is active and at least 1 year after the prior authorization's last status change.

(6) Drugs are defined for the purposes of paragraph (b)(5) of this section as any and all drugs covered by the State.

(c) *Technical requirements.* A State implementing an API under paragraph (a) of this section:

(1) Must implement and maintain API technology conformant with 45 CFR 170.215(a)(1), (b)(1)(i), (c)(1), and (e)(1);

(2) Must conduct routine testing and monitoring, and update as appropriate, to ensure the API functions properly, including assessments to verify that the API technology is fully and successfully implementing privacy and security features such as, but not limited to, those required to comply with HIPAA privacy and security requirements in 45 CFR parts 160 and 164, 42 CFR parts 2 and 3, and other applicable law protecting the privacy and security of individually identifiable data;

(3) Must comply with the content and vocabulary standard requirements in paragraphs (c)(3)(i) and (ii) of this section, as applicable to the data type or data element, unless alternate standards are required by other applicable law:

(i) Content and vocabulary standards at 45 CFR 170.213 where such standards are applicable to the data type or element, as appropriate; and

(ii) Content and vocabulary standards at 45 CFR part 162 and § 423.160 of this chapter where required by law, or where such standards are applicable to the data type or element, as appropriate.

(4) May use an updated version of any standard or all standards required under paragraphs (c)(1) or (3) of this section, where:

(i) Use of the updated version of the standard is required by other applicable law, or

(ii) Use of the updated version of the standard is not prohibited under other applicable law, provided that:

(A) For content and vocabulary standards other than those at 45 CFR 170.213, the Secretary has not prohibited use of the updated version of a standard for purposes of this section or 45 CFR part 170;

(B) For standards at 45 CFR 170.213 and 170.215, the National Coordinator has approved the updated version for use in the ONC Health IT Certification Program; and

(C) Using the updated version of the standard, implementation guide, or specification does not disrupt an end user's ability to access the data specified in paragraph (b) of this section or §§ 457.731, 457.732, and 457.760 through the required APIs.

(d) *Documentation requirements for APIs.* For each API implemented in accordance with paragraph (a) of this section, a State must make publicly accessible, by posting directly on its website or via publicly accessible hyperlink(s), complete accompanying documentation that contains, at a minimum the information listed in this paragraph. For the purposes of this section, ''publicly accessible'' means that any person using commonly available technology to browse the internet could access the information without any preconditions or additional steps, such as a fee for access to the documentation; a requirement to receive a copy of the material via email; a requirement to register or create an account to receive the documentation; or a requirement to read promotional material or agree to receive future communications from the organization making the documentation available;

(1) API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns;

(2) The software components and configurations that an application must use in order to successfully interact with the API and process its response(s); and

(3) All applicable technical requirements and attributes necessary for an application to be registered with any authorization server(s) deployed in conjunction with the API.

(e) *Denial or discontinuation of access to the API.* A State may deny or discontinue any third-party application's connection to the API required under paragraph (a) of this section if the State:

(1) Reasonably determines, consistent with its security risk analysis under 45 CFR part 164 subpart C, that allowing an application to connect or remain connected to the API would present an unacceptable level of risk to the security of protected health information on the State's systems; and

(2) Makes this determination using objective, verifiable criteria that are applied fairly and consistently across all apps and developers through which parties seek to access electronic health information, as defined in 45 CFR 171.102, including but not limited to criteria that rely on automated monitoring and risk mitigation tools.

(f) *Reporting on Patient Access API usage.* Beginning in 2026, by March 31 of each year, a State must report to CMS the following metrics, in the form of aggregated, de-identified data, for the previous calendar year at the State level in the form and manner specified by the Secretary:

(1) The total number of unique beneficiaries whose data are transferred via the Patient Access API to a health app designated by the beneficiary; and

(2) The total number of unique beneficiaries whose data are transferred more than once via the Patient Access API to a health app designated by the beneficiary.

(g) *Data availability.* (1) The State must comply with the requirements in paragraphs (a) through (f) of this section beginning January 1, 2021 with regard to data:

(i) With a date of service on or after January 1, 2016; and

(ii) That are maintained by the State.

(2) [Reserved]

(h) *Applicability.* A State must comply with the requirements in paragraphs (a) through (e) and (g) of this section beginning January 1, 2021, and with the requirements in paragraph (f) of this section beginning in 2026, with regard to data:

(1) With a date of service on or after January 1, 2016; and

(2) That are maintained by the State.

[85 FR 25636, May 1, 2020, as amended at 89 FR 8982, Feb. 8, 2024]

§457.731 Access to and exchange of health data for providers and payers.

(a) *Application programming interface to support data exchange from payers to providers—Provider Access API.* Beginning January 1, 2027, unless granted an extension or exemption under paragraph (c) of this section, a State must do the following:

(1) *API requirements.* Implement and maintain an application programming interface (API) conformant with all of the following:

(i) Section 457.730(c)(2) through (4), (d), and (e).

(ii) The standards in 45 CFR 170.215(a)(1), (b)(1)(i), (c)(1), and (d)(1).

(2) *Provider access.* Make the data specified in § 457.730(b) with a date of service on or after January 1, 2016, excluding provider remittances and beneficiary cost-sharing information, that are maintained by the State, available to enrolled CHIP providers via the API required in paragraph (a)(1) of this section no later than 1 business day after receiving a request from such a provider, if all the following conditions are met:

(i) The State authenticates the identity of the provider that requests access and attributes the beneficiary to the provider under the attribution process described in paragraph (a)(3) of this section.

(ii) The beneficiary does not opt out as described in paragraph (a)(4) of this section.

(iii) Disclosure of the data is not prohibited by other applicable law.

(3) *Attribution.* Establish and maintain a process to associate beneficiaries with their enrolled CHIP providers to enable data exchange via the Provider Access API.

(4) *Opt out and patient educational resources.* (i) Establish and maintain a process to allow a beneficiary or the beneficiary's personal representative to opt out of the data exchange described in paragraph (a)(2) of this section and to change their permission at any time. That process must be available before the first date on which the State makes beneficiary information available via the Provider Access API and at any time while the beneficiary is enrolled with the State.

(ii) Provide information to beneficiaries in plain language about the benefits of API data exchange with their providers, their opt out rights, and instructions both for opting out of data exchange and for subsequently opting in, as follows:

(A) Before the first date on which the State makes beneficiary information available through the Provider Access API.

(B) No later than 1 week after enrollment.

(C) At least annually.

(D) In an easily accessible location on its public website.

(5) *Provider resources.* Provide on its website and through other appropriate provider communications, information in plain language explaining the process for requesting beneficiary data using the Provider Access API required in paragraph (a)(1) of this section. The resources must include information about how to use the State's attribution process to associate beneficiaries with their providers.

(b) *Application programming interface to support data exchange between payers—Payer-to-Payer API.* Beginning January 1, 2027, unless granted an extension or exemption under paragraph (c) of this section a State must do the following:

(1) *API requirements.* Implement and maintain an API conformant with all of the following:

(i) Section 457.730(c)(2) through (4), (d), and (e).

