federal register

Monday
November 8, 1999

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 431, 433, 435, and 457
State Child Health; Implementing Regulations for the State Children's Health Insurance Program; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 431, 433, 435, and 457;

[HCFA–2006–P]

RIN 0938–AI28

State Child Health; Implementing Regulations for the State Children's Health Insurance Program

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act by adding a new title XXI. Title XXI provides 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. To be eligible for funds under this program, States must submit a State plan, which must be approved by the Secretary.

This proposed rule would implement provisions related to the State Children's Health Insurance Program (CHIP)including State plan requirements, coverage and benefits, eligibility, beneficiary financial responsibility, strategic planning, substitution of coverage, program integrity, and waivers. In addition, this proposed rule would implement the provisions of sections 4911 and 4912 of the BBA, which amended title XIX of the Act to expand State options for coverage of children under the Medicaid program.

DATES: Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5:00 p.m. on January 7, 2000.

ADDRESSES: Mail written comments (one original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–2006–P, P.O. Box 8010, Baltimore, MD 21244–8010.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC, or

Room C5–14–03, Central Building, 7500 Security Boulevard, Baltimore, Maryland

If you wish to submit written comments on the information collection requirements contained in this proposed rule, you may submit written comments to the following:

Lori Schack, HCFA Medicaid Desk Officer, Office of Information and Regulatory Affairs, Room 10235, New Executive Office Building, Washington, DC 20503; and

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

ATTN: John Burke, HCFA–2006–P

FOR FURTHER INFORMATION CONTACT:

Regina Fletcher for general information, (410)786–3293;

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Barbara Greenberg for subpart G, Strategic planning, (410)786–0435;

Anna Fallierias for subpart H, Substitution of coverage, (410)786–8281;

Jennifer Ryan for subpart I, Program integrity and beneficiary protections, (410)786–1304;

Cindy Ruff for subpart J, Allowable waivers, (410)786–5916;

Judy Rhoades for section K of preamble, Expanded coverage of children under Medicaid and Medicaid coordination, (410)786–4462;

Chris Hinds for section L of preamble, Medicaid disproportionate share hospital expenditures, (410)786–4578;

Joan Mahanes for section M of preamble, Vaccines for Children program, (410)786–4583

SUPPLEMENTARY INFORMATION:

Comments, Procedures, Availability of Copies, and Electronic Access

Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–2006–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's office at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 to 5 p.m. (phone: (202) 690–7890).

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I. Background

Section 4901 of the Balanced Budget Act of 1997 (BBA), Public Law 105–33, as amended by Public Law 105–100, added title XXI to the Social Security Act (the Act). Title XXI authorizes a new State Children's Health Insurance Program (CHIP) to assist State efforts to initiate and expand the provision of child health assistance to uninsured, low-income children. Under title XXI, States may provide child health assistance primarily for obtaining health benefits coverage through (1) obtaining coverage under a separate child health program that meets the requirements specified under section 2103 of the Act; or (2) expanding benefits under the State's Medicaid plan under title XIX of the Act; or (3) a combination of both. To be eligible for funds under this program, States must submit a State child health plan (State plan), which must be approved by the Secretary.

This proposed rule would implement the following sections of title XXI of the Act:

- Section 2101 of the Act, which sets forth the purpose of title XXI, the requirements of a State plan, State

entitlement to title XXI funds, and the effective date of the program.

- Section 2102 of the Act, which sets forth the requirements for a State plan, including eligibility standards and methodologies, coordination, and outreach.
- Section 2103 of the Act, which contains coverage requirements for children's health insurance.
- The following parts of section 2105 of the Act: 2105(c)(2)(B) relating to cost-effective community based health delivery systems; 2105(c)(3) relating to family coverage; 2105(c)(5) relating to cost sharing and 2105(c)(7) relating to limitations on payment for abortion.
- Section 2106 of the Act, which describes the process for submission, approval and amendment of State child health plans and plan amendments.
- Section 2107 of the Act, which sets forth requirements relating to strategic objectives, performance goals and program administration.
- Section 2108 of the Act, which requires States to submit annual reports and evaluations of the effectiveness of the State's title XXI plan.
- Section 2109 of the Act, which provides that health insurance coverage provided under a State child health program and coverage provided as a cost effective alternative are treated as ''creditable coverage'' under section 2701(c) of the Public Health Service Act (PHS).
- Section 2110 of the Act, which includes title XXI definitions.

This proposed rule would also implement the provisions of sections 4911 and 4912 of the BBA, which amended title XIX of the Act to provide expanded coverage to children under the Medicaid program. Specifically, section 4911 of the BBA set forth provisions for use of State child health assistance funds for targeted and optional low-income children eligible for enhanced Medicaid match for expanded eligibility under Medicaid. Section 4912 of the BBA added a new section 1920A to the Act creating a new optional group for presumptive eligibility for children. Both title XXI and title XIX statutory provisions are discussed in detail in section II of this preamble.

We note that on March 4, 1999, we published in the **Federal Register** a proposed rule concerning financial program allotments and payments to States under CHIP at 64 FR 10412. In that rule, we proposed to implement sections 2104 and portions of 2105 of the Act, which relate to allotments and payments to States under title XXI. For a detailed discussion of title XXI and related title XIX financial provisions including the allotment process, the payment process, financial reporting requirements and the grant award process, refer to the March 4, 1999 proposed rule.

II. Provisions of the Proposed Rule

A. Overview

Title XXI authorizes grants to States that initiate or expand health insurance programs for low-income, uninsured children. A Children's Health Insurance Program (CHIP) under title XXI is jointly financed by the Federal and State governments and is administered by the States. Within broad Federal guidelines, each State determines the design of its program, eligible groups, benefit packages, payment levels for coverage and administrative and operating procedures. CHIP provides a capped amount of funds to States on a matched basis for fiscal years (FY) 1998 through 2007. At the Federal level, CHIP is administered by the Department of Health and Human Services, through the Center for Medicaid and State Operations (CMSO) of the Health Care Financing Administration (HCFA).

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

The Department began issuing guidance to States within one month of enactment of the BBA. We provided information on each State's allotment through two **Federal Register** notices published on September 12, 1997 (62 FR 48098) and February 8, 1999 (64 FR 6102). We developed a model application template to assist State's in applying for title XXI funds. We provided over 100 answers to frequently asked questions. We issued policy guidance through a series of 20 letters to State health officials. All of this information is available on our website located on the Internet at ''http://www.HCFA.gov.'' We have also provided technical assistance to all States in development of CHIP applications.

CHIP programs operate in almost every State and Territory in the country. As of April 27 1999, we have approved 52 CHIP plans and have approved 15 amendments to these plans. Prior to the enactment of Public Law 105–174, which gave States an additional year to secure their fiscal year 1998 CHIP allotments, a number of States originally submitted ''place-holder'' plans in order to secure their fiscal year 1998 allotments. Many of these States now indicate that they will submit amendments to further expand their programs. Over half of the approved CHIP plans already provide coverage to families with income levels at or above 200 percent of the poverty line. We expect that most of the States and Territories that have not yet expanded eligibility to children in families with income at or below 200 percent of the Federal poverty line will eventually do so.

States and Territories have used the guidance we have issued to design and implement their programs. We intend to formalize this guidance in two regulations—a financial regulation mentioned previously (the proposed rule published March 4, 1999) and this proposed programmatic regulation. This proposed regulation incorporates much of the programmatic guidance that already has been issued to States.

In addition, this proposed rule addresses beneficiary protections necessary for the program to effectively function. These fundamental protections are consistent with the Presidential directive known as the Consumer Bill of Rights and Responsibilities. See subpart I for a discussion of the rights which are addressed in this proposed rule.

This proposed regulation builds upon previously released guidance and therefore, most of the regulation represents policies that have been in operation for some time. As we continue to implement the program, however, we have identified a number of areas in which we further elaborate on previous guidance or propose new policies that have not yet been made public. In an attempt to highlight the key issues, a brief summary follows:

- Subpart A—State Plan Requirements

The regulation would clarify several conditions under which States must submit amendments to approved CHIP plans. For example, we propose that States submit a plan amendment when the funding source of the State share changes, prior to such change taking effect. The purpose of this proposed requirement is to ensure that programs are operated using only permissible sources of funding. In addition, amendments to impose cost-sharing on

beneficiaries, increase existing cost-sharing charges, or increase the cumulative cost sharing maximum will be considered the same as amendments proposing a restriction in benefits. Therefore, States will be required to follow rules regarding prior public notice and retroactive effective dates.

• Subpart C—Eligibility, Screening, Applications and Enrollment

Title XXI prohibits the participation of children of public agency employees who are eligible to participate in a State health benefits plan. The only case where such a child could be covered under CHIP is the case where the employer provides no more than a nominal contribution available for the child's health benefits coverage. We propose to clarify that these children would not be considered to be ''eligible for health benefits coverage under a State health benefits plan'' and could then be eligible for coverage through CHIP.

• Subpart D—Coverage and Benefits

The proposed regulation provides some flexibility for States in keeping the benefit package current. States using the benchmark benefit package option are not required to submit an amendment each time the benchmark package changes. States need only submit amendments when proposing to make a change to the benefit package for the separate child health program, and then they only need to compare their benefit package to the most recent benchmark package.

The proposed regulation also clarifies policy regarding the conditions under which abortion services are permitted under title XXI and proposes that managed care entities providing this service must do so under a separate contract.

• Subpart E—Beneficiary Financial Responsibilities

The statute places a 5 percent cap on cost-sharing expenditures for families with incomes greater than 150 percent of the Federal Poverty Level (FPL) who are enrolled in separate child health programs. In an attempt to preserve State flexibility, the proposed regulation gives States the option to use either gross or net family income when calculating the cost-sharing cap.

In addition, the regulation proposes to place a comparable limit of 2.5 percent on cost-sharing for families with incomes below 150 percent of the poverty line, in order to ensure that those families with lower incomes will not be forced to pay the same amount of cost-sharing as those with higher incomes. In addition, States have the option to apply cost-sharing imposed on adults in CHIP family coverage plans toward the cumulative maximum cap.

The regulation proposes that States must have a process in place that will protect beneficiaries by ensuring ''due process'' before beneficiaries can be disenrolled from the program for failure to pay cost-sharing. This preamble suggests that States may look for a pattern of nonpayment, provide clear notice and opportunities for late payment, and wait at least one billing cycle before taking action to disenroll.

Finally, title XXI includes provisions to ensure enrollment and access to health care services for American Indian and Alaska Native (AI/AN) children. The regulation incorporates our interpretation that in light of the unique Federal relationship with tribal governments, cost-sharing requirements for individuals who are members of a Federally recognized tribe are not consistent with this statutory requirement.

• Subpart G—Strategic Planning, Reporting and Evaluation

The regulation includes provisions intended to ensure compliance with both the statute, the elements of the State's title XXI plan and the onsite review of State programs. In addition, monitoring will enable tracking of CHIP data submissions, which will ultimately help ensure enrollment in both the CHIP and Medicaid programs.

• Subpart I—Program Integrity and Beneficiary Protections

This subpart is intended to underscore the importance of preserving program integrity in the Children's Health Insurance Program. The regulation proposes that States must have fraud and abuse protections in place, but provides flexibility to States in developing program integrity protections for separate child health programs. States are encouraged to utilize systems already existing for Medicaid, but are not required to do so.

In addition, the regulation proposes that States have additional flexibility in setting procurement standards more broadly than Medicaid. States may choose to base payment rates on public and/or private rates for comparable services, and where appropriate, establish higher rates in order to ensure sufficient provider participation.

Finally, this regulation includes various beneficiary protections consistent with the President's directive regarding the *Consumer Bill of Rights and Responsibilities*. Provisions are included throughout the regulation to ensure that beneficiaries are given the opportunity to participate in and make informed medical decisions, to have access to needed services, and to be treated with dignity and respect.

• Subpart J—Waivers

The proposed regulation discusses the circumstances under which States may obtain a waiver in order to provide Title XXI coverage to entire families. We propose that in order to qualify for such a waiver, the State must meet several requirements, including a requirement that the proposal be cost effective.

Under our proposal, the new provisions for the Children's Health Insurance Program would be set forth in regulations at 42 CFR part 457, subchapter D. We note that the following table of contents is for all of part 457 and lists some subparts which have been reserved for provisions set forth in the March 4, 1999 proposed financial regulation.

The proposed table of contents for new part 457, subchapter D is as follows:

Subchapter D—Children's Health Insurance Program (CHIP)

PART 457—ALLOTMENTS AND GRANTS TO STATES

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

§ 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 Duration of State plans and plan amendments.
§ 457.70 Program options.
§ 457.80 Current State child health insurance coverage and coordination.
§ 457.90 Outreach.
§ 457.110 Enrollment assistance and information requirements.
§ 457.120 Public involvement in program development.
§ 457.125 Provision of child health assistance to American Indian and Alaska Native children.
§ 457.130 Civil rights assurance.
§ 457.135 Assurance of compliance with other provisions.
§ 457.140 Budget.
§ 457.150 HCFA review of State plan material.
§ 457.160 Notice and timing of HCFA action on State plan material.

§ 457.170 Withdrawal process.
§ 457.190 Administrative and judicial review of action on State plan material.

Subpart B—[Reserved]

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.
§ 457.320 Other eligibility standards.
§ 457.340 Application.
§ 457.350 Eligibility screening.
§ 457.360 Facilitating Medicaid enrollment.
§ 457.361 Application for and enrollment in CHIP.
§ 457.365 Grievances and appeals.

Subpart D—Coverage and Benefits: General Provisions

§ 457.401 Basis, scope, and applicability.
§ 457.402 Child health assistance and other definitions.
§ 457.410 Health benefits coverage options.
§ 457.420 Benchmark health benefits coverage.
§ 457.430 Benchmark-equivalent health benefits coverage.
§ 457.431 Actuarial report for benchmark-equivalent coverage.
§ 457.440 Existing comprehensive State-based coverage.
§ 457.450 Secretary-approved coverage.
§ 457.470 Prohibited coverage.
§ 457.475 Limitations on coverage: Abortions.
§ 457.480 Preexisting condition exclusions and relation to other laws.
§ 457.490 Delivery and utilization control systems.
§ 457.495 Grievances and appeals.

Subpart E—State Plan Requirements: Beneficiary 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.
§ 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/Alaska Natives.
§ 457.540 Cost sharing charges for children in families at or below 150 percent of the Federal poverty line (FPL).
§ 457.545 Cost sharing for children in families above 150 percent of the FPL.
§ 457.550 Restriction on the frequency of cost sharing charges on targeted low-income children in families at or below 150 percent of the FPL.
§ 457.555 Maximum allowable cost sharing charges on targeted low-income children at or below 150 percent of the FPL.
§ 457.560 Cumulative cost sharing maximum.
§ 457.565 Grievances and appeals.
§ 457.570 Disenrollment protections.

Subpart F—[Reserved]

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 State plan requirement: State annual reports and evaluation.
§ 457.735 State plan requirement: State assurance of the quality and appropriateness of care.
§ 457.740 State expenditures and statistical reports.
§ 457.750 Annual report.
§ 457.760 State evaluations.

Subpart H—Substitution of Coverage

§ 457.800 Basis, scope, and applicability.
§ 457.805 State plan requirements: Private coverage substitution.
§ 457.810 Premium assistance for employer-sponsored group health plans: Required protections against substitution.

Subpart I—Program Integrity and Beneficiary Protections

§ 457.900 Basis, scope, and applicability.
§ 457.902 Definitions.
§ 457.910 State program administration.
§ 457.915 Fraud detection and investigation.
§ 457.920 Accessible means to report fraud and abuse.
§ 457.925 Preliminary investigation.
§ 457.930 Full investigation, resolution, and reporting requirements.
§ 457.935 Sanctions and related penalties.
§ 457.940 Procurement standards.
§ 457.945 Certification for contracts and proposals.
§ 457.950 Contract and payment requirements including certification of payment related information.
§ 457.955 Conditions necessary to contract as a managed care entity (MCE).
§ 457.960 Reporting changes in eligibility and redetermining eligibility.
§ 457.965 Documentation.
§ 457.970 Eligibility and income verification.
§ 457.975 Redetermination intervals in cases of suspected enrollment fraud.
§ 457.980 Verification of enrollment and provider services received.
§ 457.985 Enrollee rights to file grievances and appeals.
§ 457.990 Privacy protections.
§ 457.995 Consumer Bill of Rights and Responsibilities.

Subpart J—Allowable Waivers: General Provisions

§ 457.1000 Basis, scope, and applicability.
§ 457.1005 Waiver for cost-effective coverage through a community-based health delivery system.
§ 457.1010 Waiver for purchase of family coverage.
§ 457.1015 Cost-effectiveness.

Editor's note: In the preamble we discuss new CHIP provisions (part 457) before we discuss relevant changes to the Medicaid regulations (Medicaid coordination, section K of the preamble, and parts 431, 433, and 435 of the regulations text). We believe this order is the most logical presentation for the preamble. However, because regulations text must be set forth in numerical order, proposed changes to the Medicaid regulations precede the new regulations text for part 457.

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

1. Program Description (§ 457.1)

Proposed § 457.1 states that title XXI of the Social Security Act, enacted in 1997 by the BBA, 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.

2. Basis and Scope of Subchapter D (§ 457.2)

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.

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

3. Definitions and Use of Terms (§ 457.10)

This subpart includes the definitions relevant specifically to the Children's Health Insurance Program under title XXI. We have defined in this subpart key terms that are specified in the statute or frequently used in this regulation. We note that those terms that are specific to certain subparts of this regulation are defined at the opening of those subparts, however, all the terms are listed here. For example, since the definition of ''targeted low-income child'' is specifically relevant in making eligibility determinations, the term is defined in subpart C—Eligibility. Because of the unique Federal-State relationship that is the basis for this program and because of our commitment to State flexibility, we determined States should have the discretion to define many terms.

In accordance with section 2110 of the Act, which sets forth definitions for title XXI, we propose to adopt definitions for the terms, ''creditable health coverage'', ''group health insurance coverage'', ''group health plan'' and ''preexisting condition exclusion'' from sections 2701(c) and 2791 of the Public Health Service Act (PHS) (42 U.S.C. 300gg(c)) as specifically required under the statute. These definitions are consistent with the definitions set forth in regulations at 45 CFR 144.103 and 146.113. Section 2109(a)(1) of title XXI provides that health insurance coverage provided under a State child health plan and coverage provided as a cost-effective alternative are treated as ''creditable coverage'' under section 2701(c) of the PHS Act. In addition, section 2103(f) of title XXI provides that the State plan cannot impose a preexisting condition exclusion; however, if the State plan provides for benefits through payment for, or contract with, a group health plan or health insurance coverage, the State plan can permit the imposition of a preexisting condition exclusion insofar as it is permitted under HIPAA. (Creditable coverage counts as credit for previous health coverage against the application of a preexisting condition exclusion period when moving from one group health plan to another, from a group health plan to an individual policy, or from an individual policy to a group health plan.)

We propose the following definitions:

- *American Indian/Alaska Native (AI/AN)* means (1) A member of a Federally recognized Indian tribe, band, or group or a descendant in the first or second degree, of any such member; (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;* (3) a person who is considered by the Secretary of the Interior to be an Indian for any purpose; (4) a person who is determined to be an Indian under regulations promulgated by the Secretary.
- *Child* means an individual under the age of 19.
- *Child health assistance* has the meaning assigned in § 457.402 of these proposed regulations.
- *Children's Health Insurance Program (CHIP)* means a program established and administered by a State, but 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 of both.
- *Combination program* means a program under which a State provides child health assistance through both a Medicaid expansion program and a separate child health program.
- *Contractor* has the meaning assigned in § 457.902.
- *Cost-effectiveness* has the meaning assigned in § 457.1015 of these proposed regulations.
- *Creditable health coverage* has the meaning given the term ''creditable coverage'' at 45 CFR 146.113. Under this definition, the term means the coverage of an individual under any of the following:

—A group health plan (as defined in 45 CFR 144.103).
—Health insurance coverage (as defined in 45 CFR 144.103).
—Part A or part B of title XVIII of the Act (Medicare).
—Title XIX of the Act, other than coverage consisting solely of benefits under section 1928 (the program for distribution of pediatric vaccines).
—Chapter 55 of title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents).
—A medical care program of the Indian Health Service or of a tribal organization.
—A State health benefits risk pool (as defined in 45 CFR 146.113).
—A health plan offered under chapter 89 of title 5, United States Code (Federal Employees Health Benefits Program).
—A public health plan. (For purposes of this section, a public health plan means any plan established or maintained by a State, county, or other political subdivisions of a State that provides health insurance coverage to individuals who are enrolled in the plan.
—A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

The term ''creditable health coverage'' does not include coverage consisting solely of coverage of excepted benefits including limited excepted benefits and non-coordinated benefits. (See 45 CFR 146.145)

- *Emergency medical condition* has the meaning assigned at § 457.402 of these proposed regulations.
- *Emergency services* has the meaning assigned in § 457.402 of these proposed regulations.
- *Employment with a public agency* has the meaning assigned in § 457.301 of these proposed regulations.
- *Family income* means income as determined by the State for a family as defined by the State.
- *Federal fiscal year* starts on the first day of October each year and ends on the last day of September.
- *Fee-for-service entity* has the meaning assigned in § 457.902 of these proposed regulations.
- *Grievance* has the meaning assigned in § 457.902 of these proposed regulations.
- *Group health insurance coverage* means health insurance coverage offered in connection with a group health plan as defined at 45 CFR 144.103.
- *Group health plan* means an employee welfare benefit plan, to the extent that the plan provides medical care as defined in section 2791(a)(2) of the PHS Act (including items and services paid for as medical care) to employees or their dependents directly (as defined under the terms of the plan), or through insurance, reimbursement, or otherwise, as defined at 45 CFR 144.103.

• *Health benefits coverage* has the meaning assigned in § 457.402 of these proposed regulations.

• *Health maintenance organization (HMO) plan* has the meaning assigned in § 457.420 of these proposed regulations.

• *Legal obligation* has the meaning assigned in § 457.555 of these proposed regulations.

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

• *Managed care entity (MCE)* has the meaning assigned in § 457.902 of these proposed regulations.

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

• *Medicaid expansion program* means a program where a State receives Federal funding at the enhanced matching rate available for expanding eligibility to targeted low-income children.

• *Post-stabilization services* has the meaning assigned in § 457.402 of these proposed regulations.

• *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, which provides that the term means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

• *Premium assistance for employer-sponsored group health plans* means State payment of part or all of premiums for group health plan or group health insurance coverage of an eligible child or children.

• *Public agency* has the meaning assigned in § 457.301 of these propose regulations.

• *Separate child health program* means a program under which a State receives Federal funding from its title XXI allotment under an approved plan that obtains child health assistance through obtaining coverage that meets the requirements of section 2103 of the Act.

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

• *State health benefits plan* has the meaning assigned in § 457.301 of these proposed regulations.

• *State plan* means the approved or pending title XXI State child health plan.

• *State program integrity unit* has the meaning assigned in § 457.902 of these proposed regulations.

• *Targeted low-income child* has the meaning assigned in § 457.310 of these proposed regulations.

• *Uncovered 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 and children as defined by the State. For purposes of cost sharing, the term has the meaning assigned at § 457.520 of the proposed regulations.

4. Basis, Scope, and Applicability of Subpart A (§ 457.30)

This subpart interprets sections 2101(a) and (b), 2102(a), 2102(c), 2106, 2107(c), (d) and (e) of title XXI of the Social Security Act and sets forth the related State plan requirements for a State child health assistance program. It includes the requirements related to administration of the State program and the process for Federal review of a State plan or plan amendment. This subpart applies to all States that seek to provide health benefits coverage through CHIP.

5. State Program Administration (§ 457.40)

Consistent with section 2106(d)(1) of the Act, we would specify in § 457.40(a) that it is the State's responsibility to implement and conduct its program in accordance with the approved State plan and plan amendments, the requirements of title XXI and title XIX (as appropriate), and the regulations in chapter IV.

To ensure that the State is operating its program accordingly, HCFA will review the operation of the program through on-site review or monitoring of State programs. At proposed § 457.40(a), we would provide that HCFA will monitor the operation of the approved State plan and plan amendments to ensure compliance with title XXI, title XIX (as appropriate) and the regulations in chapter IV. There are two general goals for the proposed monitoring provisions. Specifically, monitoring will assure State compliance with both statutory and regulatory requirements under title XXI and with the specifications of the State plan. In addition, monitoring will allow us to track the submission of requested data related to CHIP, including enrollment and expenditure data and other efforts related to ultimately ensuring enrollment of eligible children into both CHIP and Medicaid. Expected outcomes of CHIP monitoring include: (1) Identifying the need for corrective action, enforcement and improvement within State title XXI programs; (2) recognizing and sharing best practices that may lead to increased enrollment; (3) identifying States' needs for technical assistance; and (4) informing HCFA as we prepare for the Secretary's report to Congress.

The ongoing review of State programs is an evolving process as there is wide variation among implemented children's health insurance programs. Many programs are just being implemented, while others have been built upon programs in existence long before the passage of title XXI. Because of both variation in program design and differences in stages of program implementation, we have established a flexible review process that is focused primarily on assuring compliance with Federal law and regulations. In subsequent years Federal review of State programs may also examine how well programs are achieving the overall goals outlined in their State plans and plan amendments.

In the Federal review process, however, we will monitor to ensure consistent implementation of the core set of key policy areas specifically described in the title XXI statute. We expect our monitoring effort to be an interactive and informative process for both the Department and the States. As a result, we plan to work with the States to identify any areas of need for technical assistance, to identify best practices that will assist States in understanding what works in specific situations and to ensure policies are implemented consistently across States.

Although HCFA central and regional offices are in constant contact with the States, after the first anniversary of the

implementation of each CHIP, a formal State review will be conducted by a team led by HCFA regional staff with participation of HRSA regional staff.

The review process may include site visits and phone interviews. Regional staff will put its preliminary findings into a report and share that report with the State to provide an opportunity for response to any issues raised in the review process before they make recommendations and send the report to HCFA central office. If necessary, HCFA, with participation of HRSA regional staff, will work with States to address areas in which they are not in compliance with either the statute, applicable regulations, or a State's plan.

The review process and the implications of noncompliance are specifically addressed in § 457.200, which was set forth in the March 4, 1999 proposed financial regulation.

To ensure involvement in and commitment to the program at the highest level of State government, we are proposing in § 457.40(b) to require that the State plan and plan amendments be signed by the State Governor or by an individual who has been delegated authority by the Governor to submit it. This individual could be the Secretary of Health, the CHIP Administrator, the Medicaid Director or any other individual who has authority, delegated by the Governor, to submit the State plan or plan amendment. In order to facilitate communication between the appropriate State and HCFA staff, we are proposing in § 457.40(c) to require that the State include in the State plan or plan amendment the names of the State officials who are responsible for program administration and financial oversight.

An additional aspect of program administration for the State is the passage of enabling legislation, which a State may need to implement a State plan. When the passage of State enabling legislation is required to implement a State plan, a State can submit its State plan application before the passage of the legislation. States must indicate in their application if such legislation is necessary and when it will be in place. The State plan must include an assurance that the State will not claim expenditures for child health assistance prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by HCFA. We are proposing this provision so that we can approve State plans and plan amendments while a State's legislative authority is pending. This provision is consistent with the requirement that a State must implement and conduct its CHIP in accordance with the approved State plan.

6. State Plan (§ 457.50)

The State plan is a comprehensive written statement submitted by the State to HCFA for approval. The State plan describes the purpose, nature, and scope of its CHIP and gives assurance that the program will be administered in conformity with the specific requirements of title XXI, title XIX (as appropriate), and the regulations in chapter IV. The State plan contains all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

An approved State plan is comprised of the initial plan submission, responses to requests for additional information and subsequent approved State plan amendments. The first item that forms part of the approved State plan is the State's original application. The information that must be included in the original submission varies according to how the State chooses to provide health benefits coverage. In addition, the State's written responses to requests from HCFA for additional information, whether formal or informal, and any other written correspondence from the State are considered part of the approved State plan. The State's correspondence modifies the original submission; that is, information received from a State supersedes any contrary information that is included in the original plan or other earlier submissions. Moreover, if there are several submissions from the State that are inconsistent, the latest submission is the governing document. Most often the information in the additional responses should clarify or add to the language of the original submission. All documents that are included in the approved State plan will be referenced in the approval letter. Documents pertaining to all State plan amendments are also components of the approved State plan.

7. Amendments word (§ 457.60)

Section 2106(b)(1) of the Act permits a State to amend its approved State plan in whole or in part at any time through the submittal of a plan amendment. We propose in § 457.60(a) that the State plan must be amended whenever necessary to reflect changes in Federal law, regulations, policy interpretations or court decision; changes in State law, organization, policy or operation of the program; and changes in the source of the State share of funding.

Although the proposed language of § 457.60(a) contains no exceptions, we believe in practice only changes that are substantial and noticeable would require amendments. Changes in program elements that would not ordinarily be required to be included in the State plan at all would thus not require an amendment. For example, a change in the date for mailing enrollment material from June 1 to July 1 would not be considered substantial or noticeable and a State plan amendment would thus not be required. We are seeking comments on how to further interpret and express in regulations the necessity for State plan amendment submission.

We are proposing in § 457.60(a)(3) to require an amendment if the source of State share of funding changes. Furthermore, we are proposing in § 457.65(d) that such amendment must be submitted to HCFA prior to such change taking effect. From the beginning of the program, our policy has been to only approve State plans that can assure, to our satisfaction, that the program has a permissible source of funding. Pursuant to section 2107(e)(1)(C) of the Act, a State is required as a condition for approval of its State plan to assure that the State will comply with section 1903(w) of the Act, relating to limitations on provider taxes and donations. Section 2107(d) of the Act requires that the State plan include a description of the budget, which is an advance plan for expenditures. Section 2107(d) also provides that the budget be updated periodically as necessary. We believe that proposed § 457.60(a)(3) and § 457.65(d) will ensure ongoing compliance with our requirement for permissible sources of funding and will avoid situations that require a disallowance for non-compliance. If a State has indicated that general revenues are the source of funding, then we would require a plan amendment for changes in the State's tax structure that reflect or include a change to general revenues based on taxes related to health care used to finance the State's share of title XXI expenditures. We would not require a plan amendment to reflect changes in the type of non-health care related taxes used to generate general revenue.

We are proposing in § 457.60(b) to require that a State proposing to amend its plan include an amended 3-year budget if the proposed amendment would result in different expenditures than those described in the budget accompanying the approved State plan. Under section 2107(d) of the Act, a State plan clearly must include the budget for

the plan. If a plan amendment that affects the budget is approved without a revision to the budget, then the current description of the budget would no longer be accurate for the entire State plan. If the proposed changes in the State plan amendment have no impact on the budget, then an updated budget is not required.

8. Duration of State Plans and Plan Amendments (§ 457.65)

In § 457.65, we propose that the State may choose any effective date for its State plan or plan amendment, but no earlier than October 1, 1997. We believe that the intent of section 2106(a)(2)(B) of the Act is to provide flexibility to States in choosing an effective date. We considered requiring that a State must be providing health coverage to targeted low-income children as of the date the State specified as its effective date; however, such a requirement would preclude a State from claiming FFP for administrative start-up costs that are eligible for FFP. Therefore, in order to allow the State to claim program and administrative expenditures that the State may incur prior to providing coverage, we propose to define ''effective date'' as the date on which the State begins to incur costs to implement its State plan or plan amendment. This effective date may be prior to the date on which the State begins to provide coverage to targeted low-income children.

A State may implement a State plan prior to approval of that plan but this may put the State at some risk. If a State implements a plan prior to approval and that plan is approved, the State can receive Federal matching funds on a retroactive basis for expenses incurred for programs operated in compliance with the approved plan and all applicable statutory and regulatory requirements (other than expenses incurred earlier than October 1, 1997).

