ragraph (c) of this section, the folwing categories of payments are aied to reduce the State allotments r a fiscal year:

(1) Payments made to the State for penditures claimed during the fiscal ar under its title XIX Medicaid proam, to the extent the payments were ade on the basis of the enhanced MAP described in sections 1905(b) and 05(b) of the Act for expenditures atibutable to children described in seon 1905(u)(2) of the Act.

(2) Payments made to the State for penditures claimed during the fiscal ear under its title XIX Medicaid proram, to the extent the payments were ade on the basis of the enhanced MAP described in sections 1905(b) and 105(b) of the Act for expenditures atibutable to children described in seion 1905(u)(3) of the Act.

(3) Payments made to a State under ection 1903(a) of the Act for expendiures claimed by the State during a fisal year that are attributable to the rovision of medical assistance to a hild during a presumptive eligibility eriod under section 1920A of the Act.

(4) Payments made to a State under ts title XXI State Children's Health nsurance Program with respect to seion 2105(a) of the Act for expenditures laimed by the State during a fiscal ear.

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

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

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

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

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

(1) Applies the payments attributable o 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.

§457.618 Ten percent limit on certain State 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:

$$L_{10}\% = (a1 + u2 + u3)/9;$$

$L_{10}\%$ = 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 in 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

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(i) Promptly inform the child's parent or caretaker in writing and, if appropriate, orally that the child has been found likely to be eligible for Medicaid; provide the family with a Medicaid application and offer information about what, if any, further information, documentation, or other steps are needed to complete the Medicaid application process; and offer assistance in completing the application process;

(ii) Promptly transmit the separate child health program application; or the information obtained through the application, and all other relevant information and documentation, including the results of the screening process, to the Medicaid agency for a final determination of Medicaid eligibility in accordance with the requirements of §§ 431.636 and 457.1110 of this chapter; or

(4) Establish other effective and efficient procedures, in coordination with the Medicaid agency, as described and approved in the State plan that ensure that children who are screened as potentially eligible for Medicaid are able to apply for Medicaid without delay and, if eligible, are enrolled in Medicaid in a timely manner; and

(5) Determine or redetermine eligibility for the separate child health program, if—

(i) The State is notified pursuant to § 431.636 of this chapter that the child has been found ineligible for Medicaid, consistent with the time standards established pursuant to § 457.340(c); or

(ii) The State is notified prior to the final Medicaid eligibility determination that the child's circumstances have changed and another screening shows that the child is not likely to be eligible for Medicaid.

(g) *Informed application decisions.* To enable a family to make an informed decision about applying for Medicaid or completing the Medicaid application process, a State must provide the child's family with information, in writing, about—

(1) The State's Medicaid program, including the benefits covered, and restrictions on cost sharing; and

(2) Eligibility rules that prohibit children who have been screened eligible for Medicaid from being enrolled in a separate child health program, other than provisional temporary enrollment while a final Medicaid eligibility determination is being made.

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

(h) *Waiting lists, enrollment caps and closed enrollment.* The State must establish procedures to ensure that—

(1) The procedures developed in accordance with this section have been followed for each child applying for a separate child health program before placing the child on a waiting list or otherwise deferring action on the child's application for the separate child health program; and

(2) Families are informed that a child may be eligible for Medicaid if circumstances change while the child is on a waiting list for separate child health program.

[66 FR 2675, Jan. 11, 2001, as amended at 66 FR 33823, June 25, 2001; 67 FR 61974, Oct. 2, 2002]

§ 457.353 Monitoring and evaluation of screening process.

States must monitor and establish a mechanism to evaluate the screen and enroll process described at § 457.350 to ensure that children who are screened potentially eligible for Medicaid are enrolled in Medicaid, if eligible, and that children who are found ineligible for Medicaid are enrolled in the separate child health program, if eligible.

§ 457.355 Presumptive eligibility.

(a) *General rule.* Consistent with subpart D of this part, the State may pay costs of coverage under a separate child health program, during a period of presumptive eligibility for children applying for coverage under the separate child health program, pending the screening process and a final determination of eligibility (including applicants found through screening to be potentially eligible for Medicaid).

(b) *Expenditures for coverage during a period of presumptive eligibility.* Expenditures for coverage during a period of presumptive eligibility implemented in accordance with § 435.1102 of this chapter may be considered as expenditures for child health assistance under the plan.

[66 FR 2675, Jan. 11, 2001, as amended at 66 FR 33823, June 25, 2001]

§ 457.380 Eligibility verification.

(a) The State must establish procedures to ensure the integrity of the eligibility determination process.

(b) A State may establish reasonable eligibility verification mechanisms to promote enrollment of eligible children and may permit applicants and enrollees to demonstrate that they meet eligibility requirements through self-declaration or affirmation except that a State may permit self-declaration of citizenship only if the State has effective, fair and non-discriminatory procedures to ensure the integrity of the application process in accordance with § 457.320(c).