(ii) The standards in 45 CFR 170.215(a)(1), (b)(1)(i), and (d)(1).

(2) *Opt in.* Establish and maintain a process to allow beneficiaries or their personal representatives to opt into the State's payer to payer data exchange with the beneficiary's previous payer(s), described in paragraphs (b)(4) and (5) of this section, and with concurrent payer(s), described in paragraph (b)(6) of this section, and to change their permission at any time.

(i) The opt in process must be offered as follows:

(A) To current beneficiaries, no later than the compliance date.

(B) To new beneficiaries, no later than 1 week after enrollment.

(ii) If a beneficiary has coverage through any CHIP managed care entities within the same State while enrolled in CHIP, the State must share their opt in permission with those managed care entities to allow the Payer-to-Payer API data exchange described in this section.

(iii) If a beneficiary does not respond or additional information is necessary, the State must make reasonable efforts to engage with the beneficiary to collect this information.

(3) *Identify previous and concurrent payers.* Establish and maintain a process to identify a new beneficiary's previous and concurrent payer(s) to facilitate the Payer-to-Payer API data exchange. The information request process must start as follows:

(i) For current beneficiaries, no later than the compliance date.

(ii) For new beneficiaries, no later than 1 week after enrollment.

(iii) If a beneficiary does not respond or additional information is necessary, the State must make reasonable efforts to engage with the beneficiary to collect this information.

(4) *Exchange request requirements.* Exchange beneficiary data with other payers, consistent with the following requirements:

(i) The State must request the data specified in paragraph (b)(4)(ii) of this section through the beneficiary's previous payers' API, if all the following conditions are met:

(A) The beneficiary has opted in, as described in paragraph (b)(2) of this section, except for data exchanges between a State CHIP agency and its contracted managed care entities, which do not require a beneficiary to opt in.

(B) The exchange is not prohibited by other applicable law.

(ii) The data to be requested are all of the following with a date of service within 5 years before the request:

(A) Data specified in §457.730(b), excluding the following:

(*1*) Provider remittances and enrollee cost-sharing information.

(*2*) Denied prior authorizations.

(B) Unstructured administrative and clinical documentation submitted by a provider related to prior authorizations.

(iii) The State must include an attestation with this request affirming that the beneficiary is enrolled with the State and has opted into the data exchange.

(iv) The State must complete this request as follows:

(A) No later than 1 week after the payer has sufficient identifying information about previous payers and the beneficiary has opted in.

(B) At a beneficiary's request, within 1 week of the request.

(v) The State must receive, through the API required in paragraph (b)(1) of this section, and incorporate into its records about the beneficiary, any data made available by other payers in response to the request.

(5) *Exchange response requirements.* Make available the data specified in paragraph (b)(4)(ii) of this section that are maintained by the State to other payers via the API required in paragraph (b)(1) of this section within 1 business day of receiving a request, if all the following conditions are met:

(i) The payer that requests access has its identity authenticated and includes an attestation with the request that the patient is enrolled with the payer and has opted into the data exchange.

(ii) Disclosure of the data is not prohibited by other applicable law.

(6) *Concurrent coverage data exchange requirements.* When a beneficiary has provided sufficient identifying information about concurrent payers and has opted in as described in paragraph (b)(2) of this section, a State must do the following, through the API required in paragraph (b)(1) of this section:

(i) Request the beneficiary's data from all known concurrent payers as described in paragraph (b)(4) of this section, and at least quarterly thereafter while the beneficiary is enrolled with both payers.

(ii) Respond as described in paragraph (b)(5) of this section within 1 business day of a request from any concurrent payers. If agreed upon with the requesting payer, the State may exclude any data that were previously sent to or originally received from the concurrent payer.

(7) *Patient educational resources.* Provide information to applicants or beneficiaries in plain language, explaining at a minimum: the benefits of Payer-to-Payer API data exchange, their ability to opt in or withdraw that permission, and instructions for doing so. The State must provide the following resources:

(i) When requesting a beneficiary's permission for Payer-to-Payer API data exchange, as described in paragraph (b)(2) of this section.

(ii) At least annually, in appropriate mechanisms through which it ordinarily communicates with current beneficiaries.

(iii) In an easily accessible location on its public website.

(c) *Extensions and exemptions*—(1) *Extension.* (i) A State may submit a written application to request a one-time, 1-year extension of the requirements in paragraph (a) or (b) (or paragraphs (a) and (b)) of this section for its CHIP fee-for-service program. The written application must be submitted as part of the State's annual Advance Planning Document (APD) for Medicaid Management Information System (MMIS) operations expenditures, as described in part 433, subpart C, of this chapter, and approved before the compliance date for the requirements to which the State is seeking an extension. It must include all the following:

(A) A narrative justification describing the specific reasons why the State cannot satisfy the requirement(s) by the compliance date and why those reasons result from circumstances that are unique to the agency operating the CHIP fee-for service program.

(B) A report on completed and ongoing State activities that evidence a good faith effort towards compliance.

(C) A comprehensive plan to meet the requirements no later than 1 year after the compliance date.

(ii) CMS grants the State's request if it determines, based on the information provided, that—

(A) The request adequately establishes a need to delay implementation; and

(B) The State has a comprehensive plan to meet the requirements no later than 1 year after the compliance date.

(2) *Exemption.* (i) A State operating a separate CHIP in which at least 90 percent of the State's CHIP beneficiaries are enrolled in CHIP managed care organizations, as defined in § 457.10, may request an exemption for its fee-for-service program from either or both of the following requirements:

(A) Paragraph (a) of this section.

(B) Paragraphs (b)(1) and (3) through (7) of this section.

(ii) The State's exemption request must:

(A) Be submitted in writing as part of a State's annual APD for MMIS operations expenditures before the compliance date for the requirements to which the State is seeking an exemption.

(B) Include both of the following:

(*1*) Documentation that the State meets the threshold for the exemption, based on enrollment data from section 5 of the most recently accepted CHIP Annual Report Template System (CARTS).

(*2*) An alternative plan to ensure that enrolled providers will have efficient electronic access to the same information through other means while the exemption is in effect.

(iii) CMS grants the exemption if the State establishes to CMS's satisfaction that the State—

(A) Meets the threshold for the exemption; and

(B) Has established an alternative plan to ensure that enrolled providers will have efficient electronic access to the same information through other means while the exemption is in effect.

(iv) The State's exemption expires if either—

(A) Based on the 3 previous years of available, finalized CHIP CARTS managed care and fee-for-service enrollment data, the State's managed care enrollment for 2 of the previous 3 years is below 90 percent; or

(B)(*1*) CMS has approved a State plan amendment, waiver, or waiver amendment that would significantly reduce the percentage of beneficiaries enrolled in managed care; and

(*2*) The anticipated shift in enrollment is confirmed by the first available, finalized CARTS managed care and fee-for-service enrollment data.