Any State that implements an unapproved State plan risks the possibility that the plan will not be approved as implemented. In the event that the State plan is not approved as it was implemented, the Federal government would not match the State's prior expenditures. HCFA has no authority to pay claims for periods prior to the effective date of the approved State plan for activities that are not consistent with an approved plan, or for activities that do not meet the requirements of title XXI. Section 2106 of the Act gives the Secretary authority to disapprove an initial State plan submission that does not fully comply with title XXI, and to approve an effective date for that State plan submission. We believe this authority necessarily means that the Secretary may deny an effective date that would include any time period during which the operating program did not fully comply with title XXI. Moreover, this authority permits the Secretary to deny claims for Federal matching funds for such time periods. We base that conclusion on the reasoning that there would be no approved State plan at the time of any claimed expenditures during those time periods. Under section 2105(a), the Secretary is authorized to pay Federal matching funds to States based on child health assistance and certain other expenditures ''under'' an approved State plan (up to the amount of the State's allotment). Absent an approved State plan, no Federal matching funds may be paid to a State. Although section 2106(c)(3) states that ''* * * the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such [a] disapproval,'' this provision does not require that the Secretary accept claims in the absence of an approved State plan.

Any State that implements an unapproved State plan amendment also risks the possibility that the plan amendment will not be approved as implemented. The reasoning described above for State plans also applies to State plan amendments that result in additional Federal financial participation. For a State that implements an unapprovable State plan amendment that results in expenditures that can be identified as beyond the scope of the approved State plan, these expenditures could not be used as a basis for Federal funding under section 2105(a)(1). An example of this situation is the implementation of a State plan amendment that adds a new population. For those populations, the expenditures would simply be beyond the scope of the approved State plan.

For unapproved State plan amendments that do not result in expenditures that can be identified as beyond the scope of an approved State plan, we believe a different analysis must be applied. The implementation is a failure to conduct the State program in accordance with the approved State plan, and would be subject to the compliance remedies described in section 2106(d) of the Act. In this situation, HCFA would only withhold Federal matching funds after following the compliance procedures permitting the State a ''reasonable opportunity for correction'' in accordance with section 2106(d)(2).

On March 4, 1999, we published a proposed rule addressing the financial provisions for title XXI. We are proposing to clarify certain provisions which were set forth in subpart B of that proposed rule. Specifically, paragraph (d)(2) of § 457.204, ''Withholding of payment for failure to comply with Federal requirements,'' discusses the opportunity for correction prior to a financial sanction for failure to comply with a Federal requirement. As proposed, § 457.204(d)(2) provides that 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. The proposed regulation would implement section 2106(d)(2) of the Act, which requires that the Secretary provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of an enforcement action. We would revise the proposed regulatory text at § 457.204(d)(2) to address in more detail the possible scope of corrective action that could be required. We would specify that such corrective action can include actions to ensure that the plan is and will be administered consistent with applicable law and regulations, actions to address past deficiencies in plan administration, and actions to ensure equitable treatment of beneficiaries. We recognize that not every situation will require all of these different types of corrective action. We are reserving to the Secretary the determination of the appropriate scope of corrective action under the individual circumstances presented. Such a determination necessarily will be made in the final determination on the findings of noncompliance, and will be reflected in the final notice described in proposed § 457.204(d)(3).

Certain special provisions govern the establishment of allotments for FY 1998 and FY 1999 for States that receive approval for their State plans during FY 1999. Under Public Law 105–277, effective October 21, 1998, if a State submits a State plan during FY 1999, and the plan is approved by HCFA by the end of FY 1999 (that is, by September 30, 1999), then CHIP allotments may be obligated for the State for both FY 1998 and FY 1999. The effective date for the State plan would be the date requested by the State, but no earlier than the beginning of FY 1998, (that is, October 1, 1997).

After FY 1999, a State's initial State plan must be approved by HCFA by the end of a fiscal year in order to receive a State CHIP allotment for that fiscal year. For example, if HCFA approves a

State's initial State plan during FY 2000, the State could only receive a State allotment for FY 2000; the State could not receive an allotment for FY 1998 or for FY 1999. Since the State did not have a State plan approved by HCFA in FY 1998 or by the end of FY 1999, it could not receive a State allotment for FY 1998 or FY 1999.

If a State submits a State plan that is first approved during FY 2000, a FY 2000 allotment would be obligated for that State, but there would be no allotment for FY 1998 or FY 1999. However, the FY 2000 allotment is potentially available to provide Federal financial participation (FFP) in the State's allowable FY 1998 and FY 1999 expenditures, such as administrative costs, assuming the State has requested an effective date for its State plan in one of those fiscal years. For example, a State plan could be approved November 1, 1999, at which time the FY 2000 allotment would be obligated, and have an effective date of September 1, 1999, when the State began incurring administrative costs related to the State plan. These administrative costs could then be claimed under the FY 2000 allotment. Thus, a State may potentially have an effective date for its State plan in a fiscal year and receive FFP in expenditures incurred in a fiscal year for which it does not have a State CHIP allotment.

Medicaid rules regarding effective dates continue to apply to child health assistance provided under a Medicaid expansion program. In accordance with § 430.20(b) of the Medicaid regulations, the effective date of title XIX State plan amendments cannot be earlier than the first day of the quarter in which an approvable title XIX State plan amendment is submitted to HCFA. It is, therefore, important for a State to submit a title XIX State plan amendment either prior to or during the calendar quarter in which it wants the amendment to take effect. As discussed in proposed § 457.70, States must submit both a Medicaid State plan amendment and a title XXI plan for the Medicaid expansion. Medicaid State plan amendments will be reviewed using the established process for title XIX. We will make every effort to coordinate the approval of a Medicaid State plan amendment with the approval of the title XXI State plan.

Section 2106(b)(3)(C) of the Act provides that any State plan amendment that does not eliminate or restrict eligibility or benefits can remain in effect only until the end of the State fiscal year in which it becomes effective (or, if later, the end of the 90-day period in which it becomes effective) unless the State plan amendment is submitted to HCFA before the end of the period. We would implement this provision at proposed § 457.65(a)(2). Thus, if a State plan amendment is implemented but is not submitted within the required time frame, the State risks being found out of compliance with its State plan, and loss of Federal participation in expenditures beyond the scope of the approved plan or other financial sanctions, as discussed below and in the proposed financial regulation (64 FR 10412).

In accordance with section 2106(b)(3)(B)(ii) of the Act, an amendment that eliminates or restricts eligibility or benefits under the plan may not be effective for longer than a 60-day period unless the amendment is submitted to HCFA before the end of that 60-day period. Section 2106(b)(3)(B)(i) requires that amendments that eliminate or restrict eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior public notice of the proposed change in a form and manner provided under applicable State law. The notice must be published prior to the requested effective date of change. We propose to implement this provision at § 457.65(b). In the amendment request, the State should describe the public notice process.

We are also proposing that State plan and State plan amendments imposing new or increased cost sharing on beneficiaries would be treated as a restriction on benefits and subject to the prior public notice requirements set forth at § 457.65 of these proposed regulations. We view cost sharing as a restriction on benefits since a beneficiary's financial responsibility for certain costs associated with CHIP may be an impediment to the beneficiary's access to certain covered services. Therefore, in accordance with section 2106(a)(3)(B) of the Act, we are proposing that the State plan must comply with the prior public notice requirements at § 457.65 when the plan implements cost sharing charges, increases the existing cost sharing charges or increases the cumulative cost sharing maximum set forth at proposed § 457.555. We believe that prior public notice would give interested parties the opportunity to react to the proposed changes. In addition, our proposed notice requirements would allow States to take into account the public's concerns regarding the potential impact of cost sharing on beneficiary access to services and participation in CHIP.

As discussed previously at proposed § 457.65(d), we would specify that a State plan amendment that requests approval of changes in the source of the State share of funding must be submitted prior to such change taking effect.

In accordance with section 2106(e) of the Act, at § 457.65(e) we propose that an approved State plan shall continue in effect unless and until the State modifies its plan by obtaining approval of an amendment to the State plan. The new plan will consist of the originally approved State plan and any approved State plan amendments. The State plan shall also continue in effect unless and until the Secretary finds substantial non-compliance of the plan with the requirements of the statute and regulations. An example of substantial non-compliance would be the imposition of cost sharing that exceeds Federal limits.

9. Program options (§ 457.70)

Under section 2101(a) of the Act, a State may obtain health benefits coverage for uninsured, low-income children in one of three ways: (1) A State may provide coverage by expanding its Medicaid program; (2) a State may develop a plan that meets the requirements of section 2103 of the Act; or (3) a State may provide coverage through a combination of a Medicaid expansion program and a separate child health program. The following subparts apply to States that elect Medicaid expansions:

- Subpart A
- Subpart B (if the State claims administrative costs under title XXI).
- Subpart C (with respect to the definition of a targeted low-income child only).
- 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).
- Subpart G.
- Subpart H (if the State elects the eligibility group for optional targeted low-income children and elects to pay for employer-sponsored insurance).
- 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). Subparts D, E, and I of part 457 do not apply to Medicaid expansion programs because Medicaid rules govern benefits, cost-sharing, program integrity and other provisions included in those subparts. We note that the provisions of subparts B and F were set forth in the March 4, 1999 proposed rule.

A State that chooses to implement a separate child health program must

comply with all the requirements in part 457. We would set forth the program options at § 457.70(a).

At § 457.70(b), we propose that a State plan must include a description of the State's chosen program option. In addition, at proposed § 457.70(c) we specify that States choosing a Medicaid expansion program must submit an amendment to the State's Medicaid State plan as appropriate. These States will be required to complete an abbreviated State plan and, in most circumstances, a Medicaid State plan amendment. If a State is expanding Medicaid within the scope of an 1115 demonstration project, then that demonstration project may need to be modified by submission of a formal request for a change to the demonstration project and not through a Medicaid State plan amendment. If such a modification is needed, then the request for a change to the demonstration project must be submitted in addition to the title XXI State plan. The abbreviated State plan must include the State plan requirements specified in this subpart and subpart G of this proposed rule. A State that chooses to implement a separate child health program must include in its State plan all of the State plan requirements specified in part 457. A State selecting a combination program would need to submit a title XXI State plan, as well as a Medicaid State plan amendment.

States may choose one option and switch to a different option at any time if a State plan amendment describing this change meets the requirements of the statute and these regulations and is approved by HCFA.

10. Current State Child Health Insurance Coverage and Coordination (§ 457.80)

In accordance with sections 2102(a)(1) and (2) and 2102(c)(2) of the Act, we propose to require that the State plan describe the State's current approach to child health coverage and plans for coordination of the program with other insurance programs in the State. We specify that the State must provide a description of the following:

- 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 by § 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.
- 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.
- Procedures used by the State to accomplish coordination of the program under title XXI with other public and private health insurance programs, including procedures designed to increase the number of children with creditable health coverage, and to ensure that only eligible targeted low-income children are covered under title XXI. The degree of creditable coverage a child has impacts whether a preexisting condition exclusion applies and therefore, tracking this information would be beneficial to the child.

The purpose of this section is to require the State to justify the insurance expansion approach it has chosen to ensure that the State does not use Federal funds to supplant existing programs and funding but rather uses the funds for children who are uninsured. To the extent possible, the income level categories by which the State reports the current availability of creditable coverage should correspond to the income level categories used for other purposes such as eligibility or cost-sharing. The State may classify children by family income level, age group, race and ethnicity, urban versus rural location and any other categorization that the State finds useful in describing its situation. If sufficient information is available, the State should describe the extent to which the classes of children it sets forth are insured through Medicaid, employer-based coverage, or other forms of publicly supported insurance, such as State-only programs and public/private partnerships. In addition, the State should describe the extent to which children in the State are uninsured. The State plan should clearly identify the sources of the data it uses in this section. We recognize that States may not initially have data available for an in-depth study of the insurance status of its children. However, the information provided should be sufficient to illustrate that the State has analyzed the problem, using available data sources. The demographic information requested in this section can be used for State planning and will be used strictly for informational purposes. These data will not be used as a basis for the State's allotment. We also note that these data are not necessarily the baseline data required to be submitted as part of the annual report under subpart G.

In addition, at § 457.80(b), we propose that the State must provide an overview of current efforts made by the State through child related programs (such as Medicaid, the Maternal and Child Health Block Grant, title V, WIC, community and migrant health centers or special State programs for child health care) to provide health care services or obtain creditable health coverage for uncovered children by identifying and enrolling all uncovered children.

Section 457.80(c) would require the State plan to include a description of the coordination of the plan with other public and private health insurance programs in accordance with sections 2102(a)(3) and 2102(c)(2) of the Act. This section of the State plan should include an overview of how new enrollment outreach efforts will be coordinated with and improve upon existing State efforts as described in § 457.80(a).

A State that implements a separate child health program should describe how children who are determined to be eligible for Medicaid or another State-only program will be referred to and enrolled into that program, as required by proposed § 457.350 and § 457.360. Because children identified as Medicaid eligible are required to be enrolled in Medicaid, the State should describe how it will coordinate enrollment in CHIP and Medicaid. The State plan should also describe how Medicaid eligibility workers will refer non-Medicaid eligible children to the separate child health program.

11. Outreach (§ 457.90)

In § 457.90, we propose to require a State to implement an outreach process to inform families of the availability of health coverage programs and to assist families in enrolling their children into a health coverage program pursuant to section 2102(c) of the Act. A State plan must include a description of the procedures used for outreach. According to the statute, a State has the option to decide which methodologies and procedures it will use to inform families of uninsured, potentially eligible children about enrollment for child health assistance under the program. No single approach to reaching these children is provided in the statute. While States are expected to identify enrollment targets, they are encouraged to design and implement outreach activities that will reach diverse groups of children. We realize that the challenges States face in reaching out to families and assuring access to services

are great and will require vigorous sustained efforts.

Outreach includes identifying, educating, and enrolling uninsured children, while remaining sensitive to the cultural and linguistic differences and special health care needs of diverse populations. There is no one model for outreach and there are many examples of successfully implemented, locally developed campaigns. Outreach is intrinsically linked to eligibility and enrollment and calls for activities that remove barriers that deter families from applying to the program. At proposed § 457.90(b), we set forth examples of outreach strategies. The following two major types of outreach procedures, when designed with the targeted populations in mind, serve to encourage significant enrollment and reduction in the numbers of uninsured children:

• *Education and awareness campaigns.* A comprehensive Statewide education and awareness campaign is needed to inform the public about the importance of availability of CHIP and how to enroll eligible children. Implementing this campaign in multiple venues frequented by families, with culturally sensitive information, will help to keep the message of health insurance in front of the target audience. Families will benefit from educational programs designed to inform them of the advantages of enrolling eligible children in health insurance, including having a regular source of care, and obtaining well-child check ups including immunization. All outreach efforts should include information about how families can find out if their children are eligible and how to get them enrolled.

Identifying families with uninsured children is the first step in outreach. States must develop and sustain comprehensive education and awareness campaigns to reach these children and families. Several data sets are available to assist States in the identification of families with uninsured children (for example, immunization registries, hospital discharge databases, school lunch program participant lists and hospital charity care databases). States should assure confidentiality when using their own existing data to identify uninsured children. Schools may also help in the education and awareness process as they often know who the uninsured children are. School nurses and school health centers, Parent Teacher Associations, and school health screens and fairs offer excellent opportunities for outreach for this new insurance program.

States often begin outreach campaigns by sending printed material such as brochures, flyers, and program applications to families considered to be potentially eligible for enrollment. States may choose to target mailings to special audiences of potentially uninsured children. Hispanic/Latinos, Tribal/Native Americans, adolescents, African-Americans, Asians, migrant populations, rural and homeless, are populations considered to have large numbers of uninsured children.

States have choices as to the breadth of distribution of program materials, prepared specifically for the different targeted subpopulations. Flyers, posters and brochures, developed in appropriate languages, can be made available through many programs that are closely identified with low-income families. Programs such as Head Start, school lunch programs, Child Care Centers and WIC programs serve thousands of low-income children. Welfare/food stamp offices are frequented by low-income families who may be eligible for CHIP.

The provider community can also distribute program information. States could include major providers such as clinics (especially for newborns), hospitals, physicians (including OB/GYNs, pediatricians, and family physicians), pharmacies, mobile health units, mental health/addiction centers, and health trade associations.

Workers who live in the community, speak the language, and know its cultural beliefs and practices can be effective in disseminating information and answering basic questions. The diversity of the uninsured population requires that States, in designing outreach activities, be sensitive to the various cultural groups, their perceptions, needs, and desires. To be effective, messages and promotional materials should be developed with the assistance of people toward whom the message is directed.

Employer-based outreach is another avenue for providing targeted populations with basic information on children's insurance programs. Working families may not know that their children are potentially eligible for enrollment in either CHIP or Medicaid. Small businesses, factories, city and State chambers of commerce and labor unions are often eager to spread the word about insurance coverage to their members or community groups with whom they are associated.

A broad array of private and public sector partnerships affords States the opportunity to extend the CHIP message to many areas through groups and organizations not traditionally involved in outreach. Strategic partnerships with media, volunteer organizations, school personnel, community volunteers, clergy, and agency caseworkers may lend innovation to an outreach campaign. Churches and faith-based communities, civic clubs, YMCA, 4–H Clubs, Boy Scouts and Girl Scouts and senior citizen organizations are additional organizations committed to providing voluntary assistance for community causes. Private and public sector partnerships, enhanced by large numbers of volunteers, strengthen dissemination of program information in conjunction with State and local level campaigns.

• *Enrollment Simplification.* A major key to successfully reaching and enrolling uninsured children in CHIP and Medicaid is a simple application and enrollment process. While it is important to maintain program integrity (as described in subpart I of this proposed rule), burdensome applications and enrollment processes have created significant barriers to successful enrollment. Federal requirements for application and enrollment in Medicaid and CHIP provide broad flexibility to States in application and enrollment design. Several actions currently undertaken by States to encourage enrollment include: reducing and simplifying the application forms; providing mail-in applications; creating joint CHIP/Medicaid applications; eliminating the assets test; allowing self-declaration of income with follow-up verification by the State; reducing verification and documentation requirements that go beyond Federal regulation; implementing presumptive eligibility and 12-month continuous eligibility; allowing redeterminations by mail; and developing a follow-up process for families not completing the application. These changes, made in conjunction with other outreach activities undertaken by States, will help produce significant increases in enrollment.

When a State selects a separate child health program, the State may consider new ways of providing families with assistance in filling out applications. We encourage these States to consider outstationing eligibility workers at sites that are frequented by families with children such as schools, child care centers, churches, Head Start centers, WIC offices, Job Corps sites, GED programs, local Tribal organizations, and Social Security Field Offices. However, States that implement Medicaid expansions must follow all Medicaid rules relating to application assistance and eligibility determination.

12. Enrollment Assistance and Information Requirements (§ 457.110)

Section 2102(c) of the Act requires that State plans include procedures to inform families of the availability of child health assistance. In accordance with this provision, we are proposing to require that a State have procedures to ensure that targeted low-income children are given information and assistance needed to access program benefits. Specifically, we propose in § 457.110, that the State plan describe methods the State will use to make accurate, easily understood information available to families of targeted low-income children and provide assistance to them in making informed health care decisions about their health plans, professionals, and facilities. In order to assist families of targeted low-income children in making informed decisions about their health care, we propose in § 457.110(b) to require that States have a mechanism in place to ensure that the type of benefits and amount, duration and scope of benefits available under CHIP and the names and locations of current participating providers are made available to beneficiaries in a timely manner. This requirement is consistent with the ''right to information'' disclosure provision of the President's Consumer Bill of Rights and Responsibilities and is further discussed in subpart I.

The proposed requirements set forth in this section apply to all States that are providing child health assistance whether through a Medicaid expansion or separate child health program under fee-for-service or managed care delivery systems. Because Medicaid rules apply to States that implement Medicaid expansion programs, a State that is operating a Medicaid expansion program that uses managed care delivery systems would also be required to comply with the requirements of section 1932(a)(5) of the Act, enacted by section 4701(a)(5) of the BBA, and the regulations that implement that statutory provision. The Medicaid statute and regulations govern the kind of information that must be made available to Medicaid enrollees and potential enrollees and require that this information, and certain enrollment materials, be in a format that can be easily understood by the individuals to whom it is directed.

We propose to require that materials be made available to applicants and beneficiaries in easily understood language and format. The State should consider the special needs of those who, for example, are visually impaired or have limited reading proficiency, and the language barriers of those who may use the information. A State may overcome language barriers by establishing a methodology for determining the prevalent language or languages in a geographic area and making information available in the languages that prevail throughout the State or in limited geographic areas where appropriate. A State may also overcome language barriers by making translation services available to enrollees and potential enrollees. In any case, the State should provide instructions to enrollees and potential enrollees on how to obtain information in the appropriate language or how to access translation services. While we encourage States to apply these principles in outreach, this provision is specifically designed to provide information to targeted low-income children once they have enrolled in CHIP.

In addition to the benefit and provider information that a State must make available, other basic information should be made available to families of eligible targeted low-income children. This information could include procedures for obtaining services, including authorization requirements; the extent to which after-hours and emergency coverage are provided; cost sharing, if any; the rights and responsibilities of enrollees; complaint, grievance, and fair hearing procedures; any appeal rights that the State chooses to make available to providers; with respect to managed care organizations (MCOs) and health care facilities, their licensure, certification, and accreditation status; and, with respect to health professionals, information that includes, but is not limited to, education and Board certification and recertification.

A State that delivers services through a managed care delivery system should consider making additional information available to families of targeted low-income children. This additional information may include any restrictions on the enrollee's freedom of choice among network providers; policy on referrals for specialty care and for other services not furnished by the enrollee's primary care provider; the extent to which enrollees may obtain services from out-of-network providers; and any benefits to which they may be entitled under the program, but that are not covered under the MCO contract and specific instructions on where and how to obtain those benefits.

13. Public Involvement in Program Development (§ 457.120)

States are required under section 2107(c) of the Act to include in the State plan the process that the State used to accomplish public involvement in the design and implementation of the plan and the method to ensure ongoing public involvement. We would implement this provision at § 457.120. Beneficiaries, providers, and interested groups and organizations can provide valuable input in developing a plan and insight into the successes and challenges faced by a State during implementation and throughout the operation of the program. Experience with section 1115 demonstrations and other Medicaid programs demonstrates the benefit of early consultation in identifying and resolving issues. States should provide for participation from organizations and groups such as hospitals, community health centers, and other providers, beneficiaries, and advocacy groups. States may ensure such involvement through a wide variety of approaches. For instance, to encourage public involvement, States can—

- Hold periodic public hearings to provide a forum for comments when developing or implementing their plans;
- Establish a child health commission or a consumer advisory committee responsible for soliciting public opinion about the State plan;
- Publish notices in generally circulated newspapers advertising State plan development meetings so the public can provide input; or
- Create a mechanism enabling the public to receive copies of working proposals in order to provide comments to the State.

States may use methods other than those listed above. In fact, States may use any process for public input that affords interested parties the opportunity to learn about the State plan and allow for public input in all phases of the program.

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

Section 2102(b)(3)(D) of the Act requires a State to include in its plan a description of procedures to be used to ensure the provision of child health assistance to American Indian or Alaska Native children. We believe that a State cannot meet the requirement for ensuring the provision of child health assistance to American Indian or Alaska Native children without consultation with Tribes and Tribal organizations. Therefore, we are requesting in

457.125(a) that the State officials responsible for CHIP consult with Federally recognized Tribes and other Indian Tribes and organizations in the State (such as regional Indian health boards, urban Indian health organizations, non-Federally recognized Tribes, and units of the Indian Health Service) on development and implementation of the procedures used to ensure the provision of child health assistance to American Indian or Alaska Native children. This request is consistent with the February 24, 1998 letter to State Officials addressing consultation with Tribes and Tribal organizations.

The Federal government and the governments of American Indians and Alaska Natives (AI/AN or Indian people) have a ''government-to-government'' relationship based on the U.S. Constitution, treaties, Federal statutes, court decisions, and Executive Branch policies. This special relationship also constitutes a trust relationship between these governments. Certain benefits provided to Indian people through Federally enacted programs flow from this trust relationship. These benefits are not based upon race, but rather, are derived from the government-to-government relationship. A vital component of this relationship is consultation between the Federal and tribal governments. Increasingly, this special relationship has emphasized self-determination for Indian people and meaningful involvement by Indian people in Federal decision making (consultation) where such decisions affect Indian people, either because of their status as Indian people or otherwise. In cases where the government-to-government relationship does not exist, as with urban Indian centers, Inter-tribal organizations, State recognized tribal groups, and other Indian organizations, we nevertheless encourage States to engage in consultation.

Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making. We encourage States, in addition to consulting with Federally recognized Tribes, to consult with other Indian Tribes and organizations before taking actions that affect these governments or the Indian people residing within the State.

In consulting with tribes and tribal organizations regarding the procedures to ensure provision of child health assistance, State might want to consider the following:

- Reimbursing facilities that serve Indian populations, including tribal and urban programs, for CHIP covered services at higher rates than other facilities to assure access to adequate services.

- Improving enrollment procedures for AI/AN children by placing outstation eligibility workers in the IHS, tribal, and urban facilities, by developing culturally appropriate education materials for enrollment of AI/AN children and by using tribal and community resources to increase eligibility outreach.

We encourage States to consult with Tribes and Indian organizations throughout the process of developing and implementing their State plans, outreach strategies, and other policies and procedures. These are matters of great interest to Tribes and others in the Indian health community and on which they have significant expertise and insight.

We propose in § 457.125(b) that HCFA will not approve a State plan that imposes cost sharing on AI/AN children. We believe that the imposition of cost sharing on children in AI/AN families may impact the State's ability to ensure coverage for this group as required under section 2102(b)(3)(D) of the Act. Our rationale for exempting AI/AN children from cost sharing is further discussed in the preamble for proposed § 457.535. This proposed provision would apply to states that submit State plans for either a separate child health program or a Medicaid expansion program, including Medicaid expansion programs under a section 1115 demonstration project.

15. Civil Rights Assurance (§ 457.130)

In § 457.130, we propose to require the State to provide an assurance that the State plan will be conducted in compliance with all civil rights requirements. This assurance is necessary for all programs involving continuing Federal financial assistance in accordance with 45 CFR 80.4 and 84.5. These civil rights requirements include 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 and 45 CFR part 80, part 84 and part 91 and 28 CFR part 35.

16. Assurance of Compliance with Other Provisions (§ 457.135)

In accordance with section 2107(e) of the Act, we propose in § 457.135 to require that the State plan 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:

- Section 1902(a)(4)(C) (relating to conflict of interest standards).
- Paragraphs (2), (16) and (17) of section 1903(i) (relating to limitations on payment).
- Section 1903(w) (relating to limitations on provider donations and taxes).
- Section 1132 (relating to periods within which claims must be filed).

We note that section 2107(e)(2)(A) of the Act provides that section 1115 the of Act, pertaining to research and demonstration waivers, applies to title XXI. This provision grants the Secretary the same section 1115 waiver authority in title XXI programs as in title XIX programs. Title XXI provides a broad range of options to allow States maximum flexibility in designing the program that best meets the needs of their children. We have carefully considered the extent to which waivers of both title XIX and title XXI provisions should be granted under CHIP.

While the law permits the Secretary to use section 1115 authority to waive provisions of title XXI in order to pursue research and demonstration projects, we do not believe it would be reasonable to exercise this authority before States have experience in operating their new title XXI programs and can effectively design and monitor the results of demonstration proposals. In addition, we do not yet have sufficient experience in the operation of CHIP to review and evaluate the merits of a proposal to waive title XXI provisions. Therefore, we would consider a section 1115 demonstration proposal for waiver of title XXI provisions only after a State has had at least one year of CHIP experience and has conducted an evaluation of that experience. We are inviting comments on the best approach to considering section 1115 waivers of title XXI provisions.

Because both the Federal government and the States have substantial experience in administering title XIX, we believe that we are in a position to consider and grant waivers of title XIX provisions even when the demonstration project involves the CHIP-related enhanced match. We would consider a request for section 1115 waivers of title XIX provisions

applicable to Medicaid expansion programs without any additional experience with the program. We would require, however, that proposals be consistent with what would be allowable in a separate child health program in order to be approvable. We have approved waiver requests for three States. For example, we granted Missouri a waiver of title XIX requirements to provide non-emergency medical transportation because those services would not have been required under a title XXI benefit package. We have granted waivers for Missouri, New Mexico, and Wisconsin to waive title XIX cost sharing limitations to the extent that cost sharing is consistent with limitations of title XXI.

States that submit section 1115 research and demonstration proposals of Medicaid laws and requirements must meet the existing section 1115 requirements, including requirements for research and evaluation design. To the extent that title XIX funds could be utilized to implement the demonstration, it would be necessary to negotiate budget neutrality. A State that wishes to have a section 1115 demonstration proposal considered must submit a full section 1115 application in addition to a title XXI State plan or plan amendment request that indicates that the State intends to implement title XXI through an approved Medicaid demonstration project. The State plan or plan amendment must describe the applicable Medicaid requirements that will be waived if the section 1115 demonstration project is approved.

Although a 90-day review period applies to CHIP State plans, the 90-day review period does not apply to section 1115 demonstration requests. Section 1115 does not impose any restrictions on review of waiver applications. While the President has committed to treat requests for waivers expeditiously, the complexity of waiver proposals under Medicaid and CHIP means that a 90-day review period may not be sufficient.

To the extent that a proposed title XXI State plan or plan amendment depends upon section 1115 demonstration authority (waivers) which will take longer than 90 days for HCFA to approve or otherwise act on, HCFA may not be able to approve the proposed title XXI submission within 90 days. In such a circumstance, HCFA will advise the State that additional time will be required to review the waiver request. In addition, HCFA will ask the State for additional information on whether a final determination on the title XXI submission is required before approval of the waiver request, and how the State will implement the title XXI submission absent approved waivers. If the State does not provide information about implementation absent approved waivers, then the 90-day review period will not resume and HCFA will not proceed to final determination of the title XXI submission before acting on the related waiver request. If the State responds with information on how the submission will be implemented and implementation continues to rely upon waivers that have not yet been granted, then the 90-day review period will resume and HCFA may be required to disapprove the title XXI submission.

17. Budget (§ 457.140)

Section 2107(d) of the Act specifies that a State plan must include a description of the budget, updated periodically as necessary, including details on the planned use of funds and the source(s) of the non-Federal share of plan expenditures, including any requirements for cost-sharing by beneficiaries. We are proposing in § 457.140(a) that the State plan must include a budget that describes both planned use of funds and sources of the non-Federal share of plan expenditures for a 3-year period. An amended budget included in a State plan amendment must also include the required description for a 3-year period.

We are proposing that the planned use of funds include the projected amount to be spent on health services, the projected amount to be spent on administrative costs and assumptions on which the budget is based. The amount spent on health services would be the cost of the benefits provided to beneficiaries, such as payments to providers or health plans. Administrative costs include the costs specified in section 2105(a)(2) of the Act, examples of which are costs associated with outreach, child health initiatives and evaluation. We propose that assumptions on which the budget is based must include the cost per child and expected enrollment. We realize that a State must base the required information on projections. However, we believe it is important to have this information to ensure the State has adequately planned for its program. In particular, we want to ensure that the State understands the limits placed on administrative expenditures and that the plan is being developed in an ''effective and efficient'' manner.

Although section 2107(d) does not specifically require States to submit a 3-year budget, it provides a sufficient authority for our proposed requirement. We propose to require a 3-year budget for the initial State plan because States have up to 3 years to spend each annual allotment. A 3-year budget is useful to show if States are planning to use their unused allotments in the succeeding 2 fiscal years. In developing this policy, we also considered the budget requirements for Medicaid programs. Section 1115 demonstration projects require a 5-year budget and section 1915(b) waivers require a 2-year budget.