Subpart D—State Plan Requirements: Coverage and Benefits

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 SCHIP program to other laws;

(4) Section 2110(a) of the Act, which describes child health assistance; and

(5) Section 2110(c) of the Act, which contains definitions applicable to this subpart.

(b) *Scope.* This subpart sets forth requirements for health benefits coverage and child health assistance under a separate child health plan.

(c) *Applicability.* The requirements of this subpart apply to child health assistance provided under a separate child health program and do not apply to a Medicaid expansion program.

§ 457.402 Definition of child health assistance.

For the purpose of this subpart, the term "child health assistance" means payment for part or all of the cost of health benefits coverage provided to targeted low-income children for the following services:

(a) Inpatient hospital services.

(b) Outpatient hospital services.

(c) Physician services.

(d) Surgical services.

(e) Clinic services (including health center services) and other ambulatory health care services.

(f) Prescription drugs and biologicals and the administration of these drugs and biologicals, only if these drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

(g) Over-the-counter medications.

(h) Laboratory and radiological services.

(i) Prenatal care and pre-pregnancy family planning services and supplies.

(j) Inpatient mental health services, other than services described in paragraph (r) of this section but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

(k) Outpatient mental health services, other than services described in paragraph (s) of this section but including services furnished in a State-operated mental hospital and including community-based services.

(l) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices and adaptive devices).

(m) Disposable medical supplies.

(n) Home and community-based health care services and related supportive services (such as home health nursing services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members and minor modification to the home.)

(o) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse

services, private duty nursing, pediatric nurse services and respiratory care services) in a home, school, or other setting.

(p) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.

(q) Dental services.

(r) Inpatient substance abuse treatment services and residential substance abuse treatment services.

(s) Outpatient substance abuse treatment services.

(t) Case management services.

(u) Care coordination services.

(v) Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.

(w) Hospice care.

(x) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—

(1) Prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law;

(2) Performed under the general supervision or at the direction of a physician; or

(3) Furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

(y) Premiums for private health care insurance coverage.

(z) Medical transportation.

(aa) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

(bb) Any other health care services or items specified by the Secretary and not excluded under this subchapter.

§ 457.410 Health benefits coverage options.

(a) *Types of health benefits coverage.* States may choose to obtain any of the following four types of health benefits coverage:

(1) Benchmark coverage in accordance with § 457.420.

(2) Benchmark-equivalent coverage in accordance with § 457.430.

(3) Existing comprehensive State-based coverage in accordance with § 457.440.

(4) Secretary-approved coverage in accordance with § 457.450.

(b) *Required coverage.* Regardless of the type of health benefits coverage, described at paragraph (a) of this section, that the State chooses to obtain, the State must obtain coverage for—

(1) Well-baby and well-child care services as defined by the State;

(2) Age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP); and

(3) Emergency services as defined in § 457.10.

§ 457.420 Benchmark health benefits coverage.

Benchmark coverage is health benefits coverage that is substantially equal to the health benefits coverage in one of the following benefit plans:

(a) *Federal Employees Health Benefit Plan (FEHBP).* The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under, 5 U.S.C. 8903(1).

(b) *State employee plan.* A health benefits plan that is offered and generally available to State employees in the State.

(c) *Health maintenance organization (HMO) plan.* A health insurance coverage plan that is offered through an HMO (as defined in section 2791(b)(3) of the Public Health Service Act) and has the largest insured commercial, non-Medicaid enrollment in the State.

§ 457.430 Benchmark-equivalent health benefits coverage.

(a) *Aggregate actuarial value.* Benchmark-equivalent coverage is health benefits coverage that has an aggregate actuarial value determined in accordance with § 457.431 that is at least actuarially equivalent to the coverage under one of the benchmark packages specified in § 457.420.

(b) *Required coverage.* In addition to the coverage required under § 457.410(b), benchmark-equivalent health benefits coverage must include coverage for the following categories of services:

(1) Inpatient and outpatient hospital services.

(2) Physicians' surgical and medical services.

(3) Laboratory and x-ray services.

(c) *Additional coverage.* (1) In addition to the categories of services in paragraph (b) of this section, benchmark-equivalent coverage may include coverage for any additional services specified in § 457.402.

(2) If the benchmark coverage package used by the State for purposes of comparison in establishing the aggregate actuarial value of the benchmark-equivalent coverage package includes coverage for prescription drugs, mental health services, vision services or hearing services, then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the value of the coverage for such a category or service in the benchmark plan used for comparison by the State.

(3) If the benchmark coverage package does not cover one of the categories of services in paragraph (c)(2) of this section, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.

§ 457.431 Actuarial report for benchmark-equivalent coverage.

(a) To obtain approval for benchmark-equivalent health benefits coverage described under § 457.430, the State must submit to 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