(v) If a State's exemption expires under paragraph (c)(2)(iv) of this section, the State is required to do both of the following:

(A) Submit written notification to CMS that the State no longer qualifies for the exemption within 90 days of the finalization of annual CARTS managed

care enrollment data that demonstrates that there has been the requisite shift from managed care enrollment to fee-for-service enrollment resulting in the State's managed care enrollment falling below the 90 percent threshold.

(B) Obtain CMS approval of a timeline for compliance with the requirements in paragraph (a) or (b) (or paragraphs (a) and (b)) of this section within 2 years of the expiration of the exemption.

[89 FR 8983, Feb. 8, 2024]

§ 457.732 Prior authorization requirements.

(a) *Communicating a reason for denial.* Beginning January 1, 2026, if the State denies a prior authorization request (excluding a request for coverage of drugs as defined in § 457.730(b)(6)), in accordance with the timeframes established in § 457.495(d), the response to the provider must include a specific reason for the denial, regardless of the method used to communicate that information.

(b) *Prior Authorization Application Programming Interface (API).* Unless granted an extension or exemption under paragraph (d) of this section, beginning January 1, 2027, a State must implement and maintain an API conformant with § 457.730(c)(2) through (4), (d), and (e), and the standards in 45 CFR 170.215(a)(1), (b)(1)(i), and (c)(1) that—

(1) Is populated with the State's list of covered items and services (excluding drugs as defined in § 457.730(b)(6)) that require prior authorization;

(2) Can identify all documentation required by the State for approval of any items or services that require prior authorization;

(3) Supports a HIPAA-compliant prior authorization request and response, as described in 45 CFR part 162; and

(4) Communicates the following information about prior authorization requests:

(i) Whether the State—

(A) Approves the prior authorization request (and the date or circumstance under which the authorization ends);

(B) Denies the prior authorization request; or

(C) Requests more information.

(ii) If the State denies the prior authorization request, it must include a specific reason for the denial.

(c) *Publicly reporting prior authorization metrics.* Beginning in 2026, a State must annually report prior authorization data, excluding data on drugs as defined in § 457.730(b)(6), at the State level by March 31. The State must make the following data from the previous calendar year publicly accessible by posting them on its website:

(1) A list of all items and services that require prior authorization.

(2) The percentage of standard prior authorization requests that were approved, aggregated for all items and services.

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

(4) The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.

(5) The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.

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

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

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

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

(d) *Extensions and exemptions*—(1) *Extension.* (i) A State may submit a written application to request a one-time, 1-year extension of the requirements in paragraph (b) of this section for its CHIP fee-for-service program. The written application must be submitted and approved as part of the State's annual Advance Planning Document

(APD) for Medicaid Management Information System (MMIS) operations expenditures described in part 433, subpart C, of this chapter, and approved before the compliance date in paragraph (b) of this section. It must include all the following:

(A) A narrative justification describing the specific reasons why the State cannot satisfy the requirement(s) by the compliance date and why those reasons result from circumstances that are unique to the agency operating the CHIP fee-for service program;

(B) A report on completed and ongoing State activities that evidence a good faith effort toward compliance.

(C) A comprehensive plan to meet the requirements no later than 1 year after the compliance date.

(ii) CMS grants the State's request if it determines, based on the information provided, that—

(A) The request adequately establishes a need to delay implementation; and

(B) The State has a comprehensive plan to meet the requirements no later than 1 year after the compliance date.

(2) *Exemption.* (i) A State operating a separate CHIP in which at least 90 percent of the State's CHIP beneficiaries are enrolled in CHIP managed care organizations, as defined in § 457.10, may request an exemption for its fee-for-service program from the requirements in paragraph (b) of this section.

(ii) The State's exemption request must:

(A) Be submitted in writing as part of a State's annual APD for MMIS operations expenditures before the compliance date in paragraph (b) of this section.

(B) Include both of the following:

(*1*) Documentation that the State meets the threshold for the exemption, based on enrollment data from section 5 of the most recently accepted CARTS.

(*2*) An alternative plan to ensure that enrolled providers will have efficient electronic access to the same information through other means while the exemption is in effect.

(iii) CMS grants the exemption if the State establishes to CMS's satisfaction that the State—

(A) Meets the threshold for the exemption; and

(B) Has established an alternative plan to ensure that its enrolled providers will have efficient electronic access to the same information through other means while the exemption is in effect.

(iv) The State's exemption expires if either—

(A) Based on the 3 previous years of available, finalized CHIP CARTS managed care and fee-for-service enrollment data, the State's managed care enrollment for 2 of the previous 3 years is below 90 percent; or

(B)(*1*) CMS has approved a State plan amendment, waiver, or waiver amendment that would significantly reduce the percentage of beneficiaries enrolled in managed care; and

(*2*) The anticipated shift in enrollment is confirmed by the first available, finalized CARTS managed care and fee-for-service enrollment data.

(v) If a State's exemption expires under paragraph (d)(2)(iv) of this section, the State is required to do both of the following:

(A) Submit written notification to CMS that the State no longer qualifies for the exemption within 90 days of the finalization of annual CARTS managed care enrollment data that demonstrates that there has been the requisite shift from managed care enrollment to fee-for-service enrollment resulting in the State's managed care enrollment falling below the 90 percent threshold.

(B) Obtain CMS approval of a timeline for compliance with the requirements in paragraph (b) of this section within 2 years of the expiration of the exemption.

[89 FR 8984, Feb. 4, 2024]

§ 457.740 State expenditures and statistical reports.

(a) *Required quarterly reports.* A State must submit reports to CMS 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) Household income as a percentage of the Federal poverty level as described in paragraph (b) of this section.

(b) *Reportable household 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 household 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 CMS 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) 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.

[66 FR 2683, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

§ 457.760 Access to published provider directory information.

(a) The State must implement and maintain a publicly accessible, standards-based Application Programming Interface (API) that is conformant with the technical requirements at § 457.730(c), excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of this information to particular persons or organizations, the documentation requirements at § 457.730(d), and is accessible via a public-facing digital endpoint on the State's website.

(b) The API must provide a complete and accurate directory of—

(1) The State's provider directory information including provider names, addresses, phone numbers, and specialties, updated no later than 30 calendar days after the State receives provider directory information or updates to provider directory information.

(2) [Reserved]

(c) This section is applicable beginning January 1, 2021.

[85 FR 25637, May 1, 2020]

§ 457.770 Reporting on Health Care Quality Measures.

(a) *Reporting the Child Core Set.* The State must report on the Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (Child Core Set) for a separate child health program in accordance with part 437 of this chapter.

(b) *Reporting the Adult Core Set.* The State may elect to report on the Core Set of Adult Health Care Quality Measures in Medicaid (Adult Core Set) established by the Secretary in accordance with part 437 of this chapter. If the State reports measures on the Adult Core Set, such reporting must be in accordance with part 437 of this chapter, except that reporting on behavioral health measures on the Adult Core Set is not mandatory.