In accordance with section 2107(d), we are requiring in § 457.140(b) that the budget in the State plan describe the projected source of non-Federal plan expenditures, including any requirements for cost sharing by beneficiaries. Under § 457.224 of the March 4, 1999 proposed regulation concerning program allotments and payments to States (64 FR 10412), FFP would not be available for cost sharing amounts such as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charges as required by section 2105(c)(5). To ensure this result, the amount of expenditures under the State plan must be reduced by the amount of any premiums and other cost-sharing received by the State.

HCFA's approval of a State plan, including amendments, is contingent on the State's use of permissible funding sources for the non-Federal share of plan expenditures.

Furthermore, we reserve the right to disallow funds, to the extent we find that the State is using impermissible funding for the non-Federal share of plan expenditures under a previously approved plan. Any revenues received by a State through contribution(s) from or the imposition of tax(es) on health care providers or related entities, regardless of whether or not the State uses the contribution for Federal matching purposes, is subject to the statutory provisions of 1903(w) of the Act.

18. HCFA Review of State Plan Material (§ 457.150)

Section 2106 of the Act provides the Secretary of the Department of Health and Human Services (DHHS) with the authority to approve and disapprove State plans and plan amendments. The authority vested in the Secretary under title XXI has been delegated to the Administrator of HCFA with the limitation that no State plan or plan amendment will be disapproved without consultation and discussion by the Administrator with the Secretary.

Therefore, in § 457.150, we propose to specify that HCFA reviews, approves and disapproves all State plans and plan amendments. The Center for Medicaid and State Operations within HCFA has

the primary responsibility for administering the Federal aspects of title XXI. We will continue to work jointly with the Health Resources and Services Administration (HRSA) to implement and monitor the new program as a part of the Department's overall strategy to support coordination with other Federal and State health programs in providing outreach to uninsured children and promoting coordination of care and other public health interventions. At this time, State plans and plan amendments are reviewed by a team of DHHS staff, including HRSA staff, who must concur on approval of the plan. Departmental concurrence is an internal policy that is subject to change.

We base approval or disapproval of State plans on relevant Federal statutes, including title XXI and title XIX, regulations, and guidelines issued by HCFA. We published and will continue to publish guidelines in the format of State Health Official letters and Questions and Answers, which may be accessed through the website.

Section 2106 does not allow the Secretary to partially approve or disapprove a State plan or plan amendment. Thus, at § 457.150(b) we propose that HCFA approves or disapproves the State plan or plan amendment only in its entirety. For example, if a State submitted one proposal to implement a combination program, we would not approve the Medicaid expansion portion and disapprove the separate program portion. The proposal would only be considered as a whole. If a State wants HCFA to consider portions of a proposal separately, then the State must expressly divide the proposal into distinct and separate proposed State plan or State plan amendment submissions. For example, a State could receive approval for a Medicaid expansion program described in the State plan and then receive approval to turn the program into a combination program as described in a plan amendment. As appropriate and feasible, States may withdraw portions of a pending State plan or plan amendment that may lead to delay in its approval or disapproval of the program.

In § 457.150(d), we propose to designate an official to receive the initial submission of a State plan. By designating one official to receive all initial State plans, we eliminate any confusion of where to send the first submission. The identity of this individual is posted on HCFA's website. If this designated official is unavailable, the review period is started and counted as if the designated official was in the office.

In § 457.150(e), we propose to designate an individual to coordinate HCFA's review for each State that submits a State plan. We will notify the State of the identity of the designated individual in the first correspondence from HCFA relating to the plan, such as a formal request for additional information. We will also notify the State at any time there is a change in the designated individual. If the designated individual for a State is unavailable during regular business hours, another HCFA employee will act in place of the designated individual to ensure that the review period is counted as if the designated individual was in the office. We believe that this procedure will simplify administration of the program.

19. Notice and Timing of HCFA Action on State Plan Material (§ 457.160)

In § 457.160(a), we propose that HCFA will send written notification of the approval or disapproval of a State plan or plan amendment. While section 2106(c)(2) only requires that written notification be sent for disapproval and requests for additional information, we are proposing to require that written notification be sent for approval as well. This rule is consistent with the Medicaid approval process during which HCFA sends written notices of approval of Medicaid State plan amendments and 1915 (b) and (c) waivers.

We will closely track the review period, which begins on the first full day following receipt of the initial State plan by the designated official or the State plan amendment by the designated individual. In § 457.160(b)(2), we propose that the State plan or plan amendment be considered received on the day the designated official or individual, as determined in § 457.150 (d) and (e), receives an electronic, fax or hard copy of the complete plan. The complete plan includes any referenced documentation, such as attachments, benefits plans or actuarial analyses. If the designated official or individual receives a State plan without the referenced documentation, then the review period begins not on the first full day following receipt of the initial, incomplete plan, but rather on the first full day after the designated individual receives the documentation. We strongly encourage States to submit their State plans or plan amendments in electronic format (via disk or e-mail) to facilitate its distribution to DHHS' reviewing components. We request that the State submit the State plan and plan amendments to both the HCFA central office and the appropriate regional office at the same time. If the State submits the State plan or plan amendment in hard copy, we request that the State submit twenty (20) copies to the central office and three (3) copies to their regional office. If the State submits the State plan or plan amendment electronically, then the State should send three (3) hard copies to the central office and one (1) hard copy to their regional office. We also request that States include the name and telephone number of their primary contact person for CHIP (if different from the information required in § 457.40(c)) in the State's transmittal letter to help ensure an early and ongoing dialogue on the submission.

As required by section 2106(c)(2), a State plan or plan amendment will be considered approved unless HCFA, within 90 days after receipt of the State plan or plan amendment, sends the State written notice of disapproval or written notice of any additional information it needs in order to make a final determination. The Act does not specify calendar days or business days. We propose to measure the 90-day review period using calendar days. The 90-day review period would not expire until 12 a.m. eastern time on the 91st countable calendar day after receipt, as calculated using the rules set forth in the proposed regulation and discussed below (except that the 90-day period cannot stop or end on a non-business day).

HCFA's formal request for additional information may include a description of specific issues that need clarification, an outline of additional information required, or a request for resolution of any inconsistencies of the plan with title XXI provisions. We will make a formal request for information only when the State may need a significant amount of time to resolve issues or develop required information. In order to ensure that additional information responding to HCFA's formal requests will be sufficient to restart the approval process, we encourage States to work with HCFA in developing any responses.

In § 457.160(b)(3), we propose that if HCFA provides written notice requesting additional information, the 90-day review period is stopped on the day HCFA sends the written request for additional information. HCFA will not stop a review period on a weekend or a Federal holiday. This written request will be considered sent on the day that the letter is signed and dated except if the day is a weekend or Federal holiday, in which case the review period will stop on the next business day. We will

attempt to ensure that the State receives the letter on that same day, through some means of electronic transmission, and will try to confirm receipt by telephone contact during normal business hours. We propose that the review period will resume on the next calendar day after the complete additional information is received by the designated individual, unless the State's response is received after 5 p.m. eastern time on a day prior to a non-business day or any time on a non-business day, in which case the review period will resume on the following business day. For example, if the formal request for information is sent on day 45, the review will begin again at day 46 on the first full business day following receipt of the requested information by the designated individual. If the formal request for information is sent on day 45 and the State's response is received at 6 p.m. eastern time on a Friday, then day 46 will be the following Monday (assuming it is not a holiday). We propose in § 457.160(b)(4) that the 90-day review period cannot stop or end on a non-business day. HCFA will not stop a review period on a weekend or holiday. If the 90th day of a review period is scheduled to be on a weekend or holiday, then the 90th day will be the following business day. Additionally, in § 457.160(b)(5), we propose that the 90-day review period may be stopped as many times as necessary to obtain the necessary information for making a final decision whether to approve the State plan or plan amendment.

In developing our policy for the review period, we considered applying the review periods associated with the review of title XIX State plan amendments (SPA) and 1915 (b) and (c) waiver requests. In the review of a SPA and 1915 (b) and (c) waiver request, the 90-day clock begins on the day of receipt of the SPA or waiver request and ends 90 days later and only business days are counted. The 90-day clock can be stopped only once by a written request for additional information. A new 90-day period begins on the day the requested information is received.

We are not proposing to use the same review period policies under title XXI, as we believe the proposed process will more effectively implement title XXI objectives because it will be speedier and more flexible. Rather than having a 90-day clock that restarts at the beginning when additional information is requested and received, we propose a clock that consists of only 90 calendar days and resumes on the day additional information was requested, when that information is received. The proposed time frame allows States ample opportunity to comply with the requirements of this new program by allowing the review period to be stopped as many times as necessary rather than only once. We are proposing that the review period be started (or restarted) on the first full day following receipt of the plan (or additional information) in order to allow us the fullest amount of time for review. Furthermore, our proposal to resume the review period on the following business day if the response is received after 5 p.m. eastern time on a day prior to a non-business day would allow us maximum review time. This provision and the provision that the review period cannot end on a non-business day safeguard against a plan becoming automatically approved on a non-business day. While we are committed to expedient review, we believe it would not be reasonable to count non-business days on which we could not have reasonably taken action.

We permit and encourage informal discussion between the State and HCFA during the review period. We may informally request additional information through meetings or telephone contact, or in writing. Because an informal request does not stop the 90-day approval time frame, HCFA usually makes such a request only when HCFA has concerns that the State could address in a timely manner through clarification of information already contained in the plan. It is important that States respond as quickly as possible to informal requests for clarification because these requests do not stop the review period.

20. Withdrawal Process (§ 457.170)

In § 457.170, we propose to allow a State to withdraw its State plan during the review process by providing written notice to HCFA of the withdrawal. This process is consistent with the process for withdrawal of a Medicaid State plan amendment.

21. Administrative and Judicial Review of Action on State Plan Material (§ 457.190)

A State dissatisfied with the Administrator's action on State plan material has a right to administrative review. In § 457.190(a), we propose a procedure for administrative review under the authority of section 2107(e)(2)(B) of the Act. Specifically, we would require that 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. This procedure is consistent with the procedure for administrative review in Medicaid. Additionally, we propose that the procedures for hearings and judicial review be the same procedures used in Medicaid which are set forth in regulations at part 430, subpart D. We propose to use the same procedures that are used in Medicaid because the infrastructure supporting these procedures is already in place and well known. We believe it is important for a State to be familiar with the process for requesting reconsideration of a HCFA action in order for that State to have full opportunity to dispute the action. In addition, we propose that we will not delay the denial of Federal funds, if required by the Administrator's original determination, pending a hearing decision. If the Administrator determines that the original decision was incorrect, we pay the State a lump sum equal to any funds incorrectly denied.

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

1. Basis, Scope, and Applicability (§ 457.300)

This subpart interprets and implements section 2102(b) of the Act, which relates to eligibility standards and methodologies; section 2105(c)(6)(B), which precludes payment for 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 section 2110(b), which defines the term ''targeted low-income child.'' This subpart sets forth the requirements relating to eligibility standards and to screening, application and enrollment procedures. The requirements of this subpart apply to a separate child health program and, with respect to the definition of targeted low-income child only, a Medicaid expansion program.

2. Definitions and Use of Terms (§ 457.301)

This section includes the definitions and terms used in this subpart. Because of the unique Federal-State relationship that is the basis for this program and in keeping with our commitment to State flexibility, we determined that many terms should be left to the States to define. For example, we did not define the terms ''family'' or ''income'' as there is a great deal of variation among States. States have the option to count either

gross or net income when making eligibility determinations; and the term family can be defined any number of ways, ranging from only the individual child to including parents, grandparents or other non-related guardians. States have discretion in making these determinations.

The statutory phrase ''public agency in the State'' is not restricted to State government agencies, but would include other public agencies, such as local agencies in the State. Therefore, we propose to define ''public agency'' as 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. Such an interpretation is consistent with the use of the term under § 433.51 of the Medicaid regulations, which includes State and local governmental units, as well as Indian tribes, as public agencies. We are proposing to define the term ''employment with a public agency'' as employment either directly or with an entity under a contract with a public agency. This term includes both direct and indirect employment because we do not wish to influence or restrict the organizational flexibility of State and local governmental units.

We would define the term ''State health benefits plan'' as a plan that is offered or organized by the State government on behalf of State employees or other public agency employees within the State. For example, if a local government, such as a county or a city, has its own insurance plan that is separate from the State employee plan, the children of that entity's employees could be eligible for CHIP as long as they are uninsured and meet all other eligibility requirements under the plan. The term does not include a separately run county, city, or other public agency plan or a plan that provides coverage only for a specific type of care, such as dental or vision care. Our definition parallels the definition in section 2791(d)(8) of the Public Health Service Act, which refers to plans ''established or maintained for its employees,'' except that we would limit the term to a plan under which an actual benefit in the form of a more than nominal premium subsidy is available for coverage of a dependent child. In the absence of a more than nominal premium subsidy, we would not consider the plan to be a ''benefits plan'' with respect to the child, because no benefit would be extended by the State for that child.

3. State Plan Provisions (§ 457.305)

In accordance with the requirements of section 2102(b)(1)(A) of the Act, we propose to require that the State plan include a description of the eligibility standards under the State plan.

4. Targeted Low-income Child (§ 457.310)

Section 2110(b) of the Act defines a targeted low-income child. In accordance with this section, we have defined a targeted low-income child as a child who meets the eligibility requirements established in the State plan and certain other statutory conditions to be a targeted low-income child. At § 457.310(b), we set forth proposed standards for targeted low-income children that relate to financial need, eligibility for other coverage including coverage under a State health benefits plan. In addition, we set forth exclusions from the category of low-income children.

With regard to financial need, we propose that a child who resides in a State with a Medicaid applicable income level, must have: (1) Family income at or below 200 percent of the Federal poverty line; or (2) family income that either exceeds the Medicaid applicable income level but by not more than 50 percentage points or does not exceed the Medicaid applicable income level determined as of June 1, 1997. Section 2110(b)(1)(B)(ii)(II) of the Act refers to the term Medicaid applicable income level in the definition of targeted low-income child. As specified in a technical amendment passed by Congress, the March 31, 1997 date from section 2110(b)(4), defining Medicaid applicable income level, was replaced with the June 1, 1997 date in the text of this proposed regulation.

With regard to other coverage, we propose that a targeted low-income child must not be eligible for Medicaid (determined either through the Medicaid application process or the screening process discussed later in this preamble); or covered under a group health plan or under health insurance coverage, unless the health insurance coverage 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. However, we would not consider a child to be covered under a group health plan if the child did not have reasonable access to care under that plan. For example, if a child is covered by a health maintenance organization in another State through the employer of an absent parent and cannot get treatment (other than emergency care) in his State of residence, we would not consider the child to have health insurance coverage for purposes of eligibility in the State of residency.

Section 2110(b)(3) allows low-income children who have insurance coverage under a State program operating since before July 1, 1997 without Federal funds to be considered targeted low-income children. This rule applies to programs that are State-operated, that is, administered by the State in some respect. Children in such programs continuously operating since June 30, 1997 would not be precluded from being considered as targeted low-income children, but would have to meet other applicable eligibility requirements.

In the State plan review process, we have been asked whether children in Blue Cross/Blue Shield (BC/BS) Caring Programs for Children are eligible for a separate child health program. As of May 1997, there were more than 20 Blue Cross/Blue Shield (BC/BS) Caring Programs for Children. These programs are generally funded by contributions from the community that are matched by BC/BS and no Federal funds have been used to support these programs. Whether such children can be covered under a separate child health program depends on whether the Caring Program is State-operated. Assuming a particular Caring Program is not within the pre-existing State program exception, children would nevertheless only be ineligible to the extent that they were *covered* by the Caring program. To the extent that the Caring program terminates, or alters its eligibility criteria so that these children are no longer eligible, the children previously covered under the Caring program could be eligible for CHIP coverage as long as they meet the State's eligibility requirements. We also note that to the extent that a Caring Program does not meet the definition of ''health insurance coverage'' under HIPAA, children covered by a Caring Program may be eligible for CHIP coverage.

As defined in section 2110(b)(2)(B) of the Act, the definition of targeted low-income child excludes a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan in a State on the basis of a family member's employment with a public agency. This provision would exclude children based on eligibility rather than actual coverage. Therefore a child who is eligible and offered coverage could not be a targeted low-income child even if the family declined to accept the coverage.

There may be circumstances in which a State may cover otherwise eligible

children of public agency employees. The exclusion only extends to children ''eligible for health benefits coverage under a State health benefits plan''. We do not believe this condition is met in any meaningful sense when only a nominal employee benefit is available for health benefits coverage for the child. If the State or public agency contribution for the cost of the child's health benefits coverage is merely nominal, the child is not ''eligible for health benefits coverage under a State health benefits plan''. We would find an employee benefit available to the extent that a more than nominal State or public agency contribution was available under any health coverage option offered by the plan, regardless of the actual choice between those options made by the employee. In other words, if the State offers a cafeteria plan with multiple choices, we would look to whether a more than nominal State or public agency contribution could be available under any of the available choices, regardless of the actual choice made by the employee. This means that some children of public agency employees whose parents have access to State health benefits may be eligible for CHIP, while others may not, depending on whether the parent's public agency employer offers more than a nominal contribution that is available for the cost of the coverage of any dependent in the family.

In order to ensure that States do not change their contribution levels to make children of public agency employees eligible for CHIP, we are proposing to provide that the exception discussed above would not apply if the State made available an employee benefit to pay for part or all of dependent coverage on, the date this proposed rule is published, November 8, 1999, whether or not the State later terminates that employee benefit. This proposed limitation would ensure that CHIP coverage does not displace current coverage and substitute Federal dollars for existing private and public dollars already spent on coverage. The proposed limitation is to ensure that our overall interpretation of the public agency employee exclusion is consistent with the overall purposes of the CHIP statute, and results in effective and efficient use of CHIP resources.

We propose to find that a child is only ''eligible for health benefits coverage under a State health plan'' when an employee benefit is available to cover part or all of the cost of health benefits coverage under the State plan. Of course, such a benefit would be available if the child is the employee and directly entitled to State or public agency contribution to the cost of employee care. In the more likely instance that the child is a dependent of a State or public agency employee, the exclusion would be triggered if a State or public agency makes available a more than nominal contribution under the plan that exceeds the minimum amount necessary for coverage of the employee alone, and could be available to cover part or all of the cost of dependent coverage. This applies regardless of whether the State offers a defined benefit plan or a defined contribution applicable to a range of optional benefits. In other words, if the family must pay the full cost of coverage for dependents, with the exception of a nominal amount, then effectively no benefit is available, and children in the family could be eligible for a separate child health program. On the other hand, if the State makes available a more than nominal contribution for the cost of coverage beyond the amount needed to cover the cost of the employee alone, then a benefit would be available for dependent coverage, and children in the family would not be eligible.

We are proposing to consider any contribution over $10 towards the cost of dependent coverage to be more than nominal. We considered an interpretation that the exclusion would be triggered by any State or public agency employer contribution over the minimum amount necessary for coverage of the employee alone, but we believe that this interpretation would be administratively difficult because of the inability in some cases to accurately determine the overall cost of such coverage, particularly on a prospective basis. Moreover, the exclusion operates to prevent substitution of CHIP coverage for existing State supported coverage, which is not an issue when the State or public agency contribution is merely nominal and provides insignificant financial support toward enrolling the child.

Section 2110(b)(2)(A) of the Act excludes from the definition of targeted low-income child, a child who is an inmate of a public institution or who is a patient in an institution for mental diseases (IMD). We have proposed to use the Medicaid definition of IMD set forth at § 435.1009. This definition states, in part, that an IMD ''means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.''

We propose to apply the IMD eligibility exclusion any time an eligibility determination is made, either at the time of application or during any periodic review of eligibility (for example, at the end of an enrollment period). Therefore, a child who is an inpatient in an IMD at the time of application, or during any eligibility determination, would be ineligible for CHIP coverage. If a child is enrolled in CHIP and subsequently requires inpatient services in an IMD, the IMD services would be covered to the extent that CHIP coverage includes coverage for such services. However, eligibility would end at the time of redetermination if the child resides in an IMD at that time.

Some States have had questions regarding our policy on the provision of services to eligible individuals residing in IMDs. Under section 2110(b)(2)(A) of the Act, children who reside in IMDs are specifically excluded from being eligible for CHIP as a targeted low-income child. However, there may be situations where a child already determined eligible for CHIP may require inpatient mental health services and the State CHIP plan covers IMD services. This situation raises the issue of whether the child is eligible for CHIP services once he or she enters the IMD. In a question and answer released on July 29, 1998, we noted that a child in an IMD may not be eligible for CHIP but an eligible child who then enters an IMD may remain eligible for CHIP services until such time as the child's eligibility is redetermined. In developing this policy, we were attempting to allow services to be provided to more individuals. However, it had been suggested that our policy as stated in the July 29, 1998 question and answer has the potential for allowing services to be delivered inequitably among children with similar needs. For example, if one child is receiving services in an IMD and is redetermined after 2 months, that child will no longer be eligible for CHIP at that time. Another child may be receiving IMD services but may not be redetermined for 12 months. The second child would receive more services than the first although they are similarly situated. Moreover, the CHIP guidance is not consistent with the Medicaid IMD policy. Under Medicaid, children residing in IMDs remain eligible for Medicaid, but Federal matching funds are not available for any services

provided to the individual unless the facility is qualified as an inpatient psychiatric hospital for individuals under the age of 21.

We are currently reviewing the CHIP IMD policy and considering various options. We are soliciting comments on an appropriate way to address this issue. We note that inpatient mental health services may be available under a State CHIP program in settings and facilities other than IMDs.

We have proposed to use the Medicaid definition of inmate of a public institution set forth at § 435.1009. Accordingly, when determining eligibility for CHIP, an individual is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities. A facility is a public institution when it is under the responsibility of a governmental unit or when a governmental unit exercises administrative control.

Under Medicaid, FFP is not available for medical care provided to inmates of public institutions, except when the inmate becomes a patient in a medical institution. We believe that the underlying basis for this exception to the FFP exclusion in Medicaid is to recognize that the term ''inmate'' includes only a person involuntarily residing in a penal setting. When discharged from a penal setting, or temporarily transferred to a medical institution (which does not include institutions that are part of the State's penal system, since such an institution is primarily a penal institution rather than a medical institution) a person is no longer an ''inmate'' and is treated as part of the general health care community. While the person is in the medical institution, FFP is available for Medicaid covered services.

We propose to allow this same exception when determining eligibility for a separate child health program because we believe an inmate residing in a penal institution who is subsequently discharged or temporarily transferred to a medical institution for treatment is no longer an ''inmate.'' Therefore, an inmate who becomes an inpatient in a medical institution which is not part of the penal system (that is, is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility), would then be eligible for CHIP (subject to meeting other CHIP eligibility requirements), and the State would receive FFP for medical care provided to that child. If the child is taken out of the medical institution and returned to a public institution, the child would again be excluded from eligibility for CHIP.

4. Other Eligibility Standards (§ 457.320)

Section 2102(b) of the Act sets forth the parameters for other eligibility standards and methodologies a State may use under a separate child health program. With certain exceptions, the State may establish different standards for different groups of children. Such standards may include those related to geographic areas served by the plan, age, income and resources (including any standards relating to spenddowns and disposition of resources), residency, disability status (so long as any standard relating to disability does not restrict eligibility), access to other health coverage and duration of eligibility. Under the statute, the State may not use eligibility standards that discriminate on the basis of diagnosis, cover children with higher family income without covering children with a lower family income within any defined group of covered targeted low-income children, or deny eligibility on the basis of a preexisting medical condition.

Accordingly, with certain exceptions, States are free to choose the standards that they will use to establish eligibility under a separate child health program. A State can set the income limit or limits, consistent with title XXI and these regulations, against which to compare income to determine eligibility. With the exception of income that cannot be counted because of a prohibition in another Federal statute, a State can determine what constitutes income, what income is counted, and what income is excluded or disregarded. A State can calculate eligibility using either gross income or net income after deductions and disregards. A State can also determine who is in a child's family and therefore, whose income will be counted and under what circumstances. However, as noted, certain other Federal statutes prohibit counting certain payments in determining eligibility under certain means tested programs including a separate child health program. For example, relocation payments provided under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and student financial assistance for attendance costs received from a program funded in whole or in part under title IV of the Higher Education Act of 1965, as amended, or under the Bureau of Indian Affairs student assistance programs cannot be counted as income under a separate child health program.

A State has the option to impose a resource test. However, very few States have elected this option. Most States believe that a resource test unnecessarily complicates the eligibility process and is a barrier to enrollment. Most families who meet the income requirements for eligibility do not have significant resources. If a State chooses to impose a resource test, it may set the resource limits(s) that it will use to establish eligibility and determine what constitutes a resource and what resources, if any, will be excluded or disregarded.

The statute provides that in establishing eligibility, the standards may include those related to a ''spenddown''. We would interpret this language to allow a child who would be eligible except for excess income and/or resources, to become eligible when the family has either incurred or paid medical expenses in the amount of the excess income and/or resources. We would allow the State to establish the period of eligibility for children who become eligible for the program by virtue of a spenddown. As it already exists under the Medicaid program, we would also allow States to have a ''pay-in spenddown'' policy. Under a ''pay-in spenddown,'' a State would establish the amount of the excess income or resources that a family had and allow the family to pay that amount directly to the State to establish immediate eligibility without waiting until the family incurs the medical expenses. In the event that the family did not incur medical expenses sufficient to cover the pay-in spenddown amount for the spenddown period, the State would need to have reasonable procedures in place for the disposition of the unused pay-in spenddown amount, such as refunding the unused amount or crediting it to a future spenddown period. The State cannot use money collected for matching purposes.

The statute provides that in establishing eligibility, the standards may relate to ''disposition of resources.'' We interpret this provision to allow a State to impose a period of ineligibility, or other penalty, if the State finds that an individual, whose resources are relevant to a child's eligibility for CHIP, disposed of resources for less than fair market value in order to make the child eligible for CHIP coverage.

The statute provides that the standards used may include those related to geographic area. We interpret this language to allow a State to provide coverage only to children living in certain areas or jurisdictions within the State and to have different eligibility criteria for different areas or

jurisdictions within the State. However, we recommend that States strive to maximize coverage throughout the State.

Eligibility standards may also relate to disability status as long as any standard relating to such status does not restrict eligibility. We interpret this provision to allow a State to establish a group of children who may be eligible because they meet State-established disability criteria or have a particular disabling condition. The State could establish different eligibility criteria for each such group, as long as the criteria do not restrict eligibility for either group.

The statute provides that the standards may relate to age. We interpret this provision to allow States to provide coverage only to children of a certain age or ages or to have different eligibility criteria for children of different ages. We have specified that the age used cannot exceed age 18 because section 2110(c)(1) defines a child for purposes of title XXI as an individual under the age of 19. This means that a State cannot provide coverage to a child who has attained age 19. We considered whether there was statutory authority to continue coverage after a child's 19th birthday if the child was in a course of treatment and decided that there is no statutory authority to do so. We also considered whether a child who attains age 19 during what would otherwise have been a period of guaranteed eligibility, explained below, could remain eligible until the end of that period. We decided that there is no authority for such continuous eligibility and therefore eligibility must be terminated on the date that the child attains age 19. If coverage for a given period has been pre-paid under the State's usual and customary administrative procedures prior to the date the child attains age 19, the coverage may continue until the end of the pre-paid period even though the child is no longer eligible.

Eligibility standards may also include those related to residency. We interpret this language to allow States to provide child health assistance under a separate child health program only to residents of the State. We would also allow a State to determine what constitutes residency in the State. However, under the 1969 decision of the Supreme Court in *Shapiro* v. *Thompson* (394 US 618), a State cannot impose a durational residency requirement. Therefore, we propose to require that an eligibility standard relating residency cannot exclude those who have recently moved to the State. In addition, in establishing residency requirements we urge States to be particularly attentive to meeting the health needs of migrant targeted low-income children. We encourage States to allow migrants to maintain residency in the State in which they reside most often, if they choose, or to establish residency in the State in which they are working. We also strongly recommend that States establish written inter-State agreements setting forth rules and procedures for resolving cases of disputed residency as States do under Medicaid. (See § 435.403 for Medicaid regulations pertaining to residency.)

The eligibility standards also may relate to access to other health coverage. See Subpart H of this proposed rule for a discussion of substitution of coverage.

Furthermore, we want to ensure that the State periodically disenrolls from the program enrollees that no longer meet the eligibility standards under section 2102 and these regulations for any reason including a change in age, income, and other health coverage. For this reason, we would specify that the State agency may, at its own discretion, establish a period for regular review of eligibility, not to exceed 1 year. During the period between regular eligibility reviews, a child need not have eligibility redetermined, and thus will remain eligible throughout the period, unless the child reaches age 19 or (as discussed below) is found eligible for Medicaid. Note that, States that implement CHIP through the Medicaid expansion option are subject to the Medicaid regulations (42 CFR 435.916), under which a State must also redetermine eligibility at least every 12 months. The eligibility standard relating to duration of eligibility would not allow States to impose a maximum length durational requirement or any similar requirement. We solicit comments on this issue.

We are particularly concerned about the impact of age, income, and benefits restrictions under a separate child health program on pregnant teens and their children. We urge States to pay particular attention to the interaction of a separate child health program and the Medicaid program when it comes to the State's attention that a teen is pregnant. Although States may provide pregnancy-related and delivery services under a separate child health program, it is often to the pregnant teen and newborn's advantage to be covered by Medicaid, if eligible. Under Medicaid, once a pregnant teen is determined eligible, she remains eligible without regard to changes in income until the end of the postpartum period. Under a separate child health program, a pregnant teen may lose eligibility due to an increase in income and at that point, be unable to establish eligibility for Medicaid. She then might be without coverage for the rest of her prenatal care and her delivery. In addition, an infant born to a teen who is eligible for and receiving Medicaid on the date of the infant's birth is deemed to have filed a Medicaid application and been found eligible. The infant also remains eligible for 1 year, without regard to changes in income, as long as the infant continues to reside with the mother. An infant born to a mother whose delivery was covered by a separate child health program would not have this protection. To be eligible for separate child health program, an application would have to be filed for the infant and the infant would have to meet income eligibility standards.

In addition, we urge States to be particularly attentive to the possibility that a pregnant teen who loses eligibility under a State child health program because she attains age 19 might be eligible for Medicaid as a pregnant teen although she was not eligible for Medicaid otherwise. In some States, the income standard applied under Medicaid to a pregnant teen is higher than the standard used for non-pregnant teens of the same age, which means that pregnant teens with higher incomes than other children of the same age may be Medicaid eligible.

A State must allow any child, including a pregnant teen, to apply for Medicaid at any time and must take timely action on that application. If the teen is determined to be eligible for Medicaid, the teen is no longer eligible for CHIP. Any child who is covered under CHIP at all times is entitled to apply for and receive Medicaid, if eligible, regardless of the State's practice for determining and reestablishing eligibility under the State program. When the State determines that a child is Medicaid eligible, the child is no longer eligible for CHIP. States that have opted to provide presumptive eligibility for pregnant women under the Medicaid program must also allow providers to find pregnant teens presumptively eligible for Medicaid.

Finally, in some States, the benefits provided to pregnant teens under Medicaid, particularly those related to prenatal care and delivery, may be better and less expensive than those provided under CHIP. We urge States to provide sufficient information to a pregnant teen for her to make an informed choice about applying for Medicaid during a period of guaranteed eligibility.

In keeping with section 2102(b)(1)(B)(i) and (ii), States may not cover children with higher family income without covering children with

lower family income within any State-defined group of covered targeted low-income children or deny eligibility based on a preexisting medical condition.

We have proposed certain other restrictions on eligibility standards. The first proposed restriction is that a State not require that a social security number (SSN) of an applicant child or family member be provided as a condition of eligibility. We wish to clarify that, under section 1137 of the Act, a SSN must be supplied only by applicants for and recipients of Medicaid benefits. In all other cases, including non-applicant parents of children applying for Medicaid and children applying for a separate child health program, States are prohibited from making the provision of a SSN by another family member a condition of the child's eligibility. This rule also applies to other members of the household whose income might be used in making the child's eligibility determination.

Some States use parents' SSNs as a means of verifying family income in the process of making an eligibility determination. While the statute does not permit States to require disclosure of the SSN for applicants or non-applicants, voluntary disclosure by the parent may facilitate the verification of income and contribute to a speedier and more accurate determination of the child's eligibility. States may advise parents and other household members of this as long as they do so in a manner that does not coerce provision of the SSN or deter application for benefits. Once more, we wish to clarify that States have no legal basis for denying an application based upon the failure to supply the SSN for verification purposes.

We also propose to specifically provide that the eligibility standards used for a separate child health program cannot exclude American Indian or Alaska Native children who are eligible to receive medical care funded by the Indian Health Service (IHS). We believe this provision is effectively required by the statutory mandate that State child health plans contain procedures to ensure the provision of child health assistance to targeted low-income children who are Indians, and the statutory provision, discussed below, that CHIP payment may be made primary to any IHS payment for CHIP-covered services.

Section 2105(c)(6)(B) of the Act specifically exempts programs operated or financed by IHS from the restriction on payment to prevent duplication between CHIP and other Federally operated or financed health programs. In light of IHS policies, we read this provision to require that a separate child health program must pay for services that are covered under the plan and are provided by IHS and IHS-funded Tribal health programs participating in the separate child health program. IHS only pays for items and services not covered by any other third-party coverage. The Indian Health Care Improvement Act grants IHS and IHS-funded Tribal health programs authority to bill Medicaid and all other third party insurance for services provided directly to the Indian person. The IHS or Tribal program also may require health care providers with whom they contract for other services for Indian beneficiaries to bill Medicaid and other health insurance before billing the IHS or Tribal program.

In addition, we would provide that the eligibility standards used for a separate child health program cannot violate any other Federal law. For example, under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), as amended (8 U.S.C. 1601 *et seq.*), a State must cover those legal immigrant children who meet the Federal definition of qualified alien and who are otherwise eligible. We believe that the following qualified alien children who are otherwise eligible must be covered:

- All qualified alien children who were in the United States before August 22, 1996.
- Refugees, asylees, certain Cuban, Haitian and Amerasian immigrants, and certain aliens whose deportation is being withheld.
- Unmarried, dependent children of veterans and active duty service members of the Armed Forces.
- The following children who enter the United States on or after August 22, 1996 and who are in continuous residence for 5 years (Earliest eligibility for this group will be August 22, 2001.):

— Alien lawfully admitted for permanent residence;
—Certain battered aliens or children of battered aliens;
—Certain parolees who have been paroled for at least 1 year;

We note that States implementing a separate child health program do not have the option provided to them under Medicaid to deny Medicaid to some qualified aliens.

In establishing eligibility for CHIP coverage, States must obtain proof of citizenship, (including nationals of the U.S.) and verify qualified alien status in accordance with section 432 of PRWORA, as amended (8 U.S.C. 1642).

In addition to verifying qualified alien status, PRWORA requires that Federal public benefit programs, such as Medicaid and CHIP, must also obtain proof that an applicant who so claims is a citizen of the United States. As required by law, on August 4, 1998, the Immigration and Naturalization Service (INS) published a notice of proposed rule making in the **Federal Register** that set forth proposed procedures for providing proof of citizenship and qualified alien status.

For verification purposes, the INS proposed rules require the applicant to declare in writing, under penalty of law, whether the applicant is a national of the United States. (National means either a US citizen or a person who, though not a citizen of the United States, owes permanent allegiance to the United States). For unemancipated minors under 18, the regulations provide for the declaration to be executed by a parent, legal guardian, or other person legally qualified to act on behalf of the applicant. The proposed rules set out what constitutes primary or secondary evidence of US national status. In lieu of evidence from the applicant, the proposals allow the option to consult agency records, or to accept a third party declaration in the case of an applicant who cannot produce evidence of US national status. The regulations also permit reliance upon attestation as temporary evidence of US nationality only until the applicant can provide the required evidence.

While a letter to State Health Officials issued by HCFA on September 10, 1998, advised States that they could accept self-declarations of US citizenship without further proof, once the INS regulation cited above becomes a final rule, it is very likely that self-declaration will no longer be permitted. States that currently permit self-declaration, as well as States that employ other procedures not consistent with the INS final rule, will need to come into compliance with the INS final rule within 2 years after the rule becomes final.

Section 2102(b)(1)(A) specifies that a State may adopt eligibility standards relating to duration of eligibility but does not prescribe a particular duration. We propose at § 457.320(a)(10) to allow the State to establish the period between eligibility redeterminations as long as the period does not exceed one year. During the period between eligibility redeterminations, a child need not have eligibility redetermined and thus will remain eligible throughout the period, unless the child reaches age 19 or (as discussed above) is found eligible for Medicaid. The State is required to reestablish eligibility of a child, with

respect to circumstances that may change, at least once every twelve months. This will allow States to provide continuous eligibility for children under a separate child health program without regard to changes in circumstances other than age or Medicaid eligibility, for a guaranteed period of time in the same manner as the State provides continuous eligibility under Medicaid (Section 1902(e)(12) of the Act). We will consider all payments made during a guaranteed period of eligibility after a final determination of initial eligibility to be correct. We believe a longer period between eligibility redeterminations would be inconsistent with the requirements and objectives of title XXI, in particular the goal to extend coverage primarily to targeted low-income children.

5. Application (§ 457.340)

We propose to require that the State must afford every individual the opportunity to apply for child health assistance without delay. Section 2101(a) of the Act requires States to provide child health assistance to uninsured, low-income children in an effective and efficient manner. The opportunity to apply without delay is necessary for an effective and efficient program.

In addition, we propose that a State may use either a separate application for CHIP or a joint application for CHIP and Medicaid. If a State chooses to use a separate application, the State must ensure that the screening procedures described in proposed § 457.350 are followed.

If a State chooses to use a joint application for CHIP and Medicaid, the application does not necessarily need to be an application for Medicaid under all possible Medicaid eligibility groups. The application for Medicaid could be an application only for a child-related Medicaid eligibility group that must be used for screening purposes as explained in the discussion of § 457.350. However, if a State chooses to use this type of limited application, the application must inform the individual that it is an application only for one kind of children's health benefits under Medicaid and is not a full Medicaid application, and that even if the child is not found eligible for this kind of children's health benefits under Medicaid, the child may be eligible for Medicaid on some other basis and has a right to complete a full Medicaid application. The Medicaid denial notice must also provide this information. For the same reasons that we believe it would be overly burdensome and contrary to the intent of title XXI to require that a State screen for eligibility under all Medicaid eligibility groups, we believe that it would be overly burdensome and against the intent of the program to require a State using a joint application to use a form that allows a full application for Medicaid under any eligibility group.

We encourage States to use a joint application for their CHIP and Medicaid programs. A joint application is an actual Medicaid application. It must be processed in the same manner as any other application for Medicaid. All of the Medicaid rules pertaining to application would apply to a joint application. Joint applications would ensure that the proposed screen and enroll requirements set forth at § 457.350 are met. Joint applications also permit a family to submit information once during the application process. On September 10, 1998, we released a model joint application form as an attachment to a letter clarifying eligibility procedures. This information can be found on the HCFA website.

If a State chooses to use separate applications for CHIP and Medicaid, there is considerable flexibility, within certain limits, in developing application forms and the eligibility intake process. For example, States that implement a separate child health program have flexibility to contract with independent entities to perform initial Medicaid screening and to make preliminary eligibility determinations. Title XXI does not prohibit this type of arrangement and the requirement to provide child health assistance in an effective and efficient manner allows this flexibility for a separate child health program. In addition, the State may contract with an independent entity for the purpose of eligibility screening if the State uses a joint application because this function is being performed under title XXI requirements and the funding comes from title XXI. However, if the screening shows that the child is potentially eligible for Medicaid, the evaluation of the application for Medicaid purposes and the determination of Medicaid eligibility must be made by State or local governmental merit personnel authorized by the State to perform these functions and the cost must be paid by title XIX.

In addition, there are requirements under other laws that may apply to the administration of eligibility under separate child health programs. For example, there are requirements in the Personal Responsibility and Work Opportunity Act of 1996, as amended, that apply to separate CHIP programs which call for verification of citizenship or national status, and of immigration status. Therefore, subject to the provisions noted above, States may use State employees or non-public employees to administer part or all of the eligibility determination process, may take and process applications at locations they determine, and establish application and enrollment procedures.

6. Eligibility Screening (§ 457.350)

Among our highest priorities is to ensure that CHIP actually provides health assistance to the individuals for whom Congress designed the program. That is, we want the State plan to ensure that individuals applying for CHIP, but who are eligible for Medicaid or any other form of health care assistance programs, are enrolled in those other programs and not inappropriately enrolled in CHIP. Section 2102(b)(3) (A) and (B) of the Act require that a State plan include a description of screening procedures used, at intake and any follow up including any periodic redetermination, to ensure that only children who meet the definition of a targeted low-income child receive child health assistance under the plan, and that all children who are eligible for Medicaid are enrolled in that program. In accordance with the statutory provisions, we propose at § 457.350(a) that a State plan must include a description of these screening procedures.

We believe that in establishing CHIP, Congress intended to make health insurance available to uninsured children at higher income levels than the income levels of children eligible for Medicaid and to identify the estimated 4 million children who are eligible for Medicaid but are not enrolled in that program. We believe that section 2110(b)(1)(C) clearly provides that children who would be eligible for Medicaid if they applied are not eligible for coverage under CHIP. The statute at 2110(b)(3)(B) also clearly provides that States have a responsibility to actually enroll children in Medicaid if they are ineligible for the separate child health program because they are Medicaid eligible. A simple referral to the Medicaid agency is not enough to meet this requirement.

We considered a number of options in interpreting these ''screen and enroll'' requirements. First we considered whether ''Medicaid eligible'' meant that the child had actually applied for Medicaid and been determined eligible. We decided that the intent of the provision was to identify children who would be eligible for Medicaid if they applied. We considered permitting any screening process that represented a

reasonable attempt to identify Medicaid eligible children. We, however, do not believe that this option meets the statutory requirement that children who are eligible for Medicaid be identified and enrolled in Medicaid. Nonetheless, while a ''reasonable attempt'' to identify all Medicaid eligible children may not be enough, we are aware of the complexity of Medicaid eligibility and the burden that would be placed on both States and families if we required that children be screened for Medicaid eligibility under every possible Medicaid eligibility group.

We therefore propose only to require States to use screening procedures that identify any child who is potentially eligible for Medicaid under one of the poverty-level-related groups described in section 1902(l) of the Act. However, States are not mandated to cover children below the age of 19 who were born before October 1, 1983 under the poverty-level-related Medicaid groups. Therefore, we also propose to require, at a minimum, that a State use screening procedures that identify any child who is ineligible for Medicaid under the poverty level related groups solely because of age but is potentially eligible under the highest categorical income standard used under the State's title XIX State plan for children under age 19 born before October 1, 1983. In almost all circumstances, we expect the highest categorical income standard used for such older children to be the standard used for the optional categorically needy group of children eligible under section 1902(a)(10)(A)(ii)(I). These children are sometimes referred to as ''Ribicoff children''. Mandatory coverage of the older children in poverty-level related groups are being phased in and by October 1, 2002, all children under age 19 will be included in the poverty-level-related groups in all States.

During the screening process, we encourage States to identify any pregnant child who is eligible for Medicaid as a poverty-level pregnant woman described in section 1902(l)(1)(A) of the Act even though she is not eligible for Medicaid as a child. As discussed above, Medicaid eligibility standards may be more advantageous to a pregnant teen than coverage under a separate child health program.

We have not proposed to require that a State screen for Medicaid eligibility under all possible groups because we believe that this would place an unreasonable administrative burden on States due to the complexity of the eligibility requirements under some Medicaid groups, particularly the group of low-income families with children described in section 1931 of the Act and the medically needy groups described in 1902(a)(10)(C) of the Act. We believe that screening for eligibility under these other Medicaid groups might deter families from applying for the title XXI State program because they would have to provide all the information necessary for these complicated Medicaid eligibility determinations. We believe that simplification of the eligibility process is essential to encouraging families to enroll their children. The poverty-level-related Medicaid eligibility groups usually have the highest standard under which a child is eligible for Medicaid, have no resource requirements, and no requirements pertaining to the child's living arrangement, so we believe that almost all children who are Medicaid eligible will be identified through the proposed policy.

However, as noted above, the proposed policy will not identify every Medicaid eligible child. Therefore, we also propose to require that States choosing not to screen for Medicaid eligibility under all possible groups provide certain written information to all families of children who, through the screening process, appear unlikely to be found eligible for Medicaid if a full Medicaid eligibility determination were done. The following information must be provided to the person applying for the child: (1) A statement that, on initial review, the child does not appear to be eligible for Medicaid but that a final full determination of Medicaid eligibility can only be made based on a review of a full Medicaid application; (2) information about Medicaid benefits (if such information has not already been provided); and (3) information about how and where to apply for Medicaid.

As indicated in section 2102(b)(3)(B), Congress intended that children eligible for Medicaid be enrolled in the Medicaid program. We propose that if a child is found through a State screening process to be potentially eligible for Medicaid but fails to complete the Medicaid application process for any reason, the child cannot be enrolled in CHIP. Enrollment in CHIP can occur only after an appropriate screen shows that the child is ineligible for Medicaid.

States should make every effort to ensure that a decision by a family not to apply for Medicaid or not to complete the application process is an informed one. The screen and enroll procedures must provide the family with full and complete information about Medicaid, including the early preventive, screening, diagnostic and treatment services, the prohibition against cost sharing and the difference between Medicaid and CHIP. States should inform families that they do not have a choice of programs because children may not be enrolled in CHIP if they are Medicaid eligible. The process should ensure that the family understands the consequences of not applying for Medicaid or failing to complete the application process. We believe that these policies are consistent with the Congressional intent to provide coverage to children who are not and cannot be covered under Medicaid.

However, we are aware that there is great concern among a number of States and others that children will go without health care because of these screen and enroll policies. The concern centers around the perceived stigma of Medicaid. Some States allege that families refuse to apply for Medicaid, which is free, because they associate it with ''welfare''. It is noted that some families will not complete the Medicaid application process because it may be more complicated than the application process for CHIP, require more documentation, and may be seen as more invasive into personal lives. We particularly solicit comments on the extent of these problems and possible solutions. In the meantime we encourage States to employ outreach efforts that work to change the perception that Medicaid is ''welfare'' and to simplify the Medicaid eligibility process.

7. Facilitating Medicaid Enrollment (§ 457.360)

Under section 2102(b)(3)(B) of the Act, States are required to ensure that children found through the screening process described above to be eligible for Medicaid apply for and are actually enrolled in Medicaid. We would require that the State take reasonable action to facilitate the Medicaid application process and to promote enrollment of eligible children into Medicaid. Under 457.360(b), States must establish a process whereby the State initiates the action to begin the Medicaid enrollment process and several options for States are provided. For example, States can forward the information received from the Medicaid screen onto the Medicaid eligibility unit and then this information could automatically trigger the beginning of the Medicaid application process. We do not believe that a simple referral to the Medicaid office meets this requirement. We also do not believe that it is reasonable to make the application for and enrollment in Medicaid dependent solely on actions by the applicant or the individual applying on the applicant's behalf. We encourage States to develop procedures which will

reduce or eliminate the need for applicants to provide information more than once. We also encourage the use of outstationed Medicaid eligibility workers who can take Medicaid applications at the same site as the one used to apply for CHIP. At a minimum, we urge that Medicaid and CHIP intake workers be well informed about the other program and its application procedures.

We have also proposed to require that a State ensure that families have an opportunity to make an informed decision of whether or not to complete the Medicaid application process by providing full and complete information, in writing, about: (1) The State's Medicaid program, including the benefits covered, restrictions on cost-sharing; and (2) the effect on eligibility for CHIP of neither applying for Medicaid nor completing the Medicaid application process.

8. Application for and Enrollment in CHIP (§ 457.361)

We propose to require that States afford individuals a reasonable opportunity to complete the application process and offer assistance in understanding and completing applications and in obtaining any required documentation. Furthermore, we have proposed to require that States inform applicants, in writing and orally if appropriate, about the eligibility requirements and their rights and responsibilities under the program.

Although not specifically addressed in statute, a State may choose to provide a period of presumptive eligibility during which services are provided, although actual eligibility has not been established. Unlike presumptive eligibility under Medicaid, which has rules prescribed by statute, a State has the flexibility to establish the rules for a program of presumptive eligibility under a separate child health program. (See section 435.1101 for the proposed rules pertaining to presumptive eligibility under Medicaid.) If a presumptively eligible child is subsequently determined to have been eligible during a period of presumptive eligibility, FFP will be provided at the enhanced FMAP rate for services provided during the presumptive period. However, if a child is not subsequently determined to have been eligible during the period of presumptive eligibility because either the State determined the child to be ineligible or the child's family did not complete the application process, the costs of services provided during the presumptive period will be considered administrative expenses. (For the rules pertaining to payments to States see 457.600 of the March 4, 1999 proposed rule on allotment and payment issues.)

The State agency must establish time standards for determining eligibility and inform the applicant of those standards. These standards may not exceed forty-five calendar days. In applying the time standards, the State must count each calendar day from the day of application to the day the agency mails written notice of its decision to the applicant.

The State agency must also determine eligibility within the State-established standards except in unusual circumstances, for example, when the agency cannot reach a decision because the applicant delays or fails to take a required action, or when there is an administrative or other emergency beyond the agency's control. The agency must not use the time standards as a waiting period before determining eligibility; or as a reason for denying eligibility (because it has not determined eligibility within the time standards). The State must also make eligibility effective as of the date specified in the State plan on which eligibility becomes effective.

9. Grievances and Appeals (§ 457.365)

Finally, we propose to require that States send each applicant a written notice of the decision on his application, and if eligibility is terminated or denied, the specific reason for the action and an explanation of his right to file a grievance or appeal within a reasonable time. (See § 457.985 in subpart I of these proposed regulations for rules on appeals and grievances.)

D. Subpart D—Coverage and Benefits: General Provisions

1. Basis, Scope, and Applicability (§ 457.401)

At proposed § 457.401 we would provide that this subpart interprets and implements section 2102(a)(7) of the Act, which requires that States make assurances relating to certain types of care; section 2103 of the Act, which outlines coverage requirements for children's health insurance; section 2109 of the Act, which describes the relation of the CHIP program to other laws; section 2110(a), which describes child health assistance; and section 2110(c) of the Act, which contains definitions applicable to this subpart. The requirements of this subpart apply to child health assistance provided under a separate child health program and do not apply to Medicaid expansion programs even when funding is based on the enhanced Federal medical assistance percentage.

2. Child Health Assistance and Other Definitions (§ 457.402)

Proposed § 457.402 sets forth the definition of child health assistance as specified in section 2110(a) of the Act. We considered whether we should further define the services listed in this section or add to the list. For example, we considered defining transportation as including coverage for urgent care and not just primary and preventive health care as included in the statute at section 2110(a)(27). We also considered whether traditional healers or alternative therapies should be specifically mentioned as providers and coverage options. However, we have not included any additional services in the definition or attempted to further define these services in order to give States the flexibility to provide these services as intended under the statute. Accordingly, we propose that the term ''child health assistance'' means payment for part or all of the cost of health benefits coverage, provided to targeted low-income children through any method described in § 457.410 for any of the following services as specified in the statute:

- Inpatient hospital services.
- Outpatient hospital services.
- Physician services and surgical services.
- Clinic services (including health center services) and other ambulatory health care services.
- Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such 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.
- Over-the-counter medications.
- Laboratory and radiological services.
- Prenatal care and prepregnancy family planning services and supplies.
- Inpatient mental health services, other than inpatient substance abuse treatment services and residential substance abuse treatment services, but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
- Outpatient mental health services, other than outpatient substance abuse treatment services, but including services furnished in a State-operated mental hospital and including community-based services.
- Durable medical equipment and other medically related or remedial

devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices and adaptive devices).

- Disposable medical supplies.
- 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).
- 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.
- Abortion only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Case management services.
- Care coordination services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. '' Hospice care.
- 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 prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law; performed under the general supervision or at the direction of a physician; or 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.
- Premiums for private health care insurance coverage.
- Medical transportation.
- 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.
- Any other health care services or items specified by the Secretary and not excluded under this subchapter.

We propose to define the terms ''emergency medical condition,'' ''emergency services,'' and ''post-stabilization services'' to give full meaning to the statutory requirement that States assure access to emergency services, at section 2102(a)(7)(B), and consistent with the President's directive to Federal agencies to address the *Consumer Bill of Rights and Responsibilities,* which includes the right to access to emergency services. For purposes of consistency, we used the definitions found in the proposed regulations for Medicaid managed care, published in the **Federal Register** on September 29, 1998 (63 FR 52022). Because access to emergency services may not be possible if a delay is involved, we propose to require States to guarantee access to emergency services without any requirement for prior authorization for those services. In addition, we would expect that States and their contractors would treat post-stabilization services in the same manner as required for the Medicare and Medicaid programs, while recognizing that not all such services would necessarily be covered by the State for purposes of CHIP.

Specifically, we propose to define the term ''emergency medical condition'' as 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 —

- 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;
- Serious impairment of bodily function; or
- Serious dysfunction of any bodily organ or part. We would define the term ''emergency services'' as covered inpatient or outpatient services that are furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition.

We would define ''post-stabilization services'' to mean medically necessary non-emergency services furnished to an enrollee after he or she is stabilized following an emergency medical condition.

We would define ''health benefits coverage'' as an arrangement under which enrolled individuals are protected from some or all liability for the cost of specified health care services. We note that this term is included in the definitions at proposed § 457.10.

3. Health Benefits Coverage Options (§ 457.410)

At proposed § 457.410, we list the four options a State has in obtaining health benefits coverage for eligible children. Specifically, we propose that States may choose to provide benchmark coverage, benchmark-equivalent coverage, existing comprehensive State-based coverage, or Secretary approved coverage. These four options, specified in section 2103(a) of the Act, are described in full at §§ 457.420 through 457.450.

Based on the authority of section 2102(a)(7) of the Act, we also propose at § 457.410(b), to require that any health benefits coverage obtained in accordance with proposed § 457.410 must include coverage for well-baby and well-child care, immunizations and emergency services. We note that these services must be covered even if coverage for these services is not generally included in the health benefits coverage option selected by the State.

The statute does not define well-baby or well-child care. We have defined well-baby and well-child care for purposes of cost sharing at proposed § 457.520(b), but we propose to allow States to define well-baby and well-child care for coverage purposes. We encourage States, however, to adopt the benefits and periodicity schedules recommended by a medical or professional organization involved in child health care when defining well-baby and well-child care coverage. Well child care includes health care for adolescents and includes the cost sharing prohibitions mentioned at proposed § 457.520(b). We recommend the schedules from the American Academy of Pediatrics, the American Academy of Pediatric Dentistry, and *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.*

We propose to require all separate child health programs to follow the recommendations of the Advisory Committee on Immunization Practices (ACIP). The proposed requirements for immunizations under separate child health programs are identical to those under the Medicaid program. The Vaccines for Children (VFC) program, established under section 1928 of the Act also requires providers to immunize eligible children according to the recommendations of ACIP. We note that children enrolled in separate child health programs will not meet the VFC definition of Federally-vaccine eligible because they are not ''uninsured'' and therefore will not be eligible to receive free vaccines as part of the VFC program. State Medicaid programs are required to implement new recommendations of the ACIP within 90 days of their publication. Separate child health programs must also cover newly recommended vaccines within this timeframe. State contracts for CHIP

coverage should provide for coverage of newly recommended vaccines within 90 days of publication of the ACIP recommendations.

We have only recommended that States use the periodicity schedules recommended by certain medical or professional organizations while we propose to require the use of the ACIP schedule for the provision of immunizations. Under the Medicaid program, we do not require a specific periodicity schedule for well-baby and well-child visits except that we do require the ACIP schedule for immunizations. This is because the Medicaid program has no Federal requirements for using a certain periodicity schedule. We do not believe we can hold a State CHIP program to a higher standard than a Medicaid program.

We also propose at § 457.410(b) to require that any health benefits coverage obtained in accordance with this section include emergency services as defined in proposed § 457.402(c). We note that a State may offer different health benefit coverage to children with special needs consistent with the eligibility standards set forth at § 457.320 as long as each benefit package meets the basic coverage requirement. The State can define the health benefit coverage to include supplemental services for children with special needs or physical disabilities. Alternatively, a State may have more than one benefit package that meets all the requirements of this subpart including one designed for children with special needs or physical disabilities, as long as the State complies with the Americans with Disabilities Act in establishing eligibility standards. We also note that if no different benefit packages are offered for children with special needs, they are eligible for whatever child health assistance is available in the State if they meet all other eligibility criteria.

If a State offers a limited package of services to address special needs that is not part of the comprehensive coverage required under this subpart, State expenditures for the limited package would be subject to the 10 percent limitation on Federally-matchable expenditures for items other than the comprehensive coverage package, under section 2105(a)(2) of the Act.

4. Benchmark Health Benefits Coverage (§ 457.420)

Section 2103(b) of the Act sets forth the benchmark benefit packages from which a State may choose. We propose to implement these provisions at § 457.420. We considered the possibility that the health benefits coverage package available under a benchmark plan may change from year to year and the possible need to require an annual review to ensure that the plan continues to meet the requirements of this subpart. However, we do not propose to require an annual review in part because of the requirements of section 2106 of the Act, implemented at § 457.65 of these proposed regulations, which provides that an approved CHIP plan shall continue in effect unless and until the State amends the plan or the Secretary finds substantial noncompliance of the plan. For example, we believe it would be unduly burdensome to require States to review and alter their benchmark benefit package on an annual basis. Therefore, if a State has elected the State employee's health benefit package as its benchmark plan, and the benefit package changes from one year to another, the State is not required to submit a State plan amendment as long as it continues to offer the benefits described in its approved State plan. However, when a State chooses to increase, decrease, or substitute benefits available under its State plan, an amendment must be submitted for approval. The State would then decide whether to continue to use the benchmark plan (including any benefit changes to the original package), provide a benchmark-equivalent using an actuarial analysis, or use one of the other health benefits package options. We will monitor compliance with benchmark requirements as we will with all other requirements of the program as discussed in proposed § 457.150(e).

The statute provides that benchmark coverage must be ''equivalent'' to the benefits coverage in a reference benchmark benefit package. We are proposing to interpret this term to mean ''substantially equal,'' differing only from the reference package as necessary to meet other requirements of Title XXI. Clearly, the word ''equivalent'' cannot reasonably be read to mean ''actuarially equivalent,'' since the statute separately requires actuarial equivalence for benchmark-equivalent coverage. Therefore, we are proposing to require that a benchmark package offered under a separate child health plan can differ from what is otherwise available in the State under the benchmark package only to the extent that the CHIP package must differ to meet the requirements of title XXI. For example, benchmark coverage offered by a State under a separate child health program must include coverage for immunizations even if the benchmark coverage after which the State models the CHIP coverage does not include coverage for immunizations. If the benchmark package chosen by the State does not meet the requirements of title XXI, then the State must enlarge the benchmark benefit package so that it meets the title XXI requirements. The additional benefits should be coordinated to the greatest extent possible with the other benchmark package providers and benefits.

According to the statute, we propose to define benchmark coverage as health benefits coverage that is substantially equal to the health benefits coverage in one of the following benefit packages:

- The Federal Employee Health Benefits Program (FEHBP) Blue Cross/Blue Shield Standard Option Service Benefit Plan with Preferred Provider arrangements;
- A health benefits plan that the State offers and makes generally available to its own employees; or
- A plan offered by a Health Maintenance Organization (HMO) that has the largest insured commercial, non-Medicaid enrollment and is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act) in the State.

Each benchmark benefits package is discussed in detail below.

Federal Employee Health Benefits Plan Blue Cross/Blue Shield Standard Option Service Benefit Plan with Preferred Provider arrangements (FEHBP). The FEHBP is available to Federal employees in all parts of the United States, under 5 U.S.C. 8903(1). Contract No. CS 1039 between the Blue Cross and Blue Shield Association and the U.S. Office of Personnel Management contains a description of the benefits offered under the plan. In addition, the Federal Employees Health Benefits Plan publication RI–71–5 and the plan's home page on the Internet (http://www.fepblue.org) include descriptions of the benefits.

State Employee Plan. We propose to allow a State to design a separate child health program under which it offers coverage modeled after the coverage by a health benefits plan that is offered and generally available to its own employees.

Plan of a health maintenance organization with the largest enrollment in the State. We propose to allow a State to choose as a model for the coverage offered under its separate child health plan the coverage offered by an HMO that has the largest insured commercial non-Medicaid enrollment in the State. As defined in section 2791(b)(3) of the Public Health Service Act, the term ''health maintenance organization'' means—

- A Federally qualified health maintenance organization as defined in section 1301 of the Public Health Service Act and further described in regulations at 42 CFR part 417, subparts A, B, and C;
- An organization recognized under State law as a health maintenance organization; or
- A similar organization regulated under State law for solvency in the same manner and to same extent as a health maintenance organization as defined in State law.

If the health maintenance organization offers more than one coverage plan, the benchmark plan under the separate child health program must mirror the specific plan offered by the HMO that has the largest commercial enrollment. For example, if an HMO offers different benefit packages to Federal employees, postal employees and private industry employees, respectively, the CHIP benchmark plan must mirror the HMO plan with the largest enrollment. In calculating commercial enrollment, neither Medicaid nor public agency enrollees will be counted. However, Federal employees are considered to be commercial enrollees.

5. Benchmark-Equivalent Health Benefits Coverage (§ 457.430)

Section 2103(a)(2) of the Act provides that a State may opt to design a program under which it offers coverage with an aggregate actuarial value that is at least equal to the value of one of the benchmark benefit packages. In accordance with the statute, we propose at § 457.430 that the benchmark-equivalent coverage must have an aggregate actuarial value, determined in accordance with proposed § 457.431, that is at least actuarially equivalent to coverage under one of the benchmark packages outlined in § 457.420.

In § 457.430 we would set forth the coverage requirements for States selecting the benchmark-equivalent coverage option. Under the authority of section 2103(c)(1), we would specify that a benchmark equivalent plan must include coverage for inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, immunizations, and well-baby and well-child care, including age-appropriate immunizations provided in accordance with the recommendations of ACIP. We considered proposing minimum standards for basic sets of required services (for example, a minimum of 14 inpatient hospital days). We concluded that it would be unlikely that a State could provide greatly reduced benefits (such as only 2 inpatient hospital days) and still meet the actuarial value requirement. Therefore, we did not propose such minimum standards.

Under the authority of section 2110(a) of the Act (implemented at proposed § 457.402), a State may provide coverage for a wide range of services. If the State provides coverage for prescription drugs, mental health services, vision services, or hearing services the coverage for these services must have an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of service in the benchmark benefit package. In addition, we propose that if the benchmark plan does not cover one of the above additional categories of services, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service. A State may provide services listed in § 457.402 other than the services listed in § 457.430(b) without meeting the 75 percent actuarial value test.

6. Actuarial Report for Benchmark-Equivalent Coverage (§ 457.431)

In accordance with section 2103(c)(4) of the Act, at proposed § 457.431 we would require a State, as a condition of approval of benchmark-equivalent coverage, to provide an actuarial report, with an actuarial opinion that the benchmark-equivalent coverage meets the actuarial requirements of § 457.430.

States are free to pool their resources to obtain actuarial services. The actuarial value of the benchmark coverage and the State-designed benchmark-equivalent coverage, however, will vary from State to State so the determination of actuarial value must be made for each individual State.