(c) *Reporting of Medicaid and CHIP beneficiaries.* The State must report measures included in the Child Core Set and, if applicable, Adult Core Set for individuals enrolled in a separate CHIP separately from individuals enrolled in Medicaid in accordance with § 437.15(b) of this chapter, regardless of whether the State claims Federal financial participation for such Medicaid-enrolled individuals under title XIX or title XXI of the Act.

[88 FR 60315, Aug. 31, 2023]

Subpart H—Substitution of Coverage

SOURCE: 66 FR 2684, Jan. 11, 2001, unless otherwise noted.

§ 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.

(a) *State plan requirements.* 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.

(b) *Limitations.* A State may not, under this section, impose a waiting period before enrolling into CHIP an eligible individual who has been disenrolled from group health plan coverage, Medicaid, or another insurance affordability program. States must conduct monitoring activities to prevent substitution of coverage.

[78 FR 42313, July 15, 2013, as amended at 81 FR 86466, Nov. 30, 2016; 89 FR 22877, Apr. 2, 2024]

§ 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 CHIP 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) *Prohibition of waiting periods.* A State may not, under this section, impose a waiting period before enrolling into CHIP premium assistance coverage an eligible individual who has access to, but is not enrolled in, group health plan coverage.

(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 CHIP 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 CHIP 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.

[66 FR 2684, Jan. 11, 2001, as amended at 78 FR 42313, July 15, 2013; 89 FR 22877, Apr. 2, 2024]

Subpart I—Program Integrity

SOURCE: 66 FR 2685, Jan. 11, 2001, unless otherwise noted.

§ 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.

(x) Sections 1902(a)(77) and 1902(kk) of the Act relating to provider and supplier screening, oversight, and reporting requirements.

(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.

[66 FR 2685, Jan. 11, 2001, as amended at 76 FR 5970, Feb. 2, 2011]

§ 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 CMS 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 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 part 75, as applicable.

(c) All contracts under this part must include provisions that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable.

[81 FR 27897, May 6, 2016]

§ 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) *MCOs, PAHPs, PIHPs, PCCMs, and PCCM entities.* The contract requirements for MCOs, PAHPs, PIHPs, PCCMs, and PCCM entities are provided in § 457.1201.

(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, CMS and/or the HHS Office of the Inspector General with access to enrollee health claims data, claims payment data and related records.

[66 FR 2685, Jan. 11, 2001, as amended at 81 FR 27897, May 6, 2016]

§ 457.965 Documentation.

(a) *Basis and purpose.* This section, based on section 2101 of the Act, prescribes the kinds of records a State must maintain, the minimum retention period for such records, and the conditions under which those records must be provided or made available.

(b) *Content of records.* A State plan must provide that the State will maintain or supervise the maintenance of the records necessary for the proper and efficient operation of the plan. The records must include all of the following:

(1) Individual records on each applicant and enrollee that contain all of the following:

(i) All information provided on the initial application submitted through

any modality described in § 435.907(a) of this chapter as referenced in § 457.330, by, or on behalf of, the applicant or enrollee, including the signature on and date of application.

(ii) The electronic account and any information or other documentation received from another insurance affordability program in accordance with § 457.348(b) and (c).

(iii) The date of, basis for, and all documents or other evidence to support any determination, denial, or other adverse action, including decisions made at application, renewal, and a result of a change in circumstance, taken with respect to the applicant or enrollee, including all information provided by the applicant or enrollee, and all information obtained electronically or otherwise by the State from third-party sources.

(iv) The provision of, and payment for, services, items and other child health assistance or pregnancy-related assistance, including the service or item provided, relevant diagnoses, the date that the item or service was provided, the practitioner or provider rendering, providing or prescribing the service or item, including their National Provider Identifier, and the full amount paid or reimbursed for the service or item, and any third-party liabilities.

(v) Any changes in circumstances reported by the individual and any actions taken by the State in response to such reports.

(vi) All renewal forms returned by, or on behalf of, a beneficiary, to the State in accordance with § 457.343, regardless of the modality through which such forms are submitted, including the signature on the form and date received.

(vii) All notices provided to the applicant or enrollee in accordance with § 457.340(e) and § 457.1180.

(viii) All records pertaining to any State reviews requested by, or on behalf of, the applicant or enrollee, including each request submitted and the date of such request, the complete record of the review decision, as described in subpart K of this part, and the final administrative action taken by the agency following the review decision and date of such action.

(ix) The disposition of income and eligibility verification information received under § 457.380, including evidence that no information was returned from an electronic data source.

(2) Statistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary.

(c) *Retention of records.* The State plan must provide that the records required under paragraph (b) of this section will be retained for the period when the applicant or enrollee's case is active, plus a minimum of 3 years thereafter.

(d) *Accessibility and availability of records.* The agency must—

(1) Maintain the records described in paragraph (b) of this section in an electronic format; and

(2) To the extent permitted under Federal law, make the records available to the Secretary, Federal and State auditors and other parties who request, and are authorized to review, such records within 30 calendar days of the request (or longer period specified in the request), except when there is an administrative or other emergency beyond the agency's control.

(e) *Release and safeguarding information.* The State must provide safeguards that restrict the use or disclosure of information contained in the records described in paragraph (b) of this section in accordance with the requirements set forth in § 457.1110.

[89 FR 22877, Apr. 2, 2024]

§ 457.980 Verification of enrollment and provider services received.

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.

[66 FR 2685, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

§ 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.

§457.990 Provider and supplier screening, oversight, and reporting requirements.

The following provisions and their corresponding regulations apply to a State under title XXI of the Act, in the same manner as these provisions and regulations apply to a State under title XIX of the Act:

(a) Section 455.107.

(b) Part 455, subpart E, of this chapter.

(c) Sections 1902(a)(77) and 1902(kk) of the Act pertaining to provider and supplier screening, oversight, and reporting requirements.

[76 FR 5970, Feb. 2, 2011, as amended at 84 FR 47857, Sept. 10, 2019]

Subpart J—Allowable Waivers: General Provisions

SOURCE: 66 FR 2686, Jan. 11, 2001, unless otherwise noted.

§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 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 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.

[66 FR 2686, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

§457.1003 CMS review of waiver requests.

CMS 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 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 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

SOURCE: 66 FR 2687, Jan. 11, 2001, unless otherwise noted.

§ 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) The State must have one of the following review processes:

(1) *Program specific review.* A process that meets the requirements of §§457.1130, 457.1140, 457.1150, 457.1160, 457.1170, and 457.1180; or

(2) *Statewide Standard Review.* A process that complies with State review requirements currently in effect for all health insurance issuers (as defined in section 2791 of the Public Health Service Act) in the State.

(b) The State plan must include a description of the State's review process.

[66 FR 33824, June 25, 2001]

§457.1130 Program specific review process: 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 Program specific review process: 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 and benefits in accordance with §457.1170.