We note that some States have suggested that to spare States some of the expense of hiring actuaries, we should determine the actuarial value for the FEHBP Blue Cross Blue Shield (BC/BS) preferred provider option (PPO) because it is a national health insurance plan. We have decided that it would not be feasible for HCFA to determine the actuarial value of the FEHBP plan because the value of the coverage under the plan will vary by State even though the benefit package remains the same. If a State offers benchmark-equivalent coverage, it must obtain an opinion from a member of the American Academy of Actuaries to determine the value of the FEHBP because the actuarial value of this plan will vary from State to State for several reasons, including regional cost variations and differences in the target population.

The actuarial opinion must meet all the provisions of the statute. We propose that the report must explicitly state the following information:

- The actuary issuing the opinion is a member of the American Academy of Actuaries (and meets Academy standards for issuing such an opinion).
- The actuary used generally accepted actuarial principles and methodologies of the American Academy of Actuaries, standard utilization and price factors, and a standardized population representative of privately insured children of the age of those expected to be covered under the State child health insurance plan.
- The same principles and factors were used in analyzing both the proposed benchmark-equivalent coverage and the benchmark coverage, without taking into account differences in coverage based on the method of delivery or means of cost control or utilization used. States must assure that the assumptions used to estimate the State-designed benchmark-equivalent package are the same as those used in the actuarial analysis of the benchmark package. These same assumptions must be used consistently throughout the actuarial analysis.
- The report should also state if the analysis took into account the State's ability to reduce benefits because of the increase in actuarial value due to limitations on cost sharing in the State child health insurance plan.

The report should specify which benchmark plan is being used for comparison. It should also specify the value of the benchmark plan, the value of the coverage under the plan being offered by the State and that the plan meets the overall requirement of actuarial equivalence. In addition, the value of coverage of the specific additional services listed in the statute (prescription drugs, mental heath services, vision services and hearing services) must also meet the 75 percent requirement of substantial actuarial value for each of the additional services included in the benchmark plan. The actuarial opinion should also outline the major differences, if any, in coverage.

The opinion should provide sufficient detail regarding the methodologies used to estimate the value so that HCFA's actuaries can review the States' calculations and assumptions for accuracy and completeness. Should discrepancies arise in the course of our review, the actuaries can request States to provide detail sufficient to allow the actuaries to replicate the results.

The opinion narrative should assure the reviewer that the actuary has taken

into account all factors that affect the relative value of the plans being compared. Adjustments made to data and the rationale for the adjustments should be included. In this way, even if the specifics and the derivation of the adjustments are not specified, we can feel confident that allowances were made for all relevant considerations.

Our review of State plans that elect to adopt an actuarially equivalent benchmark benefit plan may include review by our actuaries. States must submit to HCFA all information necessary for our actuaries to perform this review. We will review the actuarial report as part of the overall plan approval process as described in subpart A of these proposed regulations. When the actuarial report is not complete or raises questions, we will contact the State to request clarification and may request additional information from the State. If, even after the complete information is received, we determine that the benefits do not meet the requirements of title XXI, we may disapprove the State's child health plan.

Several issues and questions have been raised with respect to the actuarial determinations. While these issues have been addressed in the five sets of questions and answers released by HCFA, and available on the HCFA web site, www.hcfa.gov, we will address them here to ensure that States have full knowledge of the issues involved.

We were asked if a State must determine actuarial equivalence of coverage under a benchmark plan for an individual or for a family. The statute does not specify whether the States that decide to use a benchmark-equivalent plan must calculate actuarial equivalence to family coverage or to individual coverage. Therefore, a State may make either comparison. In addition, the coverage offered to families and individuals under a benchmark plan rarely differs. Employees usually have a choice of whether to cover themselves only or themselves and additional family members. Therefore, the actuarial value of family coverage and individual coverage should be essentially the same. We also want to clarify that States should not take premiums into account when determining the actuarial value of a health insurance plan. States should take into account only benefits and cost sharing (such as copayments, coinsurance and deductibles).

7. Existing Comprehensive State-Based Coverage (§ 457.440).

In accordance with section 2103(d) of the Act, at proposed § 457.440 we provide that existing comprehensive State-based health benefits coverage must include coverage of a range of benefits, be administered or overseen by the State and receive funds from the State, be offered in the State of New York, Florida, or Pennsylvania, and have been offered as of August 5, 1997. In essence, Congress deemed the existing State-based health benefit packages of three States as meeting the requirements of section 2103 of the Act. However, these States still need to meet other requirements of title XXI, including requirements relating to cost sharing such as copayments, deductibles and premiums as specified in subpart E of this proposed rule.

We would also specify that the State (Florida, New York, or Pennsylvania) may modify its existing, comprehensive, State-based program under certain conditions. First, the program must continue to offer a range of benefits. Second, the modification must not reduce the actuarial value of the coverage available under the program below either the actuarial value of the coverage as of August 5, 1997 or the actuarial value of a benchmark benefit package. A State must submit an actuarial report when it amends its existing State-based coverage.

Even though the benefits packages offered in Florida, New York, and Pennsylvania were deemed to have met title XXI benefits requirements, these States must still submit CHIP plans for approval by HCFA. Each State plan must demonstrate that the State meets all the title XXI requirements, including the cost sharing requirements specified in subpart E of this proposed rule.

8. Secretary-approved coverage (§ 457.450)

In proposed § 457.450 we discuss the option of providing health benefits coverage under the Secretary-approved health benefits coverage option. Section 2103(a)(4) of the Act defines Secretary-approved coverage as any other health benefits coverage that provides appropriate coverage for the population of targeted low-income children to be covered by the program. A State must select this health benefit coverage option when it submits its plan to HCFA for approval.

We propose that the following coverage be recognized as Secretary-approved coverage under a separate child health program:

- Coverage that is the same as the coverage provided under a State's Medicaid benefit package as described in the existing Medicaid State plan.
- Comprehensive coverage offered under a § 1115 waiver that either includes coverage for the full EPSDT benefit or that the State has extended to the entire Medicaid population in the State.
- Coverage that includes benchmark coverage, as specified in § 457.420, plus additional coverage. Under this option, the State must clearly demonstrate that it provides all the benchmark coverage.
- Coverage, including coverage under an employer-sponsored group health plan, purchased by the State that the State demonstrates to be substantially equal to benchmark coverage, as specified in § 457.420, through use of a benefit-by-benefit comparison of the coverage compared to a benchmark plan. Under this option, if there is just one benefit that does not meet or exceed the benchmark, the State must provide an actuarial analysis to determine actuarial equivalence. At this point, it would no longer be Secretarial approved coverage and would fall under benchmark equivalent health benefits coverage under § 457.430.

While these four options have been identified for permissible Secretarial-approved coverage, we solicit comments on other specific examples of coverage packages that States have developed that meet the title XXI requirements.

We also propose that no actuarial analysis is required for Secretary-approved coverage except for coverage that does not meet or exceed benchmark coverage. States should be cognizant, however, that to date we have not allowed a State to offer a health benefits package that does not provide all of the coverage provided under a benchmark plan without requiring the State to submit an actuarial analysis. We have approved some State plans under which the States offer health benefit packages that provide all the coverage of the benchmark package plus additional coverage. In approving State child health plans, we intend to ensure that children receive services that are cost effective, comprehensive, and high-quality. If a State wants to reduce any benchmark benefit, it must use the benchmark-equivalent coverage option.

9. Prohibited Coverage (§ 457.470)

In accordance with section 2103(c)(5) of the Act, we propose at § 457.470 that 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 package includes coverage for such item or service.

10. Limitations on Coverage: Abortions (§ 457.475)

This section would implement sections 2105(c)(1) and (c)(7) of the Act, which set limitations on payment for

abortion services under the CHIP program. At § 457.475, we propose that FFP 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 is necessary to save the life of the mother or the abortion is performed to terminate a pregnancy resulting from an act of rape or incest.

Additionally, we propose that FFP is not available to a State for any amount expended under its title XXI plan to assist in the purchase, in whole or in part, of health benefits coverage that includes coverage of abortions other than to save the life of the mother or resulting from an act of rape or incest.

We also would provide that, if a State wishes to have managed care entities provide abortions in addition to those specified above, those abortions must be provided pursuant to a separate contract using non-Federal funds. Under our proposal, a State may not set aside a portion of the capitated rate to be paid with State-only funds, or to append riders, attachments, or addenda to existing contracts to separate the additional abortion services from the other services covered by the contract. We believe that these requirements are necessary to enforce the statutory prohibition against the purchase of health benefits coverage that includes abortion services not explicitly permitted by the statute. However, the proposed regulation also specifies that this requirement should not be construed as restricting the ability of any managed care provider to offer abortion coverage or the ability of a State or locality to contract separately with a managed care provider for additional abortion coverage using State or local funds.

11. Preexisting Condition Exclusions and Relation to Other Laws (§ 457.480)

In proposed § 457.480 we discuss the provisions of sections 2103(f), 2109 and 2110(c) of the Act. We propose to adopt the definitions of ''creditable coverage,'' ''group health plan,'' ''group health insurance coverage,'' ''health insurance coverage,'' and ''preexisting condition exclusion'' set forth in the HIPAA regulations at 45 CFR 144.103 and 146.133. Definitions for these terms are set forth at proposed § 457.10.

In proposed § 457.480(a) we implement section 2103(f)(1) of the Act and provide that, subject to the exceptions in paragraph (b), a State child health plan may not permit the imposition of any preexisting condition exclusion for covered benefits under the plan. Further, in paragraph (b), we would specify that if the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may only permit the imposition of a preexisting condition exclusion insofar as it is permitted under HIPAA.

In paragraphs (c)(1) through (c)(4), we would set forth the requirement of sections 2109 and 2103(f)(2) of the Act, which provides that State plans must comply with the requirements of subpart 2 of part A of title XXVII of the PHS Act and certain other provisions of law. Specifically, we have included section 514 of ERISA, HIPAA, the Mental Health Parity Act of 1996 (MHPA), regarding parity in the application of annual and lifetime dollar limits to mental health benefits, and the Newborns and Mothers Health Protection Act of 1996 (NMHPA), regarding requirements for minimum hospital stays for mothers and newborns. See regulations at 45 CFR 146.136 for a discussion of the MHPA and 45 CFR 146.130 and 148.170 for a discussion of the NMHPA.

12. Delivery and Utilization Control Systems (§ 457.490)

In accordance with section 2102(a)(4) of the Act, proposed § 457.490 requires that State plans include a description of the type of child health assistance to be provided including the proposed methods of delivery and proposed utilization control systems. In describing the methods of delivery of the child health assistance using title XXI funds, the State should address its choice of financing the insurance products and the methods for assuring delivery of the insurance product to children. These methods may include, but are not necessarily limited to, contracts with managed health care plans (including fully and partially capitated plans), contracts with indemnity health insurance plans, and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the methods for establishing and defining the delivery systems.

Utilization control systems are administrative mechanisms designed to ensure that children use only health care that is appropriate, medically necessary and approved by the State or its subcontractor. Examples of utilization control systems include, but are not limited to, requirements for referrals to specialty care, requirements that clinicians use clinical practice guidelines, or demand management systems (such as, use of an 800 number for after-hours and urgent care). The State should describe its plan for review, coordination, and implementation of utilization controls, addressing other procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner.

13. Grievances and Appeals (§ 457.495)

At proposed § 457.495, we would require States to provide enrollees in a separate child health program the right to file grievances or appeals for reduction or denial of services in accordance with proposed § 457.985.

E. Subpart E—State Plan Requirements: Beneficiary Financial Responsibilities

1. Basis, Scope, and Applicability (§ 457.500)

States that implement a separate child health program may impose cost sharing charges on beneficiaries. A State that chooses to impose cost sharing charges on beneficiaries must meet the requirements described in section 2103(e) of the Act. These requirements apply to all separate child health programs regardless of the type of coverage (benchmark, benchmark equivalent, Secretary-approved or existing comprehensive State-based coverage) provided through the program. These requirements also apply when a State purchases family coverage for the targeted low-income child under the waiver authority of section 2105(c)(3) of the Act and proposed § 457.1010 and when a State provides premium assistance for employer-sponsored group health plan coverage under proposed § 457.810.

Under section 2103(e)(1) of the Act, when a State determines it will impose cost sharing, the State plan must include a description of the amount of premiums, deductibles, coinsurance and other cost sharing charges imposed. If the State chooses to vary cost sharing charges, the State plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income. Also, the State must make available a public schedule of any cost sharing charges imposed under the State plan.

Section 2103(e)(2) specifies that a State may not impose cost sharing charges on benefits for certain preventive services. Section 2103(e)(3) specifies the limitations on the amount of cost sharing charges that may be imposed on a beneficiary, including a cumulative cost sharing maximum on

cost sharing imposed on children in families with income above 150 percent of the FPL. Section 2103(e)(4) clarifies that CHIP cost sharing rules will not apply to beneficiaries who are provided child health assistance in the form of coverage under a Medicaid expansion program.

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. This subpart does not apply to States that provide child health assistance through a Medicaid expansion program.

2. General State Plan Requirements (§ 457.505)

Section 2103(e)(1)(A) of the Act specifies that a State plan must include a description of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Section 2103(e)(1)(A) also specifies that any such charges be imposed pursuant to a public schedule. In accordance with the statute, at § 457.505, we propose that the State plan must include a description of the amount of premiums, deductibles, coinsurance, copayments, and other cost sharing imposed. We further propose that the State plan include a description of the methods, including the public schedule, the State uses to inform beneficiaries, applicants, providers, and the general public of cost sharing charges, the cumulative cost sharing maximum, and any changes in these amounts. Under § 457.525, the State may choose to include the public schedule in pamphlets, separate mailings, or newspapers to inform the public of beneficiary financial responsibilities under the program.

We also propose that States that purchase family coverage under the authority provided in section 2105(c)(3) and proposed § 457.1010, or provide premium assistance for employer-sponsored group health insurance (as defined in proposed § 457.10) have a process in place to ensure that providers do not charge beneficiaries for copayments, coinsurance, deductibles, or similar fees for well-baby and well-child care services as defined in proposed § 457.520 and do not charge AI/AN children cost sharing as required in proposed § 457.535. We would also provide that a procedure that primarily relies on a refund given by the State for a beneficiary's cost sharing payment of well-baby/well child-care services is not an acceptable procedure. An acceptable alternative approach would be one where a State requires that providers bill the State directly for copayments that are not permissible, or provides beneficiaries with identification that providers can use to verify that these beneficiaries are not subject to cost sharing on these services and therefore not charge cost sharing to such beneficiaries. We also propose that in States that purchase family coverage or provide premium assistance for employer-sponsored health insurance that the State have a process to ensure that beneficiaries do not pay cost sharing over the cumulative cost sharing maximums proposed in § 457.555. We emphasize that this process must not rely on a refund for cost sharing in excess of the cumulative cost sharing maximum.

3. Premiums, Enrollment Fees, or Similar Fees: State Plan Requirements (§ 457.510)

Section 2103(e)(1)(A) of the Act requires that the State plan include a description of the amount of premiums, deductibles, coinsurance and other cost sharing imposed pursuant to a public schedule. Section 457.510 proposes that when a State imposes premiums, enrollment fees, or similar fees on CHIP beneficiaries, the State plan must describe the amount of the premium, enrollment fee, or similar fee, the period of liability for the charge, and the group or groups that will be subject to the cost sharing charge.

We also propose that the State plan include a description of the consequences for a beneficiary who does not pay required charges. For example, some States disenroll a beneficiary for non-payment of certain co-payment or premium charges. Under our proposed regulations, these States would discuss this disenrollment policy in full, including the State's policy on reenrollment of the child once payment of the charge is made, and any ''grace period'' allowed after non-payment such as, notification to beneficiary for failure to pay after one month or cancellation after two months of non-payment. We would also require the State to indicate any beneficiary groups that are exempt from the disenrollment policy.

In addition, proposed § 457.510 would require that the State plan include a description of the methodology used to ensure that total cost sharing liability for a beneficiary's families does not exceed the cumulative cost sharing maximums as required by section 2103(e)(3)(B) of the Act and specified in proposed § 457.555. This description must explain how the State calculates total income for each family, and how the State will prevent charges over the cumulative costs sharing maximums.

The State's methodology should include a refund for a beneficiary who accidentally pays over his or her cumulative cost sharing maximum. However, as stated earlier, we propose that a methodology that primarily relies on a refund to the beneficiary for cost sharing payments made over the cumulative cost sharing maximum will not be an acceptable methodology.

Many States that impose cost sharing have established a ''shoe-box'' policy. Under this policy, the beneficiary's family is responsible for demonstrating with receipts that he or she has paid cost sharing charges up to the cumulative maximum cost sharing charges (5 percent of the family's total income). Concern has been raised that the beneficiary's family should not have the primary responsibility for ensuring that it does not make payments that exceed the cumulative cost sharing maximum.

We asked George Washington University's Center for Health Policy Research to conduct a study on the types of methods States and private insurance companies use to track cost sharing amounts against a beneficiary's out-of-pocket expenditure cap. The George Washington study concluded that the risk that a beneficiary in a family with income above 150 percent of the FPL will reach the cumulative cost sharing maximum (5 percent of family income cap) is minimal since the amounts of cost sharing States are currently imposing are relatively low. The study also found that most of the States hold the beneficiary responsible for demonstrating with receipts that he or she has paid cost sharing charges up to the cumulative cost sharing maximum. George Washington also noted that the private insurers typically rely on the beneficiary when tracking out-of-pocket expenses.

The George Washington study also found that while the risk of reaching the cumulative cost sharing maximum was relatively low for children in families above 150 percent of the FPL, this risk increases for a family that has a child with a chronic condition. The statute does not require States to count the beneficiary's costs of paying for services not covered under the plan towards the cumulative cost sharing cap. The George Washington study found that since States are not required to count non-covered services toward the cumulative cost sharing maximum, a chronically ill child could be subject to the financial burdens of cost sharing charges for services not covered under the State plan, in addition to the payments for

services that are covered under the State plan. This policy could be especially burdensome on children in States with benefit packages under a separate child health program that do not cover a wide range of services. Therefore, a family with a chronically ill child may be faced with extraordinary expenses. Based on these findings, we believe a statutory change will be needed to prevent the additional burden of cost sharing on children with chronic conditions.

Until any such statutory change is enacted, we recommend that States, when possible, develop a more formal tracking mechanism when imposing cost sharing charges, especially when States impose cost sharing charges on children with chronic conditions. We believe that a tracking mechanism that does not rely on the beneficiary demonstrating to the State that he or she has met the cumulative cost sharing maximum would be preferable. An example of a formal tracking mechanism is when a State issues a swipe card to a beneficiary at the time of enrollment which is used to record the cost sharing amounts a provider collects. Once the beneficiary reaches his or her cumulative cost sharing maximum as indicated by the swipe card, the provider cannot collect additional cost sharing amounts from the beneficiary. Another example of a formal tracking mechanism is to issue a credit card to the beneficiary. The beneficiary can use this card to pay his or her copayments to the provider. The State will bill the beneficiary for the copayments and reimburse the provider. A provider would be able to determine if the beneficiary has reached his or her credit card maximum by calling the State agency to obtain the credit limit available.

To address the needs of the chronically ill child, the George Washington University study also suggests that States assign chronically ill children to a case manager who will be responsible for assuring that the beneficiary's cost sharing does not exceed the cumulative cost sharing maximum. Also, while a State is not required to count non-covered services costs towards the cumulative maximum, we recommend that a State count these costs towards the cumulative cost sharing maximum, when possible.

While we require that the State plan describe a method of ensuring that beneficiaries do not exceed the cumulative cost sharing maximum, the previous examples are only recommendations. We solicit comments on tracking mechanisms States can use that do not place the burden of tracking cost sharing charges on the beneficiary.

4. Copayments, Coinsurance, Deductibles, or Similar Cost Sharing Charges: State Plan Requirements (§ 457.515)

In addition to proposed § 457.510, proposed § 457.515 is also based on section 2103(e)(1)(A) of the Act, which requires that the State child health plan include a description of the amount of premiums, deductibles, coinsurance and other cost sharing imposed. We propose that the State plan describe the following elements regarding copayments, coinsurance, deductibles or similar fees: the amount of the copayments, coinsurance, deductibles, or similar fees; the time period for which the charge is imposed; the group of beneficiaries to whom the charge applies; the consequences for a beneficiary who does not pay a charge; and the service on which the charge is made. Also, as stated in the discussion of § 457.510, for State plan requirements for imposing premiums, we propose that the State plan describe the methodology used to ensure that total cost sharing liability for a beneficiary's family does not exceed the cumulative cost sharing maximums. This description must explain how the State calculates total income for each family, and how the State will prevent charges over the cumulative cost sharing maximums.

Finally, we propose that, in accordance with the prudent layperson standard in the *Consumer Bill of Rights and Responsibilities*, States must provide assurances that enrollees will not be held liable for costs for emergency services above and beyond the copayment amount that is specified in the State plan. We propose that States must work with their managed care contractors to absorb any additional costs associated with providing emergency room services at a facility that is not a participating provider in the enrollee's managed care plan or network. In addition, although no State has proposed to include such a provision in a State child health plan, we considered options for requiring States to assure that copayment amounts for emergency services do not vary depending on the location (in or out of the managed care network) at which those services were provided. In keeping with the prudent layperson standard of assuring immediate access to emergency care, we have elected to propose this prohibition on differential copayments. However, we have also taken into consideration the importance of consistency between HCFA's programs (Medicare, Medicaid and CHIP) in this area. For example, we considered adopting the policy outlined in the proposed Medicare+Choice regulation, which limits cost sharing for emergency services obtained outside of the M+C plan's provider network equal to the lesser of $50 or what the organization may charge within the managed care network. We also considered that it would be appropriate to lower this dollar limit to accommodate the lower income population being served in this program. We welcome comments on these issues.

5. Cost Sharing for Well-Baby and Well-Child Care (§ 457.520)

Under section 2103(e)(2) of the Act, the State plan may not impose copayments, deductibles, coinsurance or other cost sharing with respect to well-baby and well-child care services in either the managed care or the fee-for-service delivery setting. We have set forth in the proposed regulation services that constitute well-baby and well-child care for purposes of cost sharing. We propose to define these well-baby and well-child services to include the definition of well-baby and well-child care used by the *American Academy of Pediatrics* (AAP) and incorporated in the Federal Employees Health Benefits Program (FEHBP) Blue Cross and Blue Shield benchmark plan.

We also propose to apply the prohibition on cost sharing to services that fit the definition of routine preventive dental services used by the *American Academy of Pediatric Dentistry* (AAPD) when a State opts to cover these services under its program. We propose to prohibit cost sharing for these services for two reasons. First, preventive dental care can be viewed as the oral health equivalent of immunizations in that it can prevent most cavities and subsequent tooth loss, both of which are highly correlated to poverty and lack of access to dental care. Second, we found that the prevailing practice among State employee plans and large health maintenance organizations (HMOs) is to pay 100 percent for any routine preventive and diagnostic dental benefits offered.

Accordingly, we propose at § 457.520 that when the State opts to cover the following services, they must be considered well baby and well child care services for the purposes of the prohibition of cost sharing under section 2103(e)(2):

- All healthy new born inpatient physician visits, including routine screening (inpatient and outpatient).
- Routine physical examinations.
- Laboratory tests.

• Immunizations, and related office visits as recommended in the AAP's ''Guidelines for Health Supervision III'' (June 1997), and described in ''*Bright Futures:* Guidelines for Health Supervision of Infants, Children, and Adolescents'' (Green M., (ed.). 1994).

• When covered under the State plan, at the State's option, routine preventive and diagnostic dental services (for example, oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described by the AAPD's current Reference Manual (Pediatric Dentistry, Special Issue, 1997–1998, vol 19:7, page 71–2).

6. Public Schedule (§ 457.525)

Section 2103(e)(1)(A) of the Act requires that the State provide a public schedule of all cost sharing charges. The statute does not specify the standards a State must meet when making the cost sharing schedule available to the public, and allows States a great amount of flexibility in developing cost sharing policies. Therefore, we believe that the more information the State includes in the public schedule regarding its cost sharing policy, the more informed beneficiaries will be about their financial responsibilities under their State's separate child health program. We propose that the public schedule contain at least the current CHIP cost sharing charges, the beneficiary groups on which cost sharing will be imposed (for example, cost sharing imposed only on children in families with income above 150 percent of the FPL), the cumulative cost sharing maximum allowed under § 457.555, and the consequences for a beneficiary who fails to pay a cost sharing charge. We also propose that the State must make the public schedule available to beneficiaries at the time of enrollment and when the State revises the cost sharing charges and/or cumulative cost sharing maximum, applicants at the time of application, and the general public. To ensure that providers impose appropriate cost sharing charges at the time services are rendered, we also propose that the public schedule must be made available to all CHIP participating providers.

7. General Cost Sharing Protection for Lower Income Children (§ 457.530).

At proposed § 457.530, we would implement section 2103(e)(1)(B) of the Act, which specifies that the State plan may only vary premiums, deductibles, coinsurance, and other cost sharing charges based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income. This statutory provision and the implementing regulations apply to all cost sharing imposed on children regardless of family income level. A State would not be in compliance with this provision if, for example, it imposed cost sharing charges on families at 150 percent of the FPL that were more than the cost sharing amounts imposed on children in families at 200 percent of the FPL.

8. Cost Sharing Protection To Ensure Enrollment of American Indians/Alaska Natives (§ 457.535)

Section 2102(b)(3)(D) of the Act requires the State plan to include a description of the procedures used to ensure the provision of child health assistance to targeted low-income children in the State who are American Indians. We are concerned that States that impose cost sharing on children in American Indian/Alaska Native (AI/AN) families will restrict access to essential CHIP services for this vulnerable beneficiary group, and may impact the State's ability to ensure coverage for this group as required under section 2102(b)(3)(D) of the Act.

Title VI of the Civil Rights Act of 1964 prohibits programs receiving Federal financial assistance from discriminating on the basis of race, color or national origin. But title VI does not preclude the Federal government from requiring States to recognize unique obligations to AI/ANs under Federal law. Based upon the unique legal status of Tribes under Federal law, the Federal government's trust and responsibility toward AI/ANs as authorized by Congress, and the requirements under section 2102(b)(3)(D) of the Act, HCFA must affirmatively address barriers to AI/AN enrollment. Moreover, access to health care funded by the Indian Health Service (IHS), which is available without charge, creates a unique disincentive to AI/AN enrollment in a CHIP program that imposes cost sharing. Thus, we believe that in some States, targeted incentives for AI/AN enrollment, including waiver of cost sharing, is consistent with title VI of the Civil Rights Act of 1964 and warranted by the CHIP statute.

Therefore, we propose that States must exclude children from AI/AN families from the imposition of premiums, deductibles, coinsurance, copayments or any other cost sharing charges. For the purposes of this section, we propose to use the definition of Indians referred to in section 2102(b)(3)(D) of the Act, which defines Alaska Natives and American Indians as Indians defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). We would also specify in the regulation that the State only grant this exception to AI/AN members of a Federally recognized tribe (as determined by the Bureau of Indian Affairs).

We realize that when States impose cost sharing on their CHIP beneficiaries States will need to identify AI/AN children of Federally recognized tribes for the purpose of waiving this group from premiums and other cost sharing. States will need to request from applicants identification that verifies the AI/AN status of the child. For example, the State may ask for Tribal membership identification or a Certificate of Indian Blood (CIB) to verify the applicant's AI/AN status. Eligibility enrollment staff should be trained to present, in a culturally sensitive manner, the option to AI/AN beneficiaries of either presenting their identification to the State or foregoing their option to be exempt from cost sharing.

States should strive to inconspicuously identify AI/AN children when waiving cost sharing that is typically collected by providers (for example—deductibles, copayments, and coinsurance). For example, a State that waives lower-income CHIP children from copayments in addition to AI/AN children should provide both waived groups with similar identification. The AI/AN child should not be separately identified from other beneficiary groups whose copayments have been waived. Another example of inconspicuously identifying AI/AN children is by providing identification (via a special code or color on the CHIP insurance card, or providing cost sharing amounts on the card) to those who are subject to cost sharing.

We believe that most States and their providers will not realize a negative financial impact by the mandatory waiver on AI/AN cost sharing. However, we understand that those States with a significant AI/AN population enrolled in their CHIP program may have to adjust payment rates to providers or capitation payments to MCOs since these entities can no longer collect cost sharing from AI/AN children. State eligibility systems and billing systems will also need to be adjusted to account for the mandatory waiver of cost sharing for the AI/AN children.

9. Cost Sharing Charges for Children in Families at or Below 150 Percent of the Federal Poverty Line (FPL) (§ 457.540)

Section 2103(e)(3) of the Act sets forth the limitations on premiums and other

cost sharing charges for children in families at or below 150 percent of the FPL. In accordance with section 2103(e)(3)(A)(i) of the Act, we propose that in the case of a targeted low-income child whose family income is at or below 150 percent of the FPL, the State plan may not impose any enrollment fee, premium, or similar charge that exceeds the charges permitted under the Medicaid regulations at § 447.52, which implement section 1916(b)(1) of the Act. Section 447.52 specifies the maximum monthly charges in the form of enrollment fees, premiums, and similar charges, for Medicaid eligible families. We propose to apply these Medicaid maximum monthly charges to the charges imposed on children of families whose incomes are at or below 150 percent of the FPL under CHIP. The Medicaid rules limit premiums to a specified monthly amount per family according to a sliding income scale. For example, the maximum monthly charge for a family with $1001 monthly income is $19 for a family of 1 or 2 persons, $16 for a family of 3 or 4, and $15 for a family of 5 or more. The regulations prescribe lower maximum monthly charges for families with lower income.

Section 2103(e)(3)(A)(ii) provides that copayments, coinsurance or similar charges imposed on children in families with income at or below 150 percent of the FPL must be equal to or less than the amounts considered nominal (as determined consistent with regulations referred to in section 1916(a)(3) of the Act), with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable. The Medicaid regulations that set forth these nominal amounts are located at § 447.54. For children whose family income is at or below 100 percent of the FPL, we propose that any copayments, coinsurance, deductibles or similar charges remain equal to or less than the amounts permitted under the Medicaid regulations at § 447.54. Because the statute gives the Secretary the authority to adjust the limitations found in § 447.54, for children whose family income is 101 percent to 150 percent of the FPL we propose adjusted nominal amounts for copayments, coinsurance, and deductibles to reflect the CHIP beneficiary's ability to pay higher cost sharing. We also propose that the frequency of cost sharing meet the requirements noted in proposed § 457.550. These restrictions are adopted from the Medicaid rules at § 447.53(c). The proposed restrictions are discussed more fully in the discussion regarding § 457.550 below.

We propose that the cost sharing imposed on children in families with income at or below 150 percent of the FPL be limited to a cumulative maximum. Specifically, we have proposed that total cost sharing imposed on children in this population be limited to 2.5 percent of a family's income for a year (or 12 month eligibility period). A more in-depth discussion on the cumulative cost sharing maximum as proposed in § 457.555, and our rationale for the 2.5 percent cumulative cost sharing maximum is discussed later in the preamble to this proposed rule.

10. Cost Sharing for Children in Families Above 150 Percent of the FPL (§ 457.545)

Section 2103(e)(3)(B) mandates that the total annual aggregate cost sharing with respect to all targeted low-income children in a family with income above 150 percent of the FPL not exceed 5 percent of such a family's income for the year involved. The proposed regulation provides that the plan may not impose total premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost sharing charges in excess of 5 percent of a family's income for a year (or 12 month eligibility period).