[66 FR 2687, Jan. 11, 2001, as amended at 89 FR 22877, Apr. 2, 2024]

§ 457.1150 Program specific review process: 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 Program specific review process: 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 Program specific review process: Continuation of enrollment. Program specific review process: Continuation of enrollment.

A State must ensure the opportunity for continuation of enrollment and benefits pending the completion of review of the following:

(a) A suspension or termination of enrollment, including a decision to disenroll for failure to pay cost sharing; and

(b) A failure to make a timely determination of eligibility at application and renewal.

[89 FR 22877, Apr. 2, 2024]

§ 457.1180 Program specific review process: 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 and benefits may continue pending review.

[89 FR 22877, Apr. 2, 2024]

§ 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 a program specific review or a Statewide standard review, as described in § 457.1120, 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.

[66 FR 2686, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

Subpart L—Managed Care

SOURCE: 81 FR 27897, May 6, 2016, unless otherwise noted.

GENERAL PROVISIONS

§ 457.1200 Basis, scope, and applicability.

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

(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.

(2) Section 2103(f)(3) and 2107(e)(1)(M) of the Act, which apply certain provisions of Title XIX related to Medicaid managed care to CHIP.

(3) Sections 2107(b) and 2107(e)(2) of the Act, which relate to program integrity.

(b) *Scope.* This subpart sets forth requirements for the provision of services through MCOs, PIHPs, PAHPs, and PCCM entities, as defined in § 457.10.

(c) *Applicability.* The requirements of this subpart apply to child health assistance provided under a separate child health program operating a managed care delivery system. Regulations relating to managed care that are applicable to a Medicaid expansion program are found at part 438 of this chapter.

(d) *Applicability dates.* States will not be held out of compliance with the following requirements of this subpart prior to the dates established at §§ 438.3(v), 438.10(j), 438.16(f), 438.68(h), 438.206(d), 438.207(g), 438.310(d), 438.505(a)(2), 438.602(j), and 438.608(f) of this chapter, so long as they comply with the corresponding standard(s) of this subpart, edition revised as of July 9, 2024. States will not be held out of compliance with the requirement at § 457.1207 to post comparative summary results of enrollee experience surveys by managed care plan annually on State websites, nor the requirement for States to evaluate annual enrollee experience survey results as part of the State's annual analysis of network adequacy as described at § 457.1230(b), so long as they comply with the corresponding standard(s) of this subpart, 2 years after July 9, 2024.

[81 FR 27897, May 6, 2016, as amended at 89 FR 41284, May 10, 2024]

§ 457.1201 Standard contract requirements.

(a) *CMS review.* The State must submit all MCO, PAHP, PIHP, PCCM, and PCCM entity contracts for review in the form and manner established by CMS.

(b) *Entities eligible for comprehensive risk contracts.* The State may enter into a comprehensive risk contract only with the entities specified in § 438.3(b)(1) through (3) of this chapter.

(c) *Payment.* The final capitation rates for all MCO, PIHP or PAHP contracts must be identified and developed, and payment must be made in accordance with §§ 438.3(c) and 438.16(c)(1) through (3) of this chapter, except that the requirement for preapproval of contracts, certifications by an actuary, annual cost reports, contract arrangements described in § 438.6(c), and references to pass through payments do not apply, and contract rates must be submitted to CMS upon request of the Secretary.

(d) *Enrollment discrimination prohibited.* Contracts with MCOs, PAHPs, PIHPs, PCCMs and PCCM entities must comply with prohibitions on enrollment discrimination in accordance with § 438.3(d) of this chapter, except that § 438.3(d)(2) of this chapter (related to voluntary enrollment) does not apply.

(e) *Services that may be covered by an MCO, PIHP, or PAHP.* An MCO, PIHP, or PAHP may cover, for enrollees, services that are not covered under the State plan in accordance with §§ 438.3(e) and 438.16(b), (d), and (e) of this chapter, except that references to § 438.7, IMDs, and rate certifications do not apply and that references to enrollee rights and protections under part 438 should be read to refer to the rights and protections under subparts K and L of this part.

(f) *Compliance with applicable laws and conflict of interest safeguards.* Contracts with MCOs, PAHPs, PIHPs, PCCMs or

PCCM entities must comply with Federal laws and regulations in accordance with § 438.3(f) of this chapter.

(g) *Inspection and audit of records and access to facilities.* Contracts with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities must allow for the inspection and audit of records and access to facilities in accordance with § 438.3(h) of this chapter.

(h) *Physician incentive plans.* If a contract with an MCO, PAHP, or PIHP provides for a physician incentive plan, it must comply with § 438.3(i) of this chapter (which cross references §§ 422.208 and 422.210 of this chapter).

(i) *Subcontractual relationships and delegations.* The state must ensure, through its contracts with MCOs, PIHPs, and PAHPs, that any contract or written agreement that the MCO, PIHP, or PAHP has with any individual or entity that relates directly or indirectly to the performance of the MCOs, PIHPs, or PAHPs obligations under its contract comply with § 457.1233(b) (which cross references § 438.230 of this chapter).

(j) *Choice of network provider.* The contract must allow each enrollee to choose his or her network provider in accordance with § 438.3(l) of this chapter.

(k) *Audited financial reports.* Contracts with MCOs, PAHPs, and PIHPs must comply with the requirements for submission of audited financial reports in § 438.3(m) of this chapter.

(l) *Parity in mental health and substance use disorder benefits.* Contracts with MCOs, PAHPs, and PIHPs must comply with the requirements of § 457.496.

(m) *Additional rules for contracts with PCCMs.* Contracts with PCCMs must comply with the requirements of § 438.3(q) of this chapter, except that the right to disenroll is in accordance with § 457.1212.

(n) *Additional rules for contracts with PCCM entities.* (1) States must submit PCCM entity contracts to CMS for review.

(2) Contracts with PCCMs must comply with the requirements of paragraph (o) of this section; § 457.1207; § 457.1240(b) (cross-referencing § 438.330(b)(2), (b)(3), (c), and (e) of this chapter); § 457.1240(e) (cross-referencing § 438.340 of this chapter).

(o) *Attestations.* Contracts with MCO, PAHP, PIHP, PCCM or PCCM entities must include an attestation to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury.

(p) *Guarantee not to avoid costs.* Contracts with an MCO, PAHP, PIHP, PCCM or PCCM entities must include a guarantee that the MCO, PAHP, PIHP, PCCM or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources.

(q) *Recordkeeping requirements.* Contracts with MCOs, PIHPs, and PAHPs, must comply with the recordkeeping requirements of § 438.3(u) of this chapter.

[81 FR 27897, May 6, 2016, as amended at 82 FR 40, Jan. 3, 2017; May 10, 2024]

§ 457.1203 Rate development standards and medical loss ratio.

(a) A state must use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at § 457.10. This requirement for using actuarially sound principles to develop payment rates does not prohibit a state from implementing value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; such alternate payment models should be developed using actuarially sound principles to the extent applicable.