11. Restriction on the Frequency of Cost Sharing Charges on Targeted Low-Income Children in Families at or Below 150 Percent of the FPL (§ 457.550)

Section 2103(e)(3)(A)(ii) of the Act specifies that the State plan may not impose a deductible, cost sharing, or similar charge that exceeds an amount that is nominal as determined consistent with regulations referred to in section 1916(a)(3) of the Act, ''with such appropriate adjustments for inflation or other reasons as the Secretary determines to be reasonable''. In order to protect families at or below 150 percent of the FPL from excessive charges, we would adopt the Medicaid rule at § 447.53(c) that does not permit the plan to impose more than one type of cost sharing charge (deductible, copayment, or coinsurance) on a service. Under this rule, for example, a plan could not impose a copayment for a service if there is a deductible for the same service. We would also provide that a State may not impose more than one cost sharing charge for multiple services provided during a single office visit. For example, a beneficiary cannot be charged two copayments for two sets of lab tests performed during one visit. In addition, under our proposal a beneficiary cannot be charged two copayments if the beneficiary was seen by two different physicians during one visit.

We would also adopt the Medicaid rules at § 447.55 regarding standard copayments. Specifically, we would provide that States can establish a standard copayment for any service. We propose to expand upon the Medicaid rules and allow States to provide a standard copayment amount for any visit. Similar to the provisions at § 447.55 that allow a standard copayment to be based upon the average or typical payment of the service, our provision would allow a State to impose a standard copayment per visit based upon the average cost of a visit up to the copayment limits specified at proposed § 457.555(a).

12. Maximum Allowable Cost Sharing Charges on Targeted Low-Income Children at or Below 150 Percent of the FPL (§ 457.555)

Section 2103(e)(3)(A)(ii) of the Act specifies that the State plan may not impose a deductible, cost sharing, or similar charge that exceeds an amount that is nominal as determined consistent with regulations referred to in section 1916(a)(3) of the Act, ''with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable''. Because CHIP is designed for families with incomes above the Medicaid eligibility levels, we believe it is reasonable to set maximum copayments that are higher than those under the Medicaid program, which are set forth at §§ 447.53 and 447.54. Therefore, we propose provisions regarding maximum allowable cost sharing charges on targeted low-income children at 101 to 150 percent of the FPL that mirror the provisions of §§ 447.53 and 447.54 but are adjusted to permit higher amounts.

For noninstitutional services provided to targeted low-income children whose family income is from 101 to 150 percent of the FPL, we propose a maximum copayment charge of $5.00 (as opposed to the $3.00 maximum copayment charge under Medicaid). When deciding how to adjust the Medicaid copayment maximums for the CHIP population, we considered adjusting for current dollars the copayment maximums at § 447.54(a)(3) (which were published in 1976) using the Consumer Price Index (CPI) for all items, CPI—Medical Services, and Real Personal Income Growth. After considering the figures computed using these inflation adjustments, current copayment levels under State programs, and the potential overall impact of copayments on the utilization of services by children in families with incomes at or below 150 percent of the FPL, we propose the following service

payment and copayment maximum amounts:

Payment for the service	Maximum amount chargeable to beneficiary
$15.00 or less	$1.00
$15.01 to $40	2.00
$40.01 to $80	3.00
$80.01 or more	5.00

We also propose to set a maximum per visit copayment amount for beneficiaries enrolled in managed care organizations. The Medicaid regulations do not address cost sharing for HMO enrollees and therefore do not address a maximum charge on cost sharing in this setting. The $5.00 maximum copayment per visit is based upon the maximum copayment per service amount noted in the preceding chart. We urge States to apply this requirement in a way that continues to protect beneficiaries from unnecessarily high out-of-pocket costs that would prevent children from accessing essential services.

We propose to set a maximum on deductibles of $3.00 per month per family. This CHIP maximum deductible is higher than the Medicaid maximum deductible of $2.00 per month per family. If a State imposes a deductible for a time period other than a month, the maximum deductible for that time period is the product of the number of months in the time period and $3.00. For example, the maximum deductible that a State may impose on a family for a three-month period is $9.00.

We also propose, for the purpose of maximums on copayments and coinsurance, that the maximum copayment or coinsurance rate relate to the payment made to the provider, regardless of whether the payment source is the State or an entity under contract with the State.

With regard to institutional services provided to targeted low-income children whose family income is from 101 to 150 percent of the FPL, we propose to use the standards set forth in the Medicaid regulations at § 447.54(c). Accordingly, we propose to require that for targeted low-income children whose family income is at or below 150 percent of the FPL, the State plan must provide that the maximum deductible, coinsurance or copayment charge for each institutional admission does not exceed 50 percent of the payment made for the first day of care in the institution. Again, we have clarified that the percentage applies to the payment of the service regardless of the payment source.

We propose to allow States to impose a charge for non-emergency use of the emergency room up to twice the nominal charge for noninstitutional services provided to targeted low-income children whose family income is from 101 to 150 percent of the FPL. Medicaid regulations at § 447.54(b) specify that a waiver of the nominal requirement is permitted when non-emergency services are furnished in a hospital emergency room. We propose that the State be permitted, without a waiver from HCFA, to charge twice the noninstitutional copayment amount permitted when a beneficiary uses an emergency room for nonemergency services, capped at a maximum of ten dollars. This requirement would allow States the flexibility to charge cost sharing amounts on inappropriate use of the emergency room, without the burden of requesting a waiver from HCFA. The proposed ten dollar maximum is twice the proposed nominal copayment maximum ($5.00) for noninstitutional services under CHIP. Finally, in § 457.555(d), we proposed that States must assure that enrollees can receive emergency services from any qualified provider, regardless of whether the enrollee's managed care plan has a contract with that provider. We proposed this provision because emergency care, by its nature, may need to be obtained from the nearest available qualified provider. In addition, we propose that States must assure that enrollees are not held liable for any additional costs, beyond the standard co-payment amount, of emergency services furnished outside of the individuals managed care network.

13. Cumulative Cost Sharing Maximum (§ 457.560)

Section 2103(e)(3)(B) of the Act provides that any premiums, deductibles, cost sharing or similar charges imposed on targeted low-income children in families above 150 percent of the FPL may be imposed on a sliding scale related to income, except that the total annual aggregate cost sharing with respect to all targeted low-income children in a family may not exceed 5 percent of the family's income for the year involved. We refer to this cap on total cost sharing as the cumulative cost sharing maximum.

We propose two general rules regarding the cumulative cost sharing maximum. First, a State may establish a lower cumulative cost sharing maximum than that specified in § 457.560. Second, a State must count cost sharing amount that the family has a legal obligation to pay when computing whether a family has met the cumulative cost sharing maximum. We propose to define the term ''legal obligation'' as the family's obligation to pay amounts the provider actually charges the family and any other amounts for which the family is legally liable even if the family never pays those amounts. For example, a cost sharing charge that is billed to the family but not paid must nevertheless be counted toward the cumulative cost sharing maximum. We note that a State that purchases family coverage under the authority of 2105(c)(3) of the Act may want to count cost sharing imposed on adult family members against the cumulative cost sharing maximum. This practice is permissible but not mandatory because the statutory provisions on the cumulative cost sharing maximum specify that only cost sharing charges associated with targeted low-income children be counted toward the cumulative cost sharing maximum. However, the statute does not preclude a State from including other cost sharing charges.

We propose that for children in families above 150 percent of the FPL, the plan may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost sharing charges in excess of 5 percent of a family's income for a year (or 12 month eligibility period). We propose that for targeted low-income children in families at or below 150 percent of the FPL, the plan may not impose premiums, deductibles, copayments, co-insurance or similar cost sharing charges that, in the aggregate, exceed 2.5 percent of total family income for the year. Section 2103(e)(3)(A) gives the Secretary the authority to adjust cost sharing amounts so that they remain nominal, consistent with Medicaid regulations. The requirement at section 2103(e)(1)(B), which does not allow a State to impose cost sharing that favors children from families with higher income over children from families with lower income, and the Secretary's authority to make appropriate adjustments to permissible cost sharing amounts under section 2103(e)(3)(A)(ii), serve as the basis for our proposal to place a cumulative cost sharing maximum on the amount of cost sharing imposed on children at or below 150 percent of the FPL.

We believe that the lower maximum is consistent with the Congressional intent of section 2103(e)(1)(B) because it will ensure that children from families with higher income (over 150 percent of the FPL) are not favored over children from families with lower income (at or below 150 percent of the FPL). In addition, we reviewed cost sharing and

premium maximums for families whose incomes are under 150 percent of the FPL, under approved State plans. After this review, we specifically analyzed cost sharing maximums in six States that impose a maximum other than the 5 percent maximum imposed under § 457.560(c) to determine the percentage of income that a full payment of the cost sharing represents for a family of four at 100 percent of the FPL, which for FY 1998 is $16,450. For example, one State imposed a $250 per year per family cap on cost sharing. This amount represents approximately 1.5 percent of the income of a family at 100 percent of the FPL. We found that the cost sharing maximums range from a low of .72 percent of the income at 100 percent of the FPL to a high of 3 percent of the family's income at 100 percent of the FPL.

The majority of the States' cost-sharing maximums represented between 2 to 3 percent of the income of a family at 100 percent of the FPL. We therefore propose that a cumulative cost sharing maximum of 2.5 percent of the family's income (or an equivalent dollar amount) be placed on cost sharing imposed on children in families below 150 percent of the FPL. We encourage States and beneficiary groups to submit comments regarding our proposed limit on this population, because our historical data regarding cost sharing on this part of the CHIP population is limited.

Depending on the income level of the family, the cumulative cost sharing maximum would thus be set as 2.5 or 5 percent of a family's income. The State may define family income as it chooses, as long as under the State's definition, family income is no more than gross family income used by the State for determining CHIP eligibility prior to the application of disregards or exclusions.

14. Grievances and Appeals (§ 457.565)

We propose that the State must provide enrollees in a separate child health plan the right to file grievances and appeals in accordance with proposed § 457.985 for disenrollment from the program due to failure to pay cost sharing.

15. Disenrollment Protections (§ 457.570)

Section 2101(a) of the Act 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 that is coordinated with other sources of health benefits coverage for children. Based upon this provision of the statute, we propose in § 457.570 to require that States establish a process that gives beneficiaries reasonable notice of and an opportunity to pay past due cost sharing amounts (premiums, copayments, coinsurance, deductibles and similar fees) prior to disenrollment. We would require that States have this process in place because we do not believe it would be effective and efficient to disenroll a child without notice to the family of the impending disenrollment, or if a family was experiencing temporary financial hardship and could not afford to pay a premium or any other cost sharing amount. Examples of State processes that provide a reasonable notice and opportunity to pay include—waiving cost sharing for families experiencing temporary financial hardship, implementing grace periods before disenrolling beneficiaries, observing a beneficiary's pattern of non-payment before disenrollment, or establishing payment schedules to allow beneficiaries time to pay their outstanding cost sharing debts. We request comments on this requirement, including specific comments on the determination of an amount of time that would give beneficiaries reasonable notice and opportunity to pay cost sharing amounts prior to disenrollment. HCFA will request that States with approved plans submit this additional information once this proposed rule is published and prior to the State's onsite review. We will also ask the State to include its process in future amendments to its State plan.

F. Subpart G—Strategic Planning, Reporting, and Evaluation

1. Basis, Scope, and Applicability (§ 457.700)

This subpart sets forth the State plan requirements for strategic planning, monitoring, reporting, and evaluation under title XXI. Specifically, this subpart implements sections 2107(a), (b), and (d) of the Act, which relate to strategic planning, reports and program budgets; section 2108 of the Act, which sets forth provisions regarding annual reports and evaluation; and sections 2102(a)(7)(A) and (B), relating to assurances of quality and appropriateness of care, and access to covered services.

Although States are given great flexibility in developing title XXI programs, sections 2107 and 2108 of the Act emphasize accountability at both the State and Federal level. Title XXI provides for performance measurement, evaluation, and reporting that promote the collection and analysis of data critical to understanding the impact of CHIP on children's insurance coverage, access to care, and use of health care services. Reporting and evaluating the progress of program design and implementation involve articulating program objectives and translating them into meaningful, measurable evaluation goals; using valid and reliable performance measures; and developing data collection and analysis strategies that are relevant to the measures. Sections 2107 and 2108 of the Act require the Secretary to monitor State program development and implementation, and to evaluate and compare the effectiveness of State plans. Under section 2108(a) of the Act, States must assess the operation of their State plans in each preceding Federal fiscal year and report to the Secretary annually on their progress in reducing the number of uncovered, low-income children. In addition, section 2108(b)(1) requires States to submit an evaluation of their program by March 31, 2000. Under section 2108(b)(2), the Secretary is required to submit a report to Congress based on these evaluations by December 31, 2001 and to make the report available to the public.

Sections 2107 and 2108 of the Act contain guidance on reporting, performance measurement, and evaluation activities. These activities will provide the critical information necessary for meeting Federal reporting requirements, documenting program achievements, improving program function, and assessing program effectiveness in achieving policy goals. Data that facilitate the objective assessment of how programs are working will allow States to examine critical program design decisions and take action to improve their programs. Reporting and evaluation also will assist States and program advocates in documenting title XXI achievements. We share States' concern for the need to accurately measure the impact of CHIP. While this section outlines current Federal requirements related to measuring program achievements, we are soliciting comments for additional measures that will assist in articulating the success of programs implemented under title XXI. As part of our effort to increase understanding and knowledge of title XXI programs, we plan to establish an information dissemination policy that includes making State annual reports, State evaluations, and a summary of State expenditures and statistical reports regularly available on the Internet.

States have a strong interest in developing data collection strategies and capabilities that will allow them to

document that title XXI funds are being used efficiently and effectively to provide children with affordable, quality health insurance coverage. By enacting title XXI, Congress has made a significant investment in providing health insurance coverage to a substantial proportion of uninsured children. Continued support and funding will depend on providing policy makers with objective and accurate data about the success of the program.

Reporting and evaluating data will be critical to following the progress of States as they develop their own unique approaches to insuring children. Title XXI affords States broad flexibility and choice in program design and implementation. The array of choices available to States allows them to develop programs that address their specific needs. However, the variability in programs complicates the effort to measure and document program effectiveness and to make State-to-State comparisons. In developing their reporting strategy, States may find it helpful to work with their HCFA Regional Offices to identify technical assistance needs and to coordinate approaches to meeting those needs. We plan to work collaboratively with States on technical assistance issues in order to encourage utilization of relevant and valid program and quality of care performance measures that facilitate reporting and evaluation.

2. State Plan Requirements: Strategic Objectives and Performance Goals (§ 457.710)

In accordance with section 2107(a) of the Act and the intent of the Government Performance and Results Act of 1993 (GPRA), proposed § 457.710 encourages program evaluation and accountability by requiring the State plan to describe the strategic objectives, performance goals, and performance measures the State has established for providing child health assistance to targeted low-income children under the plan and for otherwise maximizing health benefits coverage for other low-income children and children generally in the State.

In accordance with section 2107(a)(2) of the Act, at § 457.710(b), we propose that the State plan must identify specific strategic objectives related to increasing the extent of health coverage among targeted low-income children and other low-income children. We understand there will be variation among States in specific evaluation approaches and terminology. However, we encourage States to view development of strategic objectives as a process that involves translating the basic overall aims of the State plan into a commitment to achieving specific performance goals or targets. One of the strategic objectives established in the Act is the reduction in the number of low-income, uninsured children. Although this objective is of central importance, States must articulate other strategic objectives, such as increasing access to health care and improving the quality of health services delivered to beneficiaries.

Under section 2107(a)(3) of the Act, States must identify one or more performance goals for each strategic objective. We propose to implement this statutory provision at § 457.710(c). The performance goals should be central to the State's strategic objectives and should facilitate assessing the extent to which strategic objectives are being achieved. Performance goals should be more specific than strategic objectives. Performance goals express target levels of performance in the form of tangible, measurable expected levels of achievement against which actual achievements for an explicit time frame can be measured.

In formulating strategic objectives and performance goals, States should consider not only the general population targeted for CHIP enrollment but also special population subgroups of particular interest. Such subgroups may include racial or ethnic minorities, specific high-risk groups such as children with special needs, children in foster care, homeless children, or hard to reach groups such as children who live in under-served rural areas or urban areas. Health services research studies have documented racial, ethnic, and cultural differences in health insurance coverage and patterns of care. For example, studies show that non-white children are more likely to be uninsured and under-immunized. Therefore, States may want to consider developing performance goals that relate to improving coverage, access, and utilization for specific subgroups.

In accordance with section 2107(a)(4) of the Act, proposed § 457.710(d) provides that the State plan must describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals. For purposes of measurement, States may find it helpful to conceptualize performance in two broad categories: quality of care measures and program operations measures. Quality of care measures focus on access to care, health status and delivery of clinical services. A measure of performance in either category must be valid (that is, reflect the concept it is intended to capture) and reliable (that is, yield results that are reproducible in repeated analyses). For example, waiting time for appointments with health care providers is a widely used, standardized measure of access.

Developing and testing performance measures to ensure their validity and reliability can prove expensive and time-consuming. For this reason, States may want to carefully review widely used measures including all of the following:

- The percentage of Medicaid-eligible children enrolled in Medicaid;
- The percentage of children with a usual source of health care;
- The percentage of children with unmet need for physician services and/or delayed care;
- The reduction of hospitalization for ambulatory-sensitive conditions;
- The array of measures in the Health Employer Data and Information Set (HEDIS) and the Consumer Assessments of Health Plans Study (CAHPS).

We note that HEDIS is widely used by private sector purchasers of managed care services. It contains a wide range of quality measures, including child and adolescent immunization measures and well child care and well adolescent care visits. The Agency for Health Care Policy and Research (AHCPR) has sponsored the development of a set of standardized CAHPS surveys and reporting formats. CAHPS measures and reports on consumer experience and satisfaction with specific aspects of health care such as access, interpersonal interactions between patients and providers, and service availability.

States may also find it helpful to use their measures to compare performance with widely recognized standards, benchmarks or guidelines. Prominent examples include:

- The US Preventive Services Task Force Guidelines;
- Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents;
- The Office of Disease Prevention and Health Promotion's Healthy People 2000 and Healthy People 2010.

States also may want to keep apprised of major efforts that are currently underway to develop new child quality measures such as the National Committee for Quality Assurance (NCQA) and Foundation for Accountability (FACCT) Child and Adolescent Health Measurement Initiative (CAHMI).

Similarly, States should also consider using widely accepted program performance measures. For example, many States are likely to adopt outreach

and substitution of private coverage performance goals because of the substantial public policy focus on these areas. In order to report and evaluate progress in these two areas, States may want to adopt a broad measurement strategy that characterizes structural aspects of program operations, program processes, and program outcomes. To use such a broad array of performance measures, States may want to consider a variety of data collection approaches including administrative data collection; mail, in-person, or telephone beneficiary surveys; disenrollee surveys; surveys of employers; site visit interviews and observation; and focus group interviews with beneficiaries, potential enrollees and employers.

Potential substitution of coverage performance measures include: beneficiary self-reported coverage status at eligibility determination, beneficiary self-reported coverage status after disenrollment, self-reported knowledge of low-income workers and small employers about the availability of public insurance, and length of waiting period for child health insurance. We understand that substitution is particularly challenging to measure because assessment relies so heavily on beneficiaries' self reported behavior and employers reports of their motivation for reducing or eliminating employer coverage. However, the public policy importance of the issue of substitution of coverage suggests that States should try to design data collection and analysis strategies that promote assessing the effectiveness of their substitution prevention policies.

Potential outreach performance measures include: proportion of families who know about the program, application simplification, enrollment application processing time, number of outreach workers per estimated eligible child, time elapsed between initial coverage request and enrollment, the percentage of mail-in applications (instead of on-site applications), number and productivity of out-stationed eligibility workers, total expenditures on outreach per estimated number of eligible children, number of children using a 12-month continuous eligibility option, the number of times an enrollee reports having been exposed to CHIP information prior to requesting an application, and enrollee satisfaction with the intake/enrollment process.

3. State Plan Requirement: State Assurance Regarding Data Collection, Records, and Reports and State Annual Reports and Evaluation (§§ 457.720 and 457.730)

Section 2107(b)(1) of the Act requires the State plan to provide an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format that 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. In accordance with the statute, we would implement this provision at § 457.720.

Section 2107(b)(2) of the Act discusses the requirement that the State plan include a description of the State's approach to submitting annual reports and the State evaluation. Accordingly, we would implement this provision at § 457.730. In order to facilitate report submission, a group of States has worked with staff from the National Academy of State Health Policy, with HCFA representation, to develop an optional model framework for the State evaluation due March 31, 2000. This framework has been finalized and sent to every State and territory with an approved State plan. States are permitted to submit their FY 1999 annual report and their State evaluation on March 31, 2000, together as one comprehensive document. Each State's submission will need to meet the title XXI requirements for both the FY 1999 annual report and the State evaluation. The NASHP framework has been designed to accommodate these requirements. The State workgroup facilitated by NASHP will reconvene to develop an optional model framework for future annual reports. We encourage States to use this optional framework to assure the reporting of timely and consistent data. We will continue to work with States to support this effort.

4. State Plan Requirement: State Assurance of the Quality and Appropriateness of Care (§ 457.735)

Sections 2102(a)(7)(A) and (B) of the Act require the State plan to describe the strategy the State has adopted for assuring the quality and appropriateness of care, particularly with respect to providing well baby care, well-child care, well adolescent care, and childhood and adolescent immunizations and for ensuring access to covered services, including emergency services and covered post-stabilization services. We propose to implement this provision at § 457.735. In this section of the State plan, States should discuss the specific elements of its quality assessment and improvement strategies, including the use of any of the following methods: Quality of care standards; performance measurement, information and reporting strategies, licensing standards, credentialing/recredentialing processes, periodic reviews and external reviews. In developing quality assessment strategies, States may find it helpful to refer to the Medicaid Managed Care proposed rule, published on September 29, 1998, for a discussion of standardized methods and tools in quality assurance and improvement and the Quality Improvement System for Managed Care (QISMC) Initiative (63 FR 52039). States are encouraged but not required to describe the State's strategy to assure that children have access to pediatricians and other health care providers with expertise in meeting the health care needs of children.

We propose to include an additional set of assurances that we believe is necessary to ensure the quality and appropriateness of care for enrollees. In § 457.735(b) we propose that States must assure that there are appropriate procedures in place to monitor and treat enrollees with complex and serious medical conditions, including access to specialists. While we believe that treatment plans are a desirable approach to address the needs of individuals with such medical conditions, we did not propose to require treatment plans. In addition, our proposed language does not mirror the language set forth in the proposed Medicaid managed care rule, which requires an adequate number of ''direct access'' visits because this language implies the use of a managed care approach that may not be applicable under CHIP.

5. State Expenditures and Statistical Reports (§ 457.740)

The recent implementation of CHIP, results of welfare reform, increased economic stability and reductions in unemployment have affected the scope of health insurance coverage for children. Because each of these factors may confound the coverage level, additional data is needed from States to measure the effectiveness of CHIP in providing coverage to low-income, uninsured children. Consistent quarterly enrollment data for separate child health programs, Medicaid expansions, and regular Medicaid is necessary for HCFA to effectively administer CHIP, to understand its relative impact on rates of uninsurance among low-income children, and to

meet the changing needs of this population.

Therefore, section 2107(b)(1) of the Act, as implemented in proposed §§ 457.720 and 457.730, requires that the State plan contain certain assurances regarding the submission of reports to the Secretary. In addition, § .16 of the Medicaid regulations specifies that a State plan must provide that the Medicaid agency will submit all reports required by the Secretary, follow the Secretary's instructions with regard to the format and content of those reports, and comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. These statutory provisions and regulations serve as our authority for proposing State expenditure and statistical reporting requirements at § 457.740. (For information on forms that States should use in reporting expenditures and statistical data, see the proposed rule concerning State Children's Health Insurance Program Allotments and Payments to States, published in the **Federal Register** on March 4, 1999 (64 FR 10412). The final approved forms were published on December 2, 1998 (64 FR 66552).

We would require that the State collect required data beginning on the date of implementation of the approved State plan. States must submit quarterly reports on the number of children under 19 years of age who are enrolled in separate child health programs, Medicaid-expansion programs, and regular Medicaid programs (at regular FMAP) by age, income and service delivery categories. (Territories are excepted from the definition of ''State'' for the purposes of quarterly statistical reporting.) We also propose to require that thirty days after the end of the Federal fiscal year, the State must submit an unduplicated count for that Federal fiscal year of children who are enrolled in the separate child health program, the Medicaid expansion program and the Medicaid program as appropriate by age, service delivery, and income categories. Reporting an unduplicated count will provide insight into the continuity of coverage by clarifying the dynamics of program retention, dropout, and re-enrollment and facilitate designing and implementing more effective outreach policies.

We propose that the age categories that must be used to report the data are: Under 1 year of age, 1 through 5 years of age, 6 through 12 years of age, and 13 through 18 years of age. These age categories were chosen because they correspond with eligibility categories as well as with health status/health risk categories. States also are required to report by service delivery categories because it is important to understand the provider setting in which care is organized and delivered. The service delivery system categories that the State would be required to use are: Managed care, fee-for-service, and primary care case management.

We propose that States must report income by using State-defined countable income and State-defined family size to determine Federal poverty level (FPL) categories. We propose that States that do not impose cost-sharing and States that only impose cost-sharing based on a fixed percentage of income (such as 2 percent) in their Medicaid-expansion program or their separate child health program must report their CHIP and Medicaid enrollment by using two categories: At or below 150 percent of the Federal poverty level (FPL) and over 150 percent of FPL. States that impose cost-sharing at defined levels (for example, at 185 percent and over of FPL) in their Medicaid-expansion program and separate child health program would be required to report their CHIP and Medicaid enrollment by poverty level (that is, countable income and household size) categories that match their Medicaid-expansion program and separate child health program cost sharing categories.

We propose to require enrollment reporting by countable family income as defined by the State consistent with the definition at proposed § 457.10 rather than gross income. We are requiring the use of countable income because this maintains consistency with the program operational level definition of income and recognizes the wide variation that exists in how States compute enrollee family income and household size.

We also propose to require enrollment reporting by income for Medicaid as well as for CHIP. Because the income of low-income families tends to vary, children's eligibility status may change quite frequently and many children may be required to shift back and forth between Medicaid and the Medicaid-expansion or separate child health program. Therefore, it is important to understand program enrollment by income levels.

We propose that required standardized reporting be limited to expenditure data and enrollment data as reported by age, poverty level, and service delivery categories. We developed these proposed reporting requirements through extensive consultation with interested States and agencies within the Department and careful consideration of the need to document the progress of title XXI programs.

We also believe States should, as a matter of sound administration of their programs, collect other relevant demographic data on enrollees such as sex, race, national origin, and primary language. Collection of such data will encourage design of outreach and health care delivery initiatives that address disparities based on race and national origin. It also will facilitate State compliance with Office for Civil Rights data needs in the event of complaint investigations or compliance reviews.

In order to streamline State reporting requirements, we plan to develop an option for States to provide the needed CHIP data through existing statistical reporting systems in the future. We are currently evaluating possible modifications to the Medicaid Statistical Information System (MSIS), which captures State eligibility and claims records on a quarterly basis. The modifications will give States the option of using MSIS to supply the data elements that will meet the title XXI quarterly statistical reporting requirements. Under the implementation schedule for the FY 1999 MSIS changes, this option will not be available at an early enough date for States to report the data required by these regulations.

6. Annual Report (§ 457.750)

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children. We would implement the statutory provision requiring assessment of the program and submission of an annual report at proposed § 457.750(a).

At § 457.750(b), we set forth the proposed required contents of the annual report. Specifically, in accordance with the statute, the annual report must provide an assessment of the operation of the State plan in the preceding Federal fiscal year including the progress made in reducing the number of uncovered, low-income children. In addition, we propose to require that the State report on progress made in meeting other strategic objectives and performance goals identified by the State, successes in program design, planning, and implementation of the State plan, identify barriers to program development and implementation, and

the State's approach to overcoming these barriers. We also propose to require that the State report on the effectiveness of its policies in discouraging the substitution of public coverage for private coverage. Further, we would require that the annual report discuss the State's progress in addressing any specific issues, such as outreach, that it agreed to assess in its State plan. In accordance with section 2107(d) of the Act, we also propose that a State also must provide the current fiscal year budget update, including details on the planned use of funds and any changes in the sources of the non-Federal share of plan expenditures. We also propose that the State must identify the total State expenditures for family coverage and total number of children and adults covered by family coverage during the preceding Federal fiscal year. We believe that a State must report on these issues in order to appropriately assess the operations of the State plan under section 2108(a) of the Act.

We propose that, in order to report on the progress made in reducing the number of uncovered low-income children in the annual report, 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 and provide estimates, using the chosen methodology, of the annual change in this number of low-income uninsured children at two poverty levels: 200 percent FPL and at the current upper eligibility level of the State's CHIP program. In making these estimates, a State would not be required to use the same methodology that it used in identifying the estimated number of CHIP eligibles in the State plan.

We are requiring States to provide an estimate of the number of low-income, uninsured children at two poverty levels in order to gain insight into the progress made in providing low-income children with health insurance coverage. By requiring an estimate at the current upper eligibility level of the State's program, we can obtain data on the state interpretation of the number of low income children current targeted for enrollment. Over time, as some States choose to increase their upper eligibility levels, we will be able to identify how the number of targeted children has changed because of expanded income eligibility thresholds. By also requiring the State to provide a baseline estimate at the 200 percent FPL, we can obtain an aggregated state interpretation of the number of low income children in the United States. Title XXI generally defines low income children as children in families with income below 200 percent of the FPL. Most public policy and survey research experts also adopt this definition. Therefore, requiring the State to estimate the baseline number of uninsured children at this FPL will allow us to compare an aggregated State estimate with estimates obtained from other sources.

We would require that a State base the annual baseline estimates on either : (1) Data from the March supplement to the Current Population Survey (CPS); (2) data from State-specific surveys; (3) other statistically adjusted CPS data; or (4) other appropriate data. We also propose that a State must submit a description of the methodology used to develop these estimates and the rationale for its use, including the specific strengths and weaknesses of the methodology, unless the State bases the estimate on March CPS data. We propose that once a State submits a specific methodology in the annual report for estimating the baseline numbers, the State must use the same methodology to provide annual estimates unless it provides a detailed justification for adopting a different methodology.

We propose to give States the option of deciding how to estimate the number of uninsured children in the State, rather than requiring the use of one standard methodology. We note that making such estimates is inherently difficult and all the existing data sources have limitations. Traditionally, most national estimates of uninsured children have been based on the Bureau of Census March Current Population Survey (CPS). In fact, Congress used CPS estimates of the uninsured to allocate the CHIP funds available to each State. The CPS is a monthly survey of approximately 57,000 households in the United States. Each March the CPS includes supplemental survey questions about health insurance status. More specifically, individuals are asked whether they had any of various types of private or public health insurance in the previous year. Individuals who do not report insurance coverage are categorized as having been uninsured.

One major reason for the CPS's widespread use is that it is the only data source with the capacity to generate State-by-State estimates of uninsured children. However, in States with small populations, CPS State-specific estimates rely on very small sample sizes and may not be reliable. Because of this concern, Congress used 3-year averages of CPS estimates to allocate CHIP funds to States.

Despite its shortcomings, the CPS generally is relied upon by policy makers to provide an overall estimate of insurance status and insurance trends in the nation. Other major surveys that provide insight into the number of uninsured Americans include the Survey of Income and Program Participation (SIPP), the Medical Expenditure Panel Survey (MEPS), the Community Tracking Study, the National Health Interview Survey (NHIS) and the National Survey of American Families. However, these surveys produce estimates with a significant time lag, and several are conducted on an irregular or infrequent basis. For example, the Urban Institute conducted the National Survey of American Families in a sample of households in 13 States in 1997 and plans additional survey rounds in 1999 and 2001, but results of the 1997 survey will not be available until Spring of 1999 and the results of the 1999 survey will not be available until late 2000.

Although the National Center for Health Statistics has been developing the State and Local Area Integrated Survey (SLAITS) with a health care module, it currently remains unfunded and some methodological concerns have been raised about its applicability to CHIP. Therefore, we expect that most State-specific estimates of the number of uninsured children will use the CPS, a statistically adjusted CPS, or a State funded survey of the uninsured population. A well-designed State-specific survey can maximize the opportunity to capture information that is most relevant and of greatest interest. However, cost and time considerations will limit the reliability and validity testing of State-specific surveys, and these limitations can increase concerns about methodological shortcomings. Because data sources and methodologies for estimating the number of uninsured children may vary significantly across States, State-by-State comparisons of the estimates may be difficult. We will continue to work with States to give us the ability to compare estimates and develop comparable data.

7. State Evaluations (§ 457.760)

Proposed § 457.760 discusses the requirement that States submit a comprehensive evaluation by March 31, 2000 that analyzes the progress and effectiveness of the State child health program. In the evaluation, a State must report on the operation of its Medicaid expansion program, separate child health program, or combination program. As specified in section 2108(b)(1)(B) of the Act, the State evaluation must include all of the following:

- An assessment of the effectiveness of the State plan in increasing the

number of children with creditable health coverage. In addition, the State must report on progress made in meeting other strategic objectives and performance goals identified by the State plan.

- An assessment of the State's progress in meeting other strategic objectives and performance goals identified by the State plan.
- A description and analysis of the effectiveness of elements of the State plan, including the following elements:

—The characteristics of the children and families assisted under the State plan, including age of the children and family income. The State also must report on children's access to, or coverage by, other health insurance prior to the existence of the State program and after eligibility for the State program ends (the child is disenrolled). As an optional strategy, the State also should consider reporting on other relevant characteristics of children and their families such as sex, ethnicity, race, primary language, parental marital status, and family employment status.

—The quality of health coverage provided under the State plan, including the results or plans to assess the results of any quality assurance and improvement, monitoring, and performance measurement process or other process that is used to assure the quality and appropriateness of care.

—The amount and level of assistance including payment of part or all of any premiums, copayments, or enrollment fees provided by the State.

—The service area of the State plan (for example, Metropolitan Statistical Area (MSA) or non-MSA).

—The time limits for coverage of a child under the State plan. As an optional strategy, the State should consider reporting the average length of time children are assisted under the State plan.

—The extent of substitution of public coverage for private coverage and the State's effectiveness in designing policies that discourage substitution.

—The State's choice of health benefits coverage, including types of benefits provided and the scope and range of these benefits, and other methods used for providing child health assistance.

—The sources of non-Federal funding used in the State plan.

- An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.
- A review and assessment of State activities to coordinate the CHIP plan with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services;
- An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.
- A description of any plans the State has for improving the availability of health insurance and health care for children.
- Recommendations for improving the CHIP program.

G. Subpart H—Substitution of Coverage

1. Basis, Scope, and Applicability (§ 457.800)

One of the fundamental principles of title XXI is that CHIP coverage should not supplant existing public or private coverage. Title XXI contains provisions specifically designed to ensure that States use CHIP funds to provide coverage only to uninsured children. These provisions maximize the use of Federal dollars. Specifically, title XXI requires that States ensure that coverage provided under CHIP does not substitute for coverage under either private group health plans or Medicaid. Section 2102(b)(3)(C) of the Act requires that State plans include descriptions of procedures used to ensure that the insurance provided under the State child health plan does not substitute for coverage under group health plans. A final provision in title XXI relating to substitution of coverage is in section 2105(c)(3)(B), which sets out the conditions for a waiver for the purchase of family coverage as described in proposed § 457.1010. Under this provision, States must establish that family coverage would not be provided if it would substitute for other health insurance provided to children. In addition, title XXI contains three provisions aimed at preventing CHIP from substituting for current Medicaid coverage.

First, section 2102(c)(2) of the Act requires States to describe procedures used to coordinate their CHIP programs with other public and private programs. Second, section 2105(d) of the Act includes ''maintenance of effort'' provisions for Medicaid eligibility. That is, under section 2105(d) of the Act, a State that chooses to create a separate child health program cannot adopt income and resource methodologies for Medicaid children that are more restrictive than those in effect on June 1, 1997. Furthermore, title XXI also provides that a State that chooses to create a Medicaid expansion program, is not eligible for enhanced matching for CHIP coverage provided to children who would have been eligible for Medicaid in the State under the Medicaid standards in effect on March 31, 1997. Third, section 2102(b)(3)(B) of the Act requires that any child who applies for CHIP must be screened for Medicaid eligibility and, if found eligible, enrolled in Medicaid.

This subpart interprets and implements section 2102(b)(3)(C) of the Act regarding substitution of group health coverage and sets forth State plan requirements relating to substitution of coverage in general and specific requirements relating to substitution of coverage under employer-sponsored group health plans. These requirements apply to separate child health programs.

2. State Plan Requirements: Private Coverage Substitution (§ 457.805)

The potential for substitution of CHIP coverage for private group health coverage exists because CHIP coverage costs less or provides better coverage than coverage some individuals and employers purchase with their own funds. Specifically, employers who make contributions to coverage for dependents of lower-wage employees could potentially save money if they reduce or eliminate their contributions for such coverage and encourage their employees to enroll their children in CHIP. At the same time, families that make significant contributions towards dependent group health coverage could have an incentive to drop that coverage and enroll their children in CHIP if the benefits would be comparable or better and their out-of-pocket costs would be reduced.

In accordance with section 2102(b)(3)(C) of the Act, we propose at § 457.805 to require that each State plan include a description of reasonable procedures that the State will use to ensure that coverage under the plan does not substitute for group health plans. We will review State CHIP plans for the procedures.

The following is a discussion of the procedures relating to substitution of coverage under CHIP.

State plan requirements to prevent substitution. States that operate a separate child health program will be required in their State plans to describe procedures to address the potential for substitution. There is general agreement that substitution is a more significant problem at higher levels of income where a greater proportion of children have access to coverage. Therefore, we propose to more closely scrutinize State

plans that expand eligibility for children in families with higher income levels.

We would consider the following to be reasonable procedures to prevent substitution:

- States that provide coverage to children in families at or below 150 percent of the Federal poverty line (FPL) should, at a minimum, have procedures to monitor the extent of substitution of that coverage for existing private group health coverage. We believe that there is limited evidence of substitution at income levels below 150 percent of FPL.
- States that provide coverage to children in families between 150 and 200 percent of FPL should, at a minimum, have procedures to study the incidence of substitution of that coverage for existing private group health coverage. In addition, States should specify in their State plans the steps they will take to prevent substitution in the event that the States' monitoring efforts discover substitution has occurred at an unacceptable level. In the event that the Secretary finds an unacceptable level of substitution, the State in question should implement the procedures to limit substitution that were identified in its State plan. We would apply a stricter standard for this higher income group because of the increased potential risk of substitution at this income level.
- States that provide coverage to children in families above 200% of FPL should implement, concurrent with program implementation, specific procedures or a strategy to limit substitution. We will not prescribe a particular strategy, but will evaluate each State's strategy separately.

We will ask States to assess the procedures to limit substitution in their evaluations submitted in March of 2000. States that monitor substitution in their plans will also submit information on substitution in their annual reports. We will examine any data on the effectiveness of States' procedures to prevent substitution of coverage. If our review of States' experience shows that substitution is occurring at an unacceptable rate, we may issue new requirements and require States to alter their plans at a future date.

The other option that we considered was to require a set of specific procedures that each State would have to use to address substitution. We rejected this option because the statute authorizes States to design approaches to prevent substitution, not the Federal government. We also recognized that there is not substantial evidence favoring any specific approach to reduce the potential for substitution.

We have received questions about applying substitution provisions to the Medicaid eligibility group for the ''optional targeted low-income children'', which was added to section 1902(a)(10)(A)(ii)(XIV) of the Act in accordance with section 4911 of the BBA. We are not proposing to require States to apply eligibility-related substitution provisions such as periods of uninsurance to the ''optional targeted low-income children'' group, because we believe that such eligibility conditions are inconsistent with the entitlement nature of Medicaid. States that currently apply eligibility-related substitution provisions to optional targeted low-income children will need to come into compliance with this policy. We recognize that States expanding Medicaid to this group at higher income levels may be particularly concerned about the potential for substitution of coverage. We will review section 1115 demonstration requests for substitution provisions and consider those that are consistent with our proposed policy under title XXI. State proposals to apply substitution provisions must satisfactorily demonstrate how the proposal will test new ideas of policy merit and be formally evaluated, consistent with the research and demonstration objectives of section 1115 of the Act. States that have approved Medicaid demonstration projects under section 1115(a)(2) that currently apply substitution provisions, such as waiting periods, to expansion populations under this demonstration authority may continue to do so. Moreover, States may use mechanisms other than eligibility restrictions to discourage substitution of coverage.

3. Premium Assistance for Employer-Sponsored Group Health Plans: Required Protections Against Substitution (§ 457.810)

We will particularly scrutinize CHIP programs under which States subsidize coverage under employer-sponsored group health plans, regardless of the income levels of the children who benefit from the subsidies, because we believe there is a greater potential for substitution of public funding for existing private funding for health insurance in this type of arrangement. First, we believe that State subsidies of private coverage under CHIP might increase the likelihood that families that purchase dependent coverage under employer-sponsored plans would drop that coverage and seek CHIP coverage if these families could obtain the same coverage under CHIP at lower cost. Lower income families may actually be more likely to drop their contribution to employer-sponsored coverage than higher income families because of the higher cost of insurance relative to their income. Second, employers with low-wage workers may have incentives to reduce or eliminate their premium contributions for dependent coverage if the CHIP assistance could replace that contribution.

We propose under § 457.810 to require any State that implements a separate child health program under which the State provides premium assistance for coverage under employer-sponsored group health plans, to adopt specific protections against substitution. A State must describe these protections in the State plan. We believe that without these additional protections, new Federal dollars will not extend coverage to as many uninsured, low-income children. The following four requirements must be met to protect against substitution:

- The child must not have been covered by employer-sponsored group health insurance during a period of at least six months prior to application for CHIP. States may require a child to have been without insurance for a longer period, but that period may not exceed 12 months. We believe that any longer waiting period would conflict with the overall goal of title XXI to provide child health assistance to uninsured, low-income children. We do not believe a waiting period of longer than 12 months is a reasonable procedure to prevent substitution of coverage. Exceptions to the minimum period without insurance would be allowed if the prior coverage was involuntarily terminated. Newborns who are not covered by dependent coverage would not be subject to any such waiting period.

We proposed this waiting period without employer-sponsored group health insurance to ensure that coverage is targeted to children in families that previously were unable to afford dependent coverage. We chose a minimum waiting period of 6 months because we felt that this time period would be long enough to significantly deter families from dropping existing coverage. The other option we considered was a 3 month waiting period. We believe, however, that parents would be more willing to drop existing coverage and allow their children to be uninsured for this shorter time period in order to take advantage of the premium assistance coverage through CHIP.

We believe that States that do not impose a 6-month waiting period must have a viable alternative to waiting periods, subject to approval by HCFA.

For example, a State could not simply reduce the waiting period from our minimum period of 6 months. It is important to note, however, that the waiting period is based only on coverage by employer-sponsored group health insurance, not CHIP or Medicaid coverage. If an otherwise eligible child does not meet the requirement for a minimum period without employer-sponsored group health coverage, the State can enroll the child in a separate State program or in Medicaid without purchasing employer-sponsored coverage for the interim waiting period, and can still consider the child uninsured for purposes of the waiting period. That is, coverage under a separate State program or Medicaid does not count for purposes of the waiting period.

• The employer must make a substantial contribution to the cost of family coverage, equal to 60 percent of the total cost of family coverage. We propose this requirement to discourage employers from lowering or eliminating their existing contributions for dependent coverage. We chose 60 percent based on several employer studies, which show that, on average, employers contribute roughly two thirds of the cost of family coverage. The Department is reluctant to permit a rate of contribution significantly lower than the 60 percent standard. States proposing an employer contribution rate below this standard must provide the Department with data that exemplify a lower average employer contribution in their State. The data must support the State's contention that the lower level of contribution will be equally effective in ensuring maintenance of statewide levels of employer contributions. We would also consider a somewhat lower level if a State had additional, effective, provisions to limit employers' ability to lower contribution levels or a State could show through specific data that the average employer contribution in the State is lower than 60 percent. For example, one State demonstrated to us by using the Medical Expenditures Panel Survey (MEPS) that the contribution rate was lower than 60 percent (55 percent) in that State. For ease of administration, the State may establish a minimum dollar employer contribution or some other method that is roughly equivalent to the 60 percent requirement to assure that employers continue to pay a meaningful share of the costs in these programs. The employee must apply for the full premium contribution available from the employer. We propose this requirement to promote cost-effectiveness and maximum employer contribution. This employer contribution would reduce the CHIP contribution toward the premium.

• The State's premium assistance for employer-sponsored coverage must not be greater than the payment that the State otherwise would make on the child's behalf for other coverage under the State's CHIP program. We have proposed this requirement to ensure that the provision of child health assistance through employer-sponsored group health plans is cost-effective and that the State is not inappropriately providing premium assistance for coverage for the adults in a family.

• The State must collect information and evaluate the amount of substitution that occurs as a result of the subsidies and the effect of subsidies on access to coverage. To conduct this evaluation, States must assess the prior insurance coverage of enrolled children. States may obtain information on prior coverage through the enrollment process, separate studies of CHIP enrollees, or other means for reliably gathering information about prior health insurance status. States should consider collecting the following information on the application to evaluate the prevalence of substitution:

—When did you last have insurance? __ Never __ less than 3 months ago __ 3–6 months ago __ 6–12 months ago __ more than 12 months ago

—What type of insurance did you have most recently? __ Medicaid __ Employer-sponsored insurance __ Individual __ Other (e.g., CHAMPUS, Medicare , VA) [**Note:** More than one may apply.]

—What reason best characterizes why you don't have insurance today? __ No longer working for the employer who offered the insurance __ Can't afford insurance __ Employer dropped coverage __ Public benefits are better __ No longer need insurance __ Employer does not offer health insurance

These questions may need to be adapted by survey researchers to obtain the appropriate information. Proposed § 457.750 and § 457.760 provide additional information on reporting and evaluation requirements. To determine the level of substitution, we encourage States to analyze the number of families who choose to enroll in CHIP who might have retained or bought private insurance had they not received CHIP funding for employer-sponsored insurance. We would ask States that choose to provide premium assistance for children's coverage through employer-sponsored group health plans to describe in their State plan and annual reports (described in proposed § 457.750) their compliance with these guidelines. We would also ask States to discuss their adherence to these guidelines in their March 31, 2000 evaluations. Based on the State evaluations submitted in March of 2000, we will reevaluate our position on these requirements for States that subsidize employer-sponsored group health plans.

H. Subpart I—Program Integrity and Beneficiary Protections

We propose to add a new subpart I, that would specify the provisions necessary to ensure the implementation of program integrity measures and beneficiary protections within the State Children's Health Insurance Program. In addition, this subpart discusses the President's *Consumer Bill of Rights and Responsibilities* as it relates to the CHIP program. This subpart also describes how the intent of the GPRA can be upheld by including program integrity performance and measures as part of the State plans.

1. Basis, Scope, and Applicability (§ 457.900)

We remain committed to our proactive efforts to preserve the integrity of our Federal and State government health care programs. Indeed, among HCFA's top priorities is to strengthen our ability to fight waste, fraud, and abuse in the Medicare and Medicaid programs and now in CHIP. We specify in § 457.900, that sections 2101(a) and 2107(e) authorize HCFA to set forth fundamental program integrity requirements and options for the States.

Specifically, section 2101(a) of the Act specifies that the purpose of the Children's Health Insurance Program 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. We believe that assuring program integrity is an integral part of an effective and efficient CHIP program and we have used this section of the Act as part of the authority for this subpart. In addition, section 2107(e) of the Act lists specific sections of title XIX and title XI and provides that these sections apply to States under title XXI in the same manner they apply to a State under title XIX. Therefore, we include the provisions set forth in section 2107(e) in specifying the authority for this subpart.

We note that the program integrity provisions contained in this proposed rule only apply to States that implement separate child health programs under the authority of section 2101(a)(1) of the

Act. States that implement a Medicaid expansion program are subject to the Medicaid program integrity provisions set forth in the Medicaid regulations at part 455, Program Integrity: Medicaid. While we are dedicated to preserving the inherent flexibility the Act provides to States that implement separate child health programs, we are proposing that States design programs that address the fundamental program integrity protections established for the Medicaid program. We believe this approach to program integrity will ensure continuity among States in implementing CHIP, while at the same time allowing States the opportunity to maximize efficiencies from existing administrative processes and practices that States have established for program integrity.

2. Definitions (§ 457.902)

We have included five definitions for the purpose of this subpart. The terms ''contractor,'' ''managed care entity,'' and ''fee-for-service entity'' relate to the entities with which States may contract in order to provide services to the CHIP population. We defined the terms ''contractor'' and ''managed care entity'' in this subpart because the two terms are used most significantly in reference to accountability for ensuring program integrity. We wanted to find a term that would encompass all health care related entities involved in service delivery to this population. We defined the term ''grievance'' to provide some context into the section requiring States to have written procedures for grievances and appeals. In addition, we defined the term ''State program integrity unit'' because separate child health programs may elect to create an organization whose purpose is to conduct program integrity activities. We created this term to have a uniform way of describing this organization for States that take the opportunity to develop a fraud and abuse prevention system for separate child health programs. Such a system could be similar to that of the Medicaid Fraud Control Units (MFCUs), but activities would be funded through Title XXI rather than Medicaid.

Specifically, we propose that ''contractor'' means any individual or entity that enters into a contract, or a subcontract to provide, arrange, or pay for services under title XXI. This definition includes, but is not limited to, managed care organizations, prepaid health plans, primary care case managers, and fee-for-service providers and insurers.

We propose that a ''managed care entity'' is any 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. We propose that ''fee-for-service entity'' means any entity that provides services on a fee-for-service basis, including health insurance. We propose that ''State program integrity unit'' means a part of an organization designated by the State (at its option) to conduct program integrity activities for separate child health programs.

Finally, we defined the term ''grievance'' to be consistent with the proposed Medicaid managed care regulations, and to give the States the opportunity to utilize the process that is already in place for the Medicaid program.

3. State Program Administration (§ 457.910)

We are aware of the need to provide States with maximum flexibility as they implement their State plans, while balancing the need of the Federal government to remain accountable to Congress for the integrity of the program. We note that section 2101(a) of the Act allows flexibility by requiring States to provide child health assistance to uninsured, low-income children in an effective and efficient manner. Toward that end, we would specify in § 457.910 that the State child health plan must provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the State child health program. We would also provide that the State's program must provide the safeguards necessary to ensure that eligibility as set forth in subpart C of these proposed regulations will be determined appropriately, and services will be provided in a manner consistent with simplicity of administration and with the provisions of proposed subpart D regarding benefits. We believe these requirements are relevant and consistent with the general program integrity protections that are common to most Federal and State health programs and provide States with flexibility in tailoring their individual CHIP programs.

4. Fraud Detection and Investigation (§ 457.915)

Section 2107(e) references sections 1903(i)(2), and 1128A of the Act, which authorize certain fraud detection and investigation activities. Section 2107(e) states that these provisions apply under title XXI in the same manner as applied to a State under title XIX. Moreover, these provisions are cited as authority in the Medicaid regulations at part 455, subpart A—Medicaid Agency Fraud Detection and Integrity Program. We recognize that States that implement their State plans through the Medicaid expansion option are subject to all Medicaid program integrity requirements under part 455, Program Integrity: Medicaid. However, States that implement separate child health programs have more flexibility in designing and implementing program integrity procedures for their programs. In recognition of this flexibility, we considered three possible options to ensure that separate child health programs develop and implement adequate fraud detection and investigation processes and procedures.

We considered declining to specify any fraud detection and investigation assurances, thereby providing States with full discretion in designing processes and procedures to meet their specific needs. However, we are not proposing this option because we do not believe it supports the Secretary's need for accountability and responsibility to Congress for CHIP evaluation and reporting requirements. We also considered proposing to require that all separate child health programs follow the same processes and procedures for fraud detection and investigation for the Medicaid program (and CHIP Medicaid expansions) specified under § 455.13 regarding methods for identification, investigation and referral. However, while there are several advantages in maintaining a central focal point for all State Medicaid and CHIP activities, we did not propose this option because we believed that this approach was not sufficiently flexible for separate child health programs, which vary in structure from Medicaid. The compromise option that we are proposing is to require States to address, specifically, the Medicaid goals for fraud detection and investigation, but allow States to design specific procedures needed to meet the requirements of § 455.13. We believe this option balances the need for maintaining State flexibility while establishing an acceptable minimum standard that will satisfy our need for accountability in the program. For example, under this option we would indicate that States may consider Medicaid agency criteria for identifying suspected fraud cases in CHIP and work in collaboration with the State program integrity unit, legal authorities, and law enforcement officials in referring suspected fraud and abuse cases.

Specifically, we propose that the State must establish procedures for assuring program integrity and detecting fraudulent or abusive activity. We propose that HCFA and the States develop program integrity standards and

measures, such as payment error rate, acceptable levels of payment error, and the recovery of funds from erroneous payments. These examples of measures demonstrate Federal and State commitment to the principles and the intent of the GPRA. We would provide that the procedures must include, at a minimum, the methods and criteria for identifying and investigating suspected fraud and abuse cases that do not infringe on the legal rights of persons involved and afford due process of law. We also propose that the State may establish an administrative agency responsible for monitoring and maintaining the integrity of the separate child health program, which would be referred to as the ''State Program Integrity Unit.'' We further provide that in the event that a State chooses to establish a State Program Integrity Unit, the State must develop and implement procedures for referring suspected fraud and abuse cases to law enforcement officials. We would specify that law enforcement officials include, but are not limited to the Department of Health and Human Services Office of Inspector General(OIG), the Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), and the State Attorney General's office.

5. Accessible Means To Report Fraud and Abuse (§ 457.920)

We propose that States with separate child health programs must establish and provide access to a mechanism that facilitates communication between the State and the public for information exchange on instances of potentially fraudulent and abusive practices by and among participating contractors, and other entities. This communication mechanism may include a toll-free telephone number. We realize that toll-free service is the primary means for referring fraud and abuse in the Medicaid program, and that these toll-free services are unique and vary from State to State. While States that expand current Medicaid programs can utilize the existing toll-free services, we note that States with separate child health programs may establish similar toll-free service as a viable method to provide the public with an accessible means for reporting fraud and abuse. For example, States are free to use discretion in establishing new toll-free services specifically designed for their enrollees, or in maximizing the benefits of an existing Medicaid fraud and abuse toll-free service by expanding these toll-free services to include fraud and abuse reporting. As evidenced by the Medicare, Medicare+Choice, and Medicaid programs, we believe that providing access to toll-free service for the reporting of potentially fraudulent and abusive practices is an integral part of any sound program integrity strategy.

6. Preliminary Investigation (§ 457.925)

We would specify that if the State receives a complaint of fraud or abuse from any source, or identifies any questionable practices, the State agency must conduct a preliminary investigation or implement otherwise appropriate actions to determine whether there is sufficient basis to warrant a full investigation. We are proposing that the State has the option of creating a ''State program integrity unit'' for separate child health programs that would conduct fraud and abuse prevention activities parallel to the activities of Medicaid Fraud Control Units. States have flexibility to define the role, if any, that State program integrity units play. However, such activities must be funded with monies from the State's CHIP allotment. While we are proposing that preliminary investigations be conducted, we remain flexible with regard to the processes and procedures that separate child health programs may employ in conducting preliminary investigations. We would encourage States to work closely with the State Medicaid program integrity unit or units in structuring the approach to program integrity and developing procedures for conducting these investigations. Since the Medicaid and separate State program integrity units would be working on similar issues, sometimes on parallel investigations, the two units could reside in the same organization, entity, or division within the State. We believe this represents a feasible option to help States bolster their effectiveness and efficiency in conducting fraud and abuse investigations for separate child health programs.

7. Full Investigation, Resolution, and Reporting Requirements (§ 457.930)

We would specify that the State must establish and implement effective procedures for investigating and resolving suspected and apparent instances of fraud and abuse. While we would preserve State flexibility in tailoring processes to best suit their specific State program needs, we note that States may model their approaches, to the extent necessary as determined by the State, after fraud and abuse investigation, resolution, and reporting congruent with the Medicaid State agency processes and procedures as outlined in §§ 455.15, 455.16, and 455.17 of the Medicaid regulations. For example, the State must work in conjunction with law enforcement officials and the Medicaid State program integrity unit. Some States may choose to adopt the existing Medicaid State agency process for fraud and abuse investigation, resolution, and reporting activities. However, MFCUs may only use Medicaid funding for fraud and abuse activities in States that provide child health assistance under a Medicaid expansion program. Medicaid funding cannot be used for fraud investigation activities in separate child health programs. This is because all MFCU professional staff being paid with Medicaid dollars must be full-time employees of the Medicaid fraud agency and devote their efforts exclusively to Medicaid fraud activities. However, to the extent that States want to allocate additional non-MFCU full-time staff, using CHIP dollars, to work exclusively on fraud and abuse investigation in separate child health programs, they may do so. States may choose to do this in conjunction with a State program integrity unit. We note that expenditures for this purpose would be subject to the 10 percent cap on administrative costs.

States with separate child health programs may choose to implement distinct and separate processes for investigating and resolving fraud and abuse cases. In addition, some States may choose to use some of the existing processes in their Medicaid State agency together with new and separately developed fraud and abuse processes. Regardless of the approach that States choose, we believe it is imperative that fraud and abuse processes under a separate child health program maintain a sense of continuity including elements that are generally consistent with other State programs and that are familiar to State officials, law enforcement officials, and the general public. Moreover, maintaining this sense of commonality in the State's programs may help to mitigate the risk of increasing confusion among entities that report fraud and abuse, and may help to promote synergy between CHIP and other State programs regarding fraud and abuse investigation, resolution, and reporting activities.

Therefore, we propose that the State must establish and implement effective procedures for handling suspected and apparent instances of fraud and abuse. We further propose that, once the State determines that a full investigation is warranted, the State may implement certain procedures. Specifically, we would provide that, to the greatest extent possible, the State must cooperate with and refer fraud and abuse cases to the State program integrity unit when requested to do so

by that unit. The State program integrity unit would also refer fraud cases to appropriate law enforcement officials.

8. Sanctions and Related Penalties (§ 457.935)

Under the authority of section 2107(e) of the Act, and consistent with the requirements under Federal and State health care programs, we would specify that a State may not make payments for any item or service furnished, ordered, or prescribed under a separate child health program to any contractor who has been excluded from participating in the Medicare and Medicaid programs. We note that our authority stems from section 1128 of the Act regarding exclusion of certain individuals and entities from participation in Medicare and State administered health care programs. We assert this authority because section 1128 specifically references the authority in sections 1124, 1126, 1128A, and 1128B of the Act, which also have been included under section 2107(e) of the Act and apply to the Children's Health Insurance Program in the same manner as applied to a State's Medicaid program under title XIX. Accordingly, we would specify that the separate child health programs are subject to program integrity provisions set forth in the Act including: (1) Section 1124 relating to disclosure of ownership and related information; (2) section 1126 relating to disclosure of information about certain convicted individuals; (3) section 1128A relating to civil monetary penalties; and (4) section 1128B(d) relating to criminal penalties for acts involving Federal health programs. In an effort to promote enforcement of this subsection and to provide HCFA and the Secretary with critical fraud and abuse data, we would specify that the separate child health programs are subject to the requirements of section 1128E of the Act in the same manner as applied to the Medicare and Medicaid programs. In accordance with section 1128E of the Act, we would consistently specify that the State child health plan be subject to the requirements pertaining to the reporting of final adverse actions on liability findings made against health care providers, suppliers, and practitioners. In addition, States must share such information and data with the Office of the Inspector General in an effort to promote enforcement.

9. Procurement Standards (§ 457.940)

Section 2101(a) of the Act requires that States provide services in an effective and efficient manner. We believe that Congress intended that title XXI funds be used to provide health services to the maximum number of uninsured children possible. Therefore, we have an obligation to ensure that States use these funds in a cost-effective manner. In order to meet this obligation, we have set forth provisions at proposed § 457.940 regarding procurement standards. We note that these provisions do not include Federal oversight of provider payments. Rather, we propose to require that States set rates in a manner that most efficiently utilizes limited CHIP funds.

We propose to require that States provide HCFA with a written assurance that title XXI services will be provided in an effective and efficient manner. The assurance must be submitted with the initial CHIP plan or, for States with approved CHIP plans, with the first request to amend the CHIP plan submitted to HCFA following the effective date of these regulations.

If States contract with entities for CHIP services, they must provide for free and open competition, to the maximum extent possible, in the bidding of all contracts for title XXI services in accordance with the procurement requirements of 45 CFR 74.43. As a grant program, title XXI is subject to the requirements of 45 CFR part 74 (Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations; and Certain Grants and Agreements with States, Local Governments and Indian Tribal Governments), including part 74.43.

Alternatively, States may base title XXI fee-for-service or capitated rates on public or private payment rates for comparable services. We believe that this option will give States maximum flexibility and will permit them to take advantage of local market forces in establishing CHIP rates. We propose that if a State finds it necessary to establish higher rates than would be established using either of the above methods, it may do so if those rates are necessary to ensure sufficient provider participation or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. This method will allow States the flexibility to establish higher rates to attract providers in under-served areas or to enroll more costly specialty providers.

We also propose that States must provide HCFA with a description of the manner in which they develop CHIP rates. The description would include an assurance that the rates were competitively bid or an explanation of the applicability of the exceptions of 45 CFR part 74, a description of the public or private rates that were used to set the CHIP rates, if applicable, and/or an explanation of why rates higher than those that would be established using either of these two methods is necessary. The description must be submitted to HCFA when a State first determines its rates or, for approved CHIP plans, when it updates its rates or changes its reimbursement methodology.

10. Certification for Contracts and Proposals (§ 457.945)

In addition to the proposed requirements in § 457.950, which specify that contractors must certify payment data is accurate, truthful, and complete, we would also specify in § 457.945 that entities that contract with the State must also certify the accuracy, completeness, and truthfulness of information in contracts, requests for proposals, information on subcontractors, and other related documents as specified by the State. We are proposing this requirement to meet our need for accountability under CHIP (as discussed in our rationale for proposed § 457.915) and to address the concerns of the OIG, DOJ, and HCFA regarding program integrity assurances from its contractors.

11. Contract and Payment Requirements Including Certification of Data That Determines Payment (§ 457.950)

We believe it imperative that CHIP payments for health care services are based on accurate and validated claims information and supporting data from managed care organizations and health care providers. As the majority of approved State child health plans offer some type of managed care delivery, we believe the issue of certification of payment data is important to ensuring program integrity in State child health plans. In addition, we share the concerns of our other Federal government partners that adequate steps must be taken by States to ensure the accuracy, completeness, and truthfulness of data by contracting entities.

Therefore, at § 457.950 we propose that when CHIP payments to managed care entities are based on data submitted by the MCE, the State must ensure their contracts with MCEs provide that the data include, but are not limited to, enrollment information and other information required by the State. We also provide that as a condition for receiving payment, the MCE must attest to the accuracy, completeness, and truthfulness of claims and payment data. We would provide that as a condition of participation in the

separate child health program, MCEs must provide the State with access to enrollee health claims data and payment data, as determined by the State and in conformance with the appropriate privacy protections in the State. We also propose that managed care contracts must include a guarantee that the MCE will not avoid costs for services, such as immunizations, covered in its contract by referring individuals to publicly supported resources (for example, clinics that are funded by grants provided under section 317 of the Public Health Service Act).

We would provide that when CHIP payments are made to fee-for-service entities, the State must establish procedures to ensure and attest that information on provider claim forms is truthful, accurate, and complete. We also propose that as condition of participation in the State plan, fee-for-service entities must provide the State with access to enrollee health claims data and payment data, as determined by the State.