(b) A State may establish higher rates than permitted under paragraph (a) of this section if such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services.

(c) The rates must be designed to reasonably achieve a medical loss ratio standard, calculated in accordance with the provisions of § 438.8 of this chapter, that—

(1) Is equal to at least 85 percent for the rate year; and

(2) Provides for reasonable administrative costs.

(d) The State must provide to CMS, if requested, a description of the manner in which rates were developed in accordance with the requirements of paragraphs (a), (b), or (c) of this section.

(e) The State must comply with the requirements related to medical loss ratios in accordance with the terms of § 438.74 of this chapter, except contract arrangements described in § 438.6(c) do not apply and the description of the reports received from the MCOs, PIHPs and PAHPs under § 438.8(k) of this chapter will be submitted independently, and not with the rate certification described in § 438.7 of this chapter.

(f) The State must ensure, through its contracts, that each MCO, PIHP, and PAHP complies with the requirements in § 438.8 of this chapter, except that contract arrangements described in § 438.6(c) do not apply.

[81 FR 27897, May 6, 2016, as amended at 82 FR 40, Jan. 3, 2017; 89 FR 41285, May 10, 2024]

§ 457.1206 Non-emergency medical transportation PAHPs.

(a) For purposes of this section Non-Emergency Medical Transportation (NEMT) Prepaid Ambulatory Health Plan (PAHP) means an entity that provides only NEMT services to enrollees under contract with the State, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates.

(b) The following requirements and options apply to NEMT PAHPs, NEMT PAHP contracts, and States in connection with NEMT PAHPs, to the same extent that they apply to PAHPs, PAHP contracts, and States in connection with PAHPs.

(1) All contract provisions in § 457.1201 except those set forth in § 457.1201(h) (related to physician incentive plans) § 457.1201(l) (related to mental health parity).

(2) The information requirements in § 457.1207.

(3) The provision against provider discrimination in § 457.1208.

(4) The State responsibility provisions in §§ 457.1212 and 457.1214, and § 438.62(a) of this chapter, as cross-referenced in § 457.1216.

(5) The provisions on enrollee rights and protections in §§ 457.1220, 457.1222, 457.1224, and 457.1226.

(6) The PAHP standards in § 438.206(b)(1) of this chapter, as cross-referenced by §§ 457.1230(a) and (d) and 457.1233(a), (b), and (d), excluding the requirement in § 438.242(b)(7) of this chapter to comply with § 431.61(a) of this chapter.

(7) An enrollee's right to a State review under subpart K of this part.

(8) Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in § 438.610 of this chapter, as cross referenced by § 457.1285.

(9) Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in § 457.1209.

[81 FR 27897, May 6, 2016, as amended at 89 FR 8985, Feb. 8, 2024]

§ 457.1207 Information requirements.

The State must provide, or ensure its contracted MCO, PAHP, PIHP, PCCM, and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of § 438.10 of this chapter, except that the terms of § 438.10(c)(2), (g)(2)(xi)(E), and (g)(2)(xii) of this chapter do not apply and that references to enrollee rights and protections under part 438 should be read to refer to the rights and protections under subparts K and L of this part. The State must annually post comparative summary results of enrollee experience surveys by managed care plan on the State's website as described at § 438.10(c)(3) of this chapter.

[89 FR 41285, May 10, 2024]

§ 457.1208 Provider discrimination prohibited.

The state must ensure through its contracts that each MCO, PIHP, and PAHP follow the requirements related to the prohibition on provider discrimination in § 438.12 of this chapter.

§ 457.1209 Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care provider (IHCP), and Indian managed care entities (IMCE).

The State must follow, and ensure through its contracts, that each MCO, PIHP, PAHP, PCCM, and PCCM entity follows, the requirements related to Indians, IHCPs, and IMCEs in accordance with the terms of § 438.14 of this chapter.

STATE RESPONSIBILITIES

§ 457.1210 Enrollment process.

(a) *Default enrollment process.* (1) If a state uses a default enrollment process to assign beneficiaries to a MCO, PIHP, PAHP, PCCM, or PCCM entity, the process must:

(i) Assign beneficiaries to a qualified MCO, PIHP, PAHP, PCCM or PCCM entity. To be qualified, the MCO, PIHP, PAHP, PCCM or PCCM entity must:

(A) Not be subject to the intermediate sanction described in § 438.702(a)(4) of this chapter.

(B) Have capacity to enroll beneficiaries.

(ii) Maximize continuation of existing provider-beneficiary relationships. An ''existing provider-beneficiary relationship'' is one in which the provider was the main source of CHIP services for the beneficiary during the previous year. This may be established through State records of previous managed care enrollment or fee-for-service experience, encounter data, or through contact with the beneficiary.

(iii) If the approach in paragraph (a)(1)(ii) of this section is not possible, the State must distribute the beneficiaries equitably among the MCOs, PIHPs, PAHPs, PCCMs and PCCM entities. The State may not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered.

(2) The State may consider additional reasonable criteria to conduct the default enrollment process, including the previous plan assignment of the beneficiary, quality assurance and improvement performance, procurement evaluation elements, accessibility of provider offices for people with disabilities (when appropriate), and other reasonable criteria that support the objectives of the managed care program.

(3) The State must send a confirmation of the enrollee's managed care enrollment to the enrollee within 5 calendar days of the date such enrollment is processed by the State. The confirmation must clearly explain the enrollee's right to disenroll within 90 days from the effective date of the enrollment.

(b) *Priority for enrollment.* The state must have an enrollment system under which beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity are given priority to continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM entity does not have the capacity to accept all those seeking enrollment under the program.

(c) *Informational notices.* A State must provide an informational notice to each potential enrollee who may enroll in an MCO, PIHP, PAHP, PCCM, or PCCM entity. Such notice must:

(1) Include the MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities available to the potential enrollee;

(2) Explain how to select an MCO, PIHP, PAHP, PCCM, or PCCM entity;

(3) Explain the implications of making or not making an active choice of an MCO, PIHP, PAHP, PCCM or PCCM entity;

(4) Explain the length of the enrollment period as well as the disenrollment policies in § 457.1212; and

(5) Comply with the information requirements in § 457.1207 and accessibility standards established under § 457.340.

[81 FR 27897, May 6, 2016, as amended at 82 FR 40, Jan. 3, 2017]

§ 457.1212 Disenrollment.

The State must comply with and ensure, through its contracts, that each MCO, PAHP, PIHP, PCCM and PCCM entity complies with the disenrollment requirements in accordance with the terms of § 438.56 of this chapter, except that references to fair hearings should be read to refer to reviews as described in subpart K of this part.

§ 457.1214 Conflict of interest safeguards.

The State must have in effect safeguards against conflict of interest in

accordance with the terms of § 438.58 of this chapter, except that references to § 438.54(b) should be read to refer to the enrollment processes described in § 457.1210(a).

[82 FR 40, Jan. 3, 2017]

§ 457.1216 Continued services to enrollees.

The State must follow the requirements related to continued services to enrollees in accordance with the terms of § 438.62 of this chapter.

§ 457.1218 Network adequacy standards.

The State must develop network adequacy standards in accordance with the terms of § 438.68 of this chapter, and, ensure through its contracts, that each MCO, PAHP, and PIHP meets such standards.

ENROLLEE RIGHTS AND PROTECTIONS

§ 457.1220 Enrollee rights.

The State must ensure, through its contracts, that each MCO, PIHP, PAHP, PCCM, and PCCM entity follow the enrollee rights requirements in accordance with the terms of § 438.100 of this chapter.

§ 457.1222 Provider-enrollee communication.

The State must ensure, through its contracts, that each MCO, PIHP, and PAHP protects communications between providers and enrollees in accordance with the terms of § 438.102 of this chapter.

§ 457.1224 Marketing activities.

The State must ensure, through its contracts, that each MCO, PIHP, PAHP, PCCM, and PCCM entity follows the requirements related to marketing activities in accordance with the terms of § 438.104 of this chapter, except § 438.104(c) of this chapter related to state agency review does not apply.

§ 457.1226 Liability for payment.

The State must ensure, through its contracts, that enrollees of MCOs, PIHPs, and PAHPs are not held liable for services or debts of the MCO, PIHP, or PAHPs in accordance with the terms of § 438.106 of this chapter.

§ 457.1228 Emergency and poststabilization services.

The State must ensure that emergency and poststabilization care services are available and accessible to enrollees in accordance with the terms of § 438.114 of this chapter.

[82 FR 40, Jan. 3, 2017]

MCO, PIHP, AND PAHP STANDARDS

§ 457.1230 Access standards.

(a) *Availability of services.* The State must ensure that the services are available and accessible to enrollees in accordance with the terms of § 438.206 of this chapter.

(b) *Assurances of adequate capacity and services.* The State must ensure, through its contracts, that each MCO, PIHP and PAHP has adequate capacity to serve the expected enrollment in accordance with the terms of § 438.207 of this chapter, except that the reporting requirements in § 438.207(d)(3)(i) of this chapter do not apply. The State must evaluate the most recent annual enrollee experience survey results as required at section 2108(e)(4) of the Act as part of the State's analysis of network adequacy as described at § 438.207(d) of this chapter.

(c) *Coordination and continuity of care.* The State must ensure, through its contracts, that each MCO, PIHP and PAHP complies with the coordination and continuity of care requirements in accordance with the terms of § 438.208 of this chapter, except that the applicability date in § 438.208(d) does not apply.

(d) *Coverage and authorization of services.* The State must ensure, through its contracts, that each MCO, PIHP, or PAHP complies with the coverage and authorization of services requirements in accordance with the terms of § 438.210 of this chapter, except that the following do not apply:

(1) Section 438.210(a)(5) of this chapter (related to medical necessity standard).

(2) Section 438.210(b)(2)(iii) of this chapter (related to authorizing long term services and supports (LTSS)).

[81 FR 27897, May 6, 2016, as amended at 82 FR 40, Jan. 3, 2017; 89 FR 8985, Feb. 8, 2024; 89 FR 41285, May 10, 2024]

§ 457.1233 Structure and operation standards.

(a) *Provider selection.* The State must ensure, through its contracts, that each MCO, PIHP or PAHP complies with the provider selection requirements as provided in § 438.214 of this chapter.

(b) *Subcontractual relationships and delegation.* The State must ensure, through its contracts, that each MCO, PIHP, PAHP, and PCCM entity complies with the subcontractual relationships and delegation requirements as provided in § 438.230 of this chapter.

(c) *Practice guidelines.* The state must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP, complies with the practice guidelines requirements as provided in § 438.236 of this chapter.

(d) *Health information systems.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP complies with the health information systems requirements as provided in § 438.242 of this chapter, except that the applicability date in § 438.242(e) of this chapter does not apply. The State is required to submit enrollee encounter data to CMS in accordance with § 438.818 of this chapter.

(e) *Privacy protections.* The state must ensure, through its contracts, that each MCO, PIHP, and PAHP complies with the privacy protections as provided in § 457.1110.

[81 FR 27897, May 6, 2016, as amended at 82 FR 40, Jan. 3, 2017; 85 FR 25637, May 1, 2020; 85 FR 72842, Nov. 13, 2020]

QUALITY MEASUREMENT AND IMPROVEMENT; EXTERNAL QUALITY REVIEW

§ 457.1240 Quality measurement and improvement.

(a) *Scope.* This section sets forth requirements related to quality assessment and performance improvement that the State must meet in contracting with an MCO, PIHP, PAHP, or certain PCCM entities.

(b) *Quality assessment and performance improvement program.* (1) The State must require, through its contracts, that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees, in accordance with the requirements and standards in § 438.330 of this chapter, except that the terms of § 438.330(d)(4) of this chapter (related to dually eligible beneficiaries) do not apply.

(2) In the case of a contract with a PCCM entity described in paragraph (f) of this section, § 438.330(b)(2) and (3), (c), and (e) of this chapter apply.

(c) *State review of the accreditation status of MCOs, PIHPs, and PAHPs.* The State must review the accreditation status of each MCO, PIHP, and PAHP in accordance with the requirements as set forth in § 438.332 of this chapter.

(d) *Managed care quality rating system.* The State must determine a quality rating or ratings for each MCO, PIHP, and PAHP in accordance with the requirements set forth in subpart G of part 438 of this chapter, except that references to dually eligible beneficiaries, a beneficiary support system, and the terms related to consultation with the Medical Care Advisory Committee do not apply.

(e) *Managed care quality strategy.* The State must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in § 438.340 of this chapter, except that the reference to consultation with the Medical Care Advisory Committee described in § 438.340(c)(1)(i) of this chapter does not apply.

(f) *Applicability to PCCM entities.* For purposes of paragraphs (b) and (e) of this section and § 457.1250(a), a PCCM entity described in this paragraph is a PCCM entity whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes.

[81 FR 27897, May 6, 2016, as amended at 82 FR 40, Jan. 3, 2017; 85 FR 72842, Nov. 13, 2020; 89 FR 41285, May 10, 2024]

§ 457.1250 External quality review.

(a) Each State that contracts with MCOs, PIHPs, or PAHPs must follow all applicable external quality review requirements as set forth in §§ 438.350 (except for references to § 438.362), 438.352, 438.354, 438.356, 438.358 (except for references to § 438.6), 438.360 (only

for nonduplication of EQR activities with private accreditation) and 438.364 of this chapter.

(b) A State may amend an existing EQRO contract to include the performance of EQR-related activities and/or EQR in accordance with paragraph (a) of this section.

[81 FR 27897, May 6, 2016, as amended at 82 FR 40, Jan. 3, 2017; 89 FR 41285, May 10, 2024]

GRIEVANCE SYSTEM

§ 457.1260 Grievance system.

(a) *Statutory basis and definitions*—(1) *Statutory basis.* This section implements section 2103(f)(3) of the Act, which provides that the State CHIP must provide for the application of section 1932(a)(4), (a)(5), (b), (c), (d), and (e) of the Act (relating to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations. Section 1932(b)(4) of the Act requires managed care plans to establish an internal grievance procedure under which an enrollee, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for covered benefits.

(2) *Definitions.* The following definitions from § 438.400(b) of this chapter apply to this section—

(i) Paragraphs (1) through (5) and (7) of the definition of ''adverse benefit determination''; and

(ii) The definitions of ''appeal'', ''grievance'', and ''grievance and appeal system''.

(b) *General requirements.* (1) The State must ensure that its contracted MCOs, PIHPs, and PAHPs comply with the provisions of § 438.402(a), (b), and (c)(2) and (3) of this chapter with regard to the establishment and operation of a grievances and appeals system.

(2) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State external review in accordance with the terms of subpart K of this part after receiving notice under paragraph (e) of this section that the adverse benefit decision is upheld by the MCO, PIHP, or PAHP.

(3) If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State external review in accordance with the terms of subpart K of this part, on behalf of an enrollee. When the term ''enrollee'' is used throughout this section, it includes providers and authorized representatives consistent with this paragraph (b).

(c) *Timely and adequate notice of adverse benefit determination.* (1) The State must ensure that its contracted MCOs, PIHPs, and PAHPs comply with the provisions at § 438.404(a) and (b)(1), (2), and (5) of this chapter (regarding the content of the notice of an adverse benefit determination).

(2) In addition to the requirements referenced in paragraph (c)(1) of this section, the notice must explain:

(i) The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal described at § 438.402(b) of this chapter referenced in paragraph (b)(1) of this section, and the right to request a State external review in accordance with the terms of subpart K of this part; and

(ii) The procedures for the enrollee to exercise his or her rights provided under this paragraph (c).

(3) The MCO, PIHP, or PAHP must provide timely written notice to the enrollee of the adverse benefit determination. The terms of §§ 438.404(c)(6) and 438.210(d)(2) of this chapter apply in the circumstances of expedited service authorization decisions.

(d) *Handling of grievances and appeals.* The State must ensure that its contracted MCOs, PIHPs, and PAHPs comply with the provisions at § 438.406 of this chapter.

(e) *Resolution and notification: Grievances and appeals.* (1) The State must ensure that its contracted MCOs, PIHPs, and PAHPs comply with the provisions at § 438.408(b) (relating to the timeframe for resolution of grievances and appeals), (c)(1) and (2) (the extension of timeframes for resolution of grievances and appeals), (d) (relating to the format of the notice of resolution for grievances and appeals), and

(e)(1) (relating to the content of the notice of resolution for grievances and appeals) of this chapter.

(2) Each MCO, PIHP, or PAHP must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this paragraph (e).

(3) In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State external review in accordance with the terms of subpart K of this part.

(4) For appeals not resolved wholly in favor of an enrollee, in addition to the information required under paragraph (e)(1) of this section and § 438.408(e)(1) of this chapter, the content of the notice of appeal resolution must include the enrollee's right to request a State external review in accordance with the terms of subpart K of this part, and how to do so.

(5) Except as provided in paragraph (e)(3) of this section, an enrollee may request a State external review only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination. The State must provide enrollees no less than 90 calendar days and no more than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution to request a State external review. The parties to the State external review include the MCO, PIHP, or PAHP, as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

(f) *Expedited resolution of appeals.* The State must ensure that its contracted MCOs, PIHPs, and PAHPs comply with the provisions at § 438.410 of this chapter.

(g) *Information about the grievance and appeal system to providers and subcontractors.* The State must ensure that its contracted MCOs, PIHPs, and PAHPs comply with the provisions at § 438.414 of this chapter.

(h) *Recordkeeping requirements.* The State must ensure that its contracted MCOs, PIHPs, and PAHPs comply with the provisions at § 438.416 of this chapter.

(i) *Effectuation of reversed appeal resolutions.* If the MCO, PIHP, or PAHP, or the result of a State external review, in accordance with the terms of subpart K of this part, reverses a decision to deny, limit, or delay services, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

[85 FR 72842, Nov. 13, 2020]

SANCTIONS

§ 457.1270 Sanctions.

(a) *General.* The State must comply with §§ 438.700 through 438.704, 438.706(c) and (d), and 438.708 through 438.730 of this chapter.

(b) *Optional imposition of temporary management.* Except as provided in paragraph (c) of this section, the State may impose temporary management under § 438.702(a)(2) of this chapter as referenced in paragraph (a) of this section, only if it finds (through onsite surveys, enrollee or other complaints, financial status, or any other source) any of the following:

(1) There is continued egregious behavior by the MCO, including but not limited to behavior that is described in § 438.700 of this chapter (as referenced in paragraph (a) of this section), or that is contrary to any of the requirements of this subpart.

(2) There is substantial risk to enrollees' health.

(3) The sanction is necessary to ensure the health of the MCO's enrollees—

(i) While improvements are made to remedy violations under § 438.700 of this chapter as referenced in paragraph (a) of this section.

(ii) Until there is an orderly termination or reorganization of the MCO.

(c) *Required imposition of temporary management.* The State must impose temporary management (regardless of any other sanction that may be imposed) if it finds that an MCO has repeatedly failed to meet substantive requirements in this subpart. The State must also grant enrollees the right to

terminate enrollment without cause, as described in § 438.702(a)(3) of this chapter as referenced in paragraph (a) of this section, and must notify the affected enrollees of their right to terminate enrollment.

[85 FR 72843, Nov. 13, 2020]

§ 457.1280 Conditions necessary to contract as an MCO, PAHP, or PIHP.

(a) The State must assure that any entity seeking to contract as an MCO, PAHP, or PIHP 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 MCO, PAHP, and PIHP compliance with all applicable Federal and State statutes, regulations, and standards.

(2) Prohibit MCOs, PAHPs, and PIHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity.

(3) Include a mechanism for MCOs, PAHPs, and PIHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PAHP, or PIHP 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 MCOs, PIHPs, and PAHPs at any time, as necessary, in instances where the State determines that there is a reasonable possibility of fraudulent or abusive activity.

[66 FR 2685, Jan. 11, 2011. Redesignated and amended at 81 FR 27900, May 6, 2016]

§ 457.1285 Program integrity safeguards.

The State must comply with the program integrity safeguards in accordance with the terms of subpart H of part 438 of this chapter, except that the terms of §§ 438.66(e), 438.362(c), 438.602(g)(6) and (10), 438.604(a)(2), 438.608(d)(4) and references to LTSS of this chapter do not apply and that references to subpart K under part 438 should be read to refer to parity requirements at § 457.496.

[89 FR 41285, May 10, 2024]