12. Conditions Necessary To Contract as a Managed Care Entity (MCE) (§ 457.955)

In addition to implementing program integrity protections at the State level, we would specify under § 457.955 that the State must ensure MCEs have in place fraud and abuse detection and prevention processes. These processes would include mechanisms for the reporting of information to appropriate State and Federal agencies on any unlawful practices by subcontractors or enrollees of MCEs. In order to maintain privacy protections for enrollees, we propose that the reporting of information on enrollees would be limited only to information on violations of law pertaining to the actual enrollment, provision of, and payment for health services. Furthermore, we would provide that the State maintains the authority and the ability to inspect, evaluate and audit MCEs as determined necessary by the State in instances where the State determines that there is a reasonable possibility of fraudulent or abusive activity.

We believe these requirements are necessary because the majority of States utilize managed care delivery for children's health benefits coverage. In addition, we believe that our proposed requirements for CHIP managed care contracting in the area of program integrity are similar to the program integrity assurances specified in § 438.606 of the proposed Medicaid managed care provisions, published on September 29, 1998 (63 FR 52022). However, we note that MCEs are accountable to the State, and not to the Federal government. We believe this approach allows MCEs and States maximum flexibility in developing mechanisms for reporting on violations of law that are most effective and efficient for the unique operation of the MCE, and are also in the best interest of the specific State child health plan.

We propose that States that have Medicaid expansion programs and contract with MCEs under section 1903(m) of the Act may arrange for an annual independent, external review of the quality of services (EQR) delivered by each MCE as provided for under section 1932(c)(2) of the Act. States are permitted to draw down 75 percent FFP for this activity. States with separate child health programs are encouraged to provide for EQR of each MCE under contract to provide services to CHIP enrollees; however, the State must use funds within the 10 percent limit for administrative activities.

13. Reporting Changes in Eligibility and Redetermining Eligibility (§ 457.960)

If a State chooses to require that individuals report changes in circumstances during an eligibility period, we propose to require that the State: (1) establish procedures to ensure that beneficiaries make timely and accurate reports of any changes in circumstances that may affect eligibility; and (2) promptly redetermine eligibility when it receives information about changes in a child's circumstances that may affect his or her eligibility.

We believe that these two requirements are important in addressing our concern that children are appropriately enrolled in the program.

14. Documentation (§ 457.965)

To ensure the integrity of the program, we propose to require that each applicant's record include certain facts that would, if necessary, support the State's determination of a child's eligibility. This documentation should be consistent with standard State laws and procedures.

15. Eligibility and Income Verification (§ 457.970)

A key to successfully enrolling children in CHIP and Medicaid is a simple application and enrollment process. A burdensome application and enrollment process can be a significant barrier to successful enrollment. However, it is important that States have in place procedures designed to assure program integrity. We propose to require that States have in place procedures designed to assure the integrity of the eligibility determination process, and to abide by verification and documentation requirements applicable to separate child health programs under other Federal laws and regulations. We propose that States have flexibility to determine these documentation and verification requirements, and can use self-declaration of income and assets.

States with separate child health programs are not required to use the Medicaid income and eligibility verification system (IEVS) for income and resources or to adopt a similar system.

Nonetheless, the establishment of effective program integrity procedures as part of the eligibility determination process is an integral part of providing coverage under a separate child health program in an effective and efficient manner as required under section 2101(a), and of ensuring accountability to State and Federal executive and legislative authorities. We encourage States to adopt procedures that assure accountability but do not create barriers in the application and enrollment process. For example, a State that provides for self-declaration by the applicant of income and assets could conduct random post-eligibility verification or adopt other procedures designed to assure program integrity.

The State could also use the Medicaid IEVS verification system, or some variation of it. For eligibility requirements that pose particular program integrity problems, the State could require verification or documentation as part of the eligibility determination process.

We would also allow a State to terminate the eligibility of a beneficiary for ''good cause'' other than failure to continue to meet the requirements for eligibility. An example of ''good cause'' would be if any information or other action causes the beneficiary to fail to meet the requirements of income and eligibility verification as reasonably determined by the State. For example, a reasonable basis for termination would exist in a case where the applicant provided false information about an eligibility requirement. Beneficiaries terminated for good cause must be given a notice of the termination decision that sets forth the reasons for termination and provides a reasonable opportunity to appeal the termination decision as specified in section 457.985.

16. Redetermination Intervals in Cases of Suspected Enrollment Fraud (§ 457.975)

Among our highest priorities is to ensure that a State child health assistance program actually provides health assistance to the individuals

Congress designed the program to serve. That is, we want the State to ensure that children applying for CHIP, but who are eligible for Medicaid or any other form of health assistance, are enrolled in those programs if appropriate. Furthermore, if a State suspects enrollment fraud, the State should periodically disenroll from the program beneficiaries that no longer meet the eligibility standards under section 2102 of the Act for any reason including a change in age, income, or source of other health coverage. If a State suspects enrollment fraud, the State may, at its own discretion, perform eligibility redeterminations at any frequency that the State considers to be in the best interest of the CHIP program.

17. Verification of Enrollment and Provider Services Received (§ 457.980)

Integral to a sound program integrity strategy is the ability to ensure that services billed by contractors are actually received by enrollees. Under the Medicaid program, this is accomplished in large part by the claims processing system used by States, the Medicaid Management Information System (MMIS). The MMIS captures provider and service information on claims and provides individual notices, within 45 days of the payment of claims to all or a sample group of enrollees receiving the services. These requirements and procedures under the Medicaid program are specified under §§ 455.20 and 433.116 accordingly. While States with Medicaid expansion programs are subject to these Medicaid requirements, we want to ensure that separate child health programs have procedures in place to verify receipt of provider services. We recognize that some States may choose to use the existing claims processing system for Medicaid expansion programs. However, some States may choose to use separate systems for the separate child health program. In these cases, we would specify that the program must have established systems and procedures for verifying enrollee receipt of provider services. In addition, we would specify that the State must establish and maintain systems to distinguish and report enrollee claims for which the State receives enhanced FMAP payments under section 2105 of the Act. We believe that the requirements specified above would serve as a fundamental component of other program integrity activities in this proposed rule, including the fraud detection and investigation efforts as discussed under §§ 457.915, 457.925, 457.930.

18. Enrollee Rights To File Grievances and Appeals (§ 457.985)

Section 2101 of the Act allows the Secretary to provide health assistance in an effective and efficient manner that promotes the best interests of enrollees. Under this authority, we would specify that the State must allow enrollees the right to due process in circumstances where their health care services were denied, suspended, terminated or reduced by the State or by its providers. Specifically, we propose that States must afford individuals the opportunity to file grievances and appeals regarding denial, suspension or termination of eligibility; reduction or denial of services provided for in the State's plan; and disenrollment for failure to pay cost-sharing. Sections 457.365, 457.495, and 457.560 respectively require that this section applies in these specific circumstances.

We would specify that separate child health programs must establish and maintain written procedures for grievances that are consistent with the health industry practices currently in effect in the particular State. Such procedures must include a guarantee that the grievance and appeals processes will be resolved within a reasonable period of time. An example of a reasonable period of time would be as proposed in the Medicaid managed care rule (63 FR 52022), a period of 30 calendar days or 72 hours in an expedited case.

We would further require that these procedures for grievances meet the State rules and regulations for grievances and appeals that are currently in effect for health insurance issuers (as defined in section 2791(b) of the Public Health Service Act) within the State. We would require these provisions for grievances and appeals on a State-specific basis because we realize that procedures may vary from State to State, and States may also modify their own requirements as circumstances warrant. Furthermore, we encourage States to use the grievance procedures as described in part , subpart E regarding fair hearings for Medicaid applicants and recipients, and the Medicaid grievance and appeal procedures for Medicaid managed care entities, which were set forth in the Medicaid Managed Care proposed rule (63 FR 52022).

The State should maintain effective, efficient, and timely processes for grievances, appeals, and determinations for its enrollees. In addition, the State child health program and its providers should ensure that all enrollees receive written information about the grievance and appeal procedures that are available to them. We believe that assuring CHIP enrollees of their grievance rights is consistent with the Administration's ongoing efforts to institute the *Consumer Bill of Rights and Responsibilities* for all Federal health programs.

We are concerned that beneficiaries be afforded the right to make informed decisions about their medical care free from any form of financial incentive or conflict of interest involving their provider of care that could directly or indirectly affect the kinds of services or treatment offered or provided. Therefore, we propose that the State must guarantee, in all contracts for coverage and services, beneficiary access to information related to actions which could be subject to appeal in accordance with the ''Medicare+Choice'' regulation at § 422.206, which discusses the prohibition of ''gag rules'' and protection of enrollee-provider communications, and § 422.208 and § 422.210(a) and (b) which discuss physician incentive limitations and requirements for information disclosure to beneficiaries. We remain committed to ensuring that appropriate actions are taken to guarantee the protection of enrollee rights regarding their health care services under the Medicare, Medicaid, and CHIP programs.

19. Privacy Protections (§ 457.990)

Privacy protections are an essential part of an effective and efficient program because these protections ensure beneficiary trust and honest communication with caregivers and payers. Furthermore, protecting the rights of beneficiaries is of paramount importance in our overall efforts to manage and oversee Federal and State health care programs. This can be evidenced through recent activities including the Administration's commitment to the *Consumer Bill of Rights and Responsibilities,* as well as HCFA's focus on beneficiary rights as demonstrated in the recent Medicare+Choice regulations set forth at part 422 and the proposed Medicaid managed care regulations published on September 29, 1998 (63 FR 52022). For example, the Medicare+Choice regulations at § 422.118 and the proposed Medicaid managed care regulations at § 438.324 set forth provisions that address enrollee privacy protections in the areas of ensuring original medical records and information are released only in accordance with Federal or State law, or court orders or subpoenas; safeguarding the privacy of information; maintaining accurate and timely information and

records; abiding by all State and Federal laws concerning confidentiality and disclosure of information; protecting the confidentiality and privacy of minors in accordance with Federal and State law; prohibiting the access to or tampering with records by unauthorized individuals; ensuring that enrollees have timely access to their records and to information that pertains to them; and ensuring that MCOs release records and information only to authorized individuals.

In light of these concerns, and our obligation under section 2102(a)(1) to ensure that States provide child health assistance in an effective and efficient manner, we would specify that the State plan must assure that the program complies with the title XIX provisions as set forth under part , subpart F—Safeguarding Information on Applicants and Recipients. Moreover, we would provide that the State plan must assure the protection of information and data pertaining to beneficiaries by providing that all contracts will include guarantees that:

- Original medical records are released only in accordance with Federal or State law, or court orders or subpoenas;
- Information from or copies of medical records are released only to authorized individuals;
- Medical records and other information are accessed only by authorized individuals;
- Confidentiality and privacy of minors is protected in accordance with applicable Federal and State law;
- Enrollees have timely access to their records and to information that pertains to them; and
- Beneficiary information is safeguarded by following all Federal and State laws that pertain to confidentiality and disclosure of mental health records, medical records, and all other applicable health and other information specific to enrollees.

Furthermore, we continue to be concerned about privacy issues as more States utilize electronic media such as the Internet to transmit enrollee health care information. For example, some States have indicated their intent to allow for the completion of CHIP applications on-line, to allow for the downloading of completed applications and patient enrollment records by authorized users, and to allow on-line access to eligibility systems for qualified providers. For States choosing to pursue these types of activities, we would specify that State child health plans sending data to HCFA through the Internet will be subject to *HCFA's Internet Security Policy* regarding confidentiality of data transmissions (found on HCFA's website at ''www.hcfa.gov''). Data transmissions between providers, health plans, and the State would also be subject to these requirements. In addition, we would specify that State child health plans are subject to any Federal requirements as well as requirements set forth by their State regarding information disclosure, including use of the Internet to transmit CHIP data between and among the State and its providers. Data transmissions between providers, health plans, and the State would be subject to these requirements also. Finally, we would provide that the State must assure that the program will be operated in compliance with all applicable State and Federal requirements to protect the confidentiality of information transmitted by electronic means, including the Internet.

20. Overview of Beneficiary Rights (§ 457.995)

In February 1998, the President directed the Department of Health and Human Services, along with the Departments of Labor, Defense and Veterans' Affairs and the Office of Personnel Management, to use their regulatory and administrative authority to bring their health programs into compliance with the *Consumer Bill of Rights and Responsibilities,* as proposed by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Since that time, HHS has moved aggressively to strengthen existing consumer protections under the Medicare and Medicaid programs. In particular, in developing regulations implementing the Medicare and Medicaid managed care provisions of the Balanced Budget Act of 1997, we have been able to meet or substantially address all of the rights identified in the *Consumer Bill of Rights and Responsibilities.* The Interim Final Rule for Medicare, published on June 26, 1998 (63 FR 34968), has largely taken effect as of January 1999, with the implementation of the Medicare+Choice program. The Notice of Proposed Rulemaking for Medicaid managed care, published on September 29, 1998 (63 FR 52022), expanded and codified protections for Medicaid beneficiaries enrolled in managed care arrangements. However, this regulation will not be fully implemented until the States incorporate the changes into their new contracts, one year after the publication of the final rule, which is expected to be issued in late 1999.

The Children's Health Insurance Program was also established by the Balanced Budget Act of 1997. The protections that apply to the general Medicaid program also apply to States that expand existing Medicaid programs as a means of implementing CHIP. In considering how to apply the President's directive for consumer protections in separate child health programs, we have attempted to balance the Administration's desire to ensure consumer rights for the broadest population with the need to preserve State flexibility. In this spirit, we have identified the following rights for enrollees in separate child health programs. We welcome public comments on how best to address the *Consumer Bill of Rights and Responsibilities* or other needed beneficiary protections in this regulation.

- Information Disclosure

The Consumer Bill of Rights and Responsibilities provides that consumers should receive accurate, easily understood information and assistance in making informed health care decisions about their health plans, professionals, and facilities.

Section 2102(c) of the Act requires that State plans include procedures ''to inform children of the availability of child health assistance and to assist in enrolling children.'' We implement this provision of the Act at § 457.65—Duration of State plans and plan amendments, and § 457.110—Enrollment assistance and information requirements, and § 457.525—Public notice of cost sharing requirements.

- Choice of Providers and Plans

The State must provide applicants and enrollees with assistance in making informed health care decisions (§§ 457.110 and 457.985(e)) and have methods to assure appropriate and timely procedures to monitor and treat enrollees with complex and serious medical conditions, including access to specialists (§ 457.735). We note that this provision is similar to the provisions set forth in the proposed Medicaid Managed Care regulation.

- Access to Emergency Services

The *Consumer Bill of Rights and Responsibilities* provides that consumers should have access to emergency health services. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—that a ''prudent layperson'' could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily

functions, or serious dysfunction of any bodily organ or part.

Section 2102(a)(7)(B) of the Act expressly requires that States include in their CHIP plans methods ''to assure access to covered services, including emergency services.'' We have proposed to apply in the benefits section (§ 457.402) the definitions of emergency services, emergency medical condition, and post-stabilization services, which were included in the President's directive and proposed in the Medicaid managed care regulation. In addition, the proposed regulation text at § 457.735—State plan requirement: State assurance of the quality and appropriateness of care, further addresses the right to emergency services.

- Participation in Treatment Decisions

The *Consumer Bill of Rights and Responsibilities* would give consumers the right and responsibility to participate in treatment decisions and to be represented if not able to do so. Enrollees in separate child health programs have the opportunity to make such decisions and to receive the pertinent information (§ 457.110). In addition, States must prohibit gag rules and establish principles for disclosure of physician financial arrangements that could affect treatment decisions (§ 457.985(e)).

- Respect and Nondiscrimination

The *Consumer Bill of Rights and Responsibilities* sets forth that consumers have the right to considerate, respectful care that is free of discrimination in the delivery of health care services, as well as, marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

We have proposed to apply general grant requirements to both States and contractors (health plans) that preclude discrimination based on race, sex, ethnicity, national origin, religion, or disability. The proposed regulation text addresses this right at § 457.130—Civil rights assurance.

- Confidentiality of Health Information

The *Consumer Bill of Rights and Responsibilities* provides that consumers should be permitted to communicate with health care providers in confidence and to have the confidentiality of their individually-identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

We believe that privacy protections are essential to effective and efficient operation of a separate child health program, and have proposed to require such protections at proposed § 457.990—Privacy protections. In addition, we would require that the State program comply with other applicable Federal and State laws used to enforce confidentiality. These proposed requirements are based on our authority under section 2102(a)(1) of the Act to require that child health assistance is furnished in an effective and efficient manner. We believe protecting the confidentiality of patient information is essential to ensure that families will be willing to enroll eligible children and seek benefits under the program. We would require the program to be in compliance with all applicable State and Federal rules concerning confidentiality.

- Grievances and Appeals

The *Consumer Bill of Rights and Responsibilities* provides that a fair and efficient process should be in place for resolving differences with health plans and other health care providers, including a system of timely internal and external review of grievances and a meaningful process for addressing complaints.

Section 2103 specifies the parameters of the coverage that must be part of a CHIP plan. In order to ensure that this coverage is actually furnished as specified in that section, and in the approved State plan, we propose to require that States and their contractors afford beneficiaries a ''fair and efficient'' appeals process, consistent with rules applicable to health insurance issuers in the State.

The regulation also proposes at § 457.985 that States must have written processes in place and notify enrollees of those processes and rights in accordance with procedures used by health insurance issuers in the State and that States must ensure that resolution is reached within a reasonable time period (for example, 30 days or 72 hours in an expedited case).

I. Subpart J—Allowable Waivers: General Provisions

1. Basis, Scope, and Applicability (§ 457.1000)

At proposed § 457.1000 we would provide that this subpart interprets and implements the requirements for a waiver to permit a State to exceed the 10 percent cost limit on expenditures under section 2105(c)(2)(B) and to permit the purchase of family coverage under section 2105(c)(3) of the Act. This subpart applies to a separate child health program and to a Medicaid expansion program only to the extent that the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims in light of a community-based health delivery system.

2. Waiver for Cost-Effective Coverage Through a Community-Based Health Delivery System (§ 457.1005)

Proposed § 457.1005 would interpret and implement section 2105(c)(2)(B) of the Act regarding waivers authorized for cost-effective alternatives. As stated above, on March 4, 1999, we published a proposed regulation that set forth financial requirements for the CHIP program (64 FR 10412). In § 457.618 of that proposed rule, we set forth requirements to implement sections 2105(c)(1) and (c)(2)(A) of the Act, which contain provisions related to the 10 percent limit on certain CHIP expenditures. In § 457.1005, we specify the proposed requirements for a State wishing to obtain a waiver of the 10 percent limit on expenditures not used for child health assistance in the form of health benefits coverage that meets the requirements of § 457.410 of these proposed regulations. This section also clarifies the extent to which the State will be allowed to exceed the 10 percent limitation on expenditures in order to provide child health assistance to targeted low-income children under the State plan through cost-effective, community-based health care delivery systems. This waiver was designed to create flexibility for States to provide child health coverage using community-based delivery systems. A State could use the waiver, for example, to provide child health coverage for special groups, such as children who are homeless or who have special health care needs. Congress did not intend that the waiver be used simply to allow for more administrative spending or outreach services under section 2105(a)(2), and the statute does not provide this flexibility.

To receive payment for cost effective coverage through a community-based health delivery system under an approved waiver, we propose that the State must demonstrate that—

- Such coverage meets the coverage requirements of section 2103 of the Act and subpart D of these proposed regulations; and
- The cost of coverage through the community-based health care delivery system, on an average per child basis, does not exceed the cost of coverage that

would otherwise be provided under the State plan.

A State may establish a community-based health delivery system through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals receiving disproportionate share payment adjustments under section 1886(d)(5)(F) or section 1923 of the Act. However, these are not the only types of community-based health delivery systems. We believe a community-based delivery system would include a network of providers that has a contract with the State to provide care under title XXI and that traditionally serves the population of targeted low-income children. A State may define a community-based delivery system to meet the specific needs and resources of a community. A State must ensure that its community-based delivery system (either through direct provision or referral) can provide all appropriate services to targeted low-income children in accordance with section 2103 of the Act. In addition, all participating community-based providers must comply with all other title XXI provisions.

It is not necessary for States to serve all of their CHIP enrollees through a cost-effective, community-based delivery system in order to receive an approved waiver. A State may receive a waiver for each system or network delivering care in a particular geographic area in order to avail itself of cost-effective health coverage alternatives.

We propose that an approved waiver will remain in effect for two years. A State may reapply three months before the end of the two-year period.

We propose that, notwithstanding the 10 percent limit on expenditures described in proposed § 457.618, 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 cost savings for—

- Child health assistance to targeted low-income children and other low-income children other than the required health benefits coverage, health services initiatives, and outreach; or
- Any reasonable costs necessary to administer the State Children's Health Insurance Program.

The following example clarifies this permissible use of cost savings. In a given State, assume that a child has three health benefit plans under title XXI from which to choose. Two options are title XXI managed care plans that have annual capitated rates of $1000 and $1020 respectively. One option is a plan offered through a community-based delivery system at an annual cost of $900. By enrolling a child in the community-based plan, the State has saved at least $100. If there are 4,000 children enrolled in the community-based provider system, the State has saved at least $400,000. As a result, the State could exceed the 10 percent cap by, and receive match for, an additional $400,000. If the 10 percent cap on expenditures in this State had been estimated to be $1,000,000 without the waiver, then the waiver under this scenario would increase the estimated cap to $1,400,000.

3. Waiver for Purchase of Family Coverage (§ 457.1010)

A State must apply for a family coverage waiver when any title XXI funds are used to purchase coverage for adult family members in addition to targeted low-income children. For example, the State may wish to purchase employer sponsored group health coverage for a child but the employer does not offer a policy that covers only the child(ren) in addition to the employee. In this case, the State will be subsidizing the cost of both children and adults and, therefore, the State must apply for a family coverage waiver. In the case where employers offer ''tiered'' coverage where a State can identify the cost of one, two or more dependents, the State may use title XXI funds to only cover a child and, therefore, does not need to seek a family coverage waiver. In addition, if the State has created a special child-only option in which employers may participate and, as a result, is providing coverage for children only, a family coverage waiver would not be needed. In this context, the State simply needs to identify in its State plan how it intends to provide this coverage. All other requirements of title XXI must be met.

We are seeking comments on whether the benefits specified in title XXI also apply to adults in a family coverage waiver. For example, if a State offers ''wraparound coverage'' to bring an employer's benefits up to the title XXI standards, we would seek comments as to whether the State should be required to offer this additional coverage to adults under the family waiver.

Proposed § 457.1010 would implement section 2105(c)(3) of the Act under which the Secretary may allow a State to purchase family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children. As set forth in subpart A of this proposed rule, ''group health plan'' has the same meaning as given the term under section 2791 of the Public Health Service Act. The term means an employee welfare benefit plan (as defined in section 3(1) of ERISA) to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.

Also as set forth in subpart A, ''health insurance coverage'' has the same meaning as given the term under section 2791 of the Public Health Service Act. It means benefits consisting of medical care (provided directly through insurance or reimbursement or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

There is no statutory definition of family coverage for the purposes of this subpart. We are therefore soliciting input from commenters on the definition of ''family'' for purposes of this subpart. We believe ''family'' may be defined differently for different subparts of this regulation and are requesting input on this issue. A specific definition may be important for this subpart because it may define what types of adult family members can receive health benefits coverage under a family coverage waiver. However, we may not want to define ''family'' in this subpart since it is also possible that a group health plan offered by an employer may include a definition of ''family'' for coverage purposes.

Based on the language of section 2105(c)(3) of the Act, we propose at § 457.1010 that a waiver for family coverage will be approved by the Secretary if—

- Purchase of family coverage is cost-effective under the standards described in § 457.1015 of this subpart;
- The State will not purchase such coverage if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage; and
- The coverage for the child otherwise meets the requirements of this part.

4. Cost-Effectiveness (§ 457.1015)

This section defines cost-effectiveness and describes the procedures for establishing cost-effectiveness for the purpose of a waiver for the purchase of family coverage.

We propose that cost-effectiveness means that the cost of purchasing family

coverage under a group health plan or health insurance coverage that includes coverage for targeted low-income children is not greater than the State's cost of obtaining such coverage only for the eligible targeted low-income children involved. Stated more simply, cost effectiveness means that the cost of providing family coverage (including coverage for the parents) under title XXI is equal to or less than the cost of covering only the uninsured children.

• Cost Comparisons

The following is a discussion of our proposed requirements regarding methods for cost comparison the State may use to demonstrate cost-effectiveness. A State may demonstrate cost-effectiveness by comparing the cost of family coverage that meets the requirements of § 457.1010 and 457.1015 of this subpart, to the cost of coverage only for the targeted low-income children under the health benefits packages offered by the State under the State plan for which the child is eligible. We have not identified specific alternatives for cost comparison for family coverage under CHIP. However, we recognize the growing interest of States to utilize this option in order to keep families together under one health plan as this practice may result in increased access to and utilization of preventive and other necessary health services for children. Therefore, we are willing to examine alternatives and invite comment on additional methods to demonstrate cost-effectiveness. We note that the most likely option for meeting the cost-effectiveness standard is the purchase of family coverage through an employer sponsored group health plan because the employer is subsidizing a large part of the costs. States must meet the requirements designed to prevent substitution of coverage (as specified in subpart H), when employer-sponsored coverage is purchased.

Illustration of cost comparison. The cost of employer-sponsored family coverage (for the employee and two children) is $600. The employer pays 60 percent of the cost, which is $360, and the employee therefore pays $240. Under the State's CHIP plan there is a $10 monthly premium for each child with a maximum premium amount of $30 per family. The State pays $150 per child per month for the State CHIP coverage less the premiums paid by the family. The State would apply the cost-effectiveness test by calculating the cost to the State of the family coverage, which would be $220 for the employee and two children ($240 − $20 premium = $220), and comparing that cost to the cost of the State CHIP coverage for the children, which would be $280 ($150×2 − 2×$10 premium = $280). The comparison of $220 compared to $280 shows that family coverage costs $60 less per month than CHIP coverage only for the children. When there is such a savings the State could buy family coverage through the employer or provide CHIP coverage to the uninsured child or children only.

Thus far, no State has proposed to provide cost-effective family coverage other than through employer-sponsored coverage. However, the proposed regulation provides flexibility so that, if a State develops another type of cost-effective coverage, we may consider that alternative. We are also working with States to identify other feasible, cost-effective models. We have identified this method through the State plan approval process as one that States have proposed for applying the cost-effectiveness test that meets Federal requirements. We also note that the cost comparison must be made to the health benefits package the child is actually eligible for if a State offers different packages of services to different populations of children. For example, a State may offer children with special health care needs additional services under a separate health benefits package. The cost comparison would have to be made to this separate health benefits package if the cost effectiveness test was being done for a special needs child.

• Cost-Effective Comparison to Actual Coverage Available in the State

We propose that the determination of cost-effectiveness must be made based on costs for health benefit coverage that is actually available for purchase in the State. States should not use hypothetical premium rates and family sizes in demonstrating cost-effectiveness. For example, if a State proposed to demonstrate cost-effectiveness based on the assumption that the average family consists of 3.14 family members (1.7 children and 1.44 adults), we would not approve of this approach as further explained. Using this example and assumptions, the cost to cover 1.7 children in a State employees' health plan would be $407.13 (if the total family premium was $752 divided by 3.14 family members, times 1.7 children). The State asserts it can cover the entire family under its separate child health program for $367.38 (3.14 family members times $117 per member per month). This comparison shows that it costs $39.75 less to cover the family ($407.13 to cover 1.7 children minus $367.38 to cover the family). However, this would not be acceptable because it is a hypothetical plan and not a plan that a family can actually buy for its children in the State. In addition, we believe demonstrations of cost-effectiveness must examine the actual family sizes, rather than average family size.

With respect to applying the cost-effective test, we are requiring States to make available to HCFA documentation on how much was spent on family coverage and report how many children and adults were covered. We are proposing that the State may base its demonstration of the cost-effectiveness of family coverage on an assessment of cost-effectiveness of family coverage for individual families, done on a case-by-case basis, or for family coverage in the aggregate.

We are proposing to require the State to apply the cost-effectiveness test annually. If an annual assessment of the cost-effectiveness of family coverage in the aggregate reveals that it is not cost-effective, the State must begin assessing cost-effectiveness on a case-by-case basis.

• Cost-Effectiveness of Family Coverage on a Case-by-Case Basis

If a State chooses to apply the cost-effectiveness test on a case-by-case basis, the State must compare the cost of coverage for each family to the cost of coverage for only the child or children in the family under CHIP.

This approach favors larger families because most insurers offer one rate for family coverage regardless of the number of children in the family. Also, this approach may be resource and labor intensive for some States.

• Cost-Effectiveness of Family Coverage in the Aggregate

If a State chooses to apply the cost-effective test in the aggregate, the State must provide an estimate of the projected total costs of the family coverage program compared to the cost the State would have incurred for covering just the children in those families under the publicly available CHIP plan. Subsequently, on an annual basis, the State must compare the total cost of covering all families for whom the State has purchased family coverage to the cost the State would have incurred covering just the children in those families under the publicly available CHIP plan as outlined below. If the aggregate cost of family coverage was less than the cost to cover the children in the publicly available program, then the family coverage would be considered cost-effective. If the State determines through its annual

assessment of cost effectiveness that family coverage is not cost-effective in the aggregate, then the State must begin to apply the cost-effectiveness test on a family-by-family basis.

Under this approach, States would report how much was spent on family coverage and report how many children and adults were covered. This test would be applied retrospectively and would represent an aggregate cost of family coverage across all plans. The aggregate cost would be verified by the claims submitted by the State. No additional FFP above the cost-effective amount will be paid for these children and families if the test shows that family coverage is not cost-effective for the period. This option requires States clearly to separate the costs of the family coverage from the costs of coverage under the rest of the program.

Using the retrospective approach may potentially create some difficulties for States in calculating cost-effectiveness (for example, timely submission of State data, State systems may not be able to produce necessary data, vagaries of using historical data that may not capture recent changes). We will work with States to develop guidance on how to conduct retrospective assessments of cost-effectiveness.

K. Expanded Coverage of Children Under Medicaid and Medicaid Coordination

The proposed regulations discussed in this subsection are changes to Medicaid regulations found in parts, 433, and 435. This subpart applies to Medicaid only.

Section 4911 of the Balanced Budget Act of 1997 (BBA '97), Public Law 105–33, enacted on August 5, 1997 and amended by section 162 of the DC Appropriations Act, Public Law 105–100, enacted on November 19, 1997, established a new optional categorically needy eligibility group known as ''optional targeted low-income children.'' The law provides for an enhanced Federal matching rate to be used to determine the Federal share of State expenditures for services to children eligible under this group. The BBA also provides for States to receive this enhanced Federal matching rate for services to children who meet the definition of ''optional targeted low-income children'' and whom the State covers by expanding an existing Medicaid eligibility group (for example, poverty-related children). ''CHIP'' itself is not a new or separate Medicaid eligibility group. Medicaid expansion programs under CHIP, which may be referred to as ''M–CHIP,'' consist of the new optional Medicaid eligibility group just mentioned, or coverage of optional targeted low-income children through an expansion of an existing Medicaid eligibility group, or a combination of the two. Section 4912 of the BBA added a new section 1920A to the Act to allow States to provide services to children during a period of presumptive eligibility. Although these proposed regulations are related to title XXI and CHIP, they constitute changes to the Medicaid program. All existing Medicaid regulations also continue to apply.

1. Enhanced FMAP Rate for Children

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

In order to be eligible to receive Federal payments at the enhanced FMAP, a State must:

(1) Not adopt income and resource standards and methodologies for purposes of determining a child's eligibility under the Medicaid State plan that are more restrictive than those applied under the State plan in effect on June 1, 1997;

(2) Have an approved title XXI State plan in effect;

(3) Have sufficient funds available under the State's title XXI allotment to cover the payments involved; and

(4) Maintain a valid method of identifying services eligible for the enhanced FMAP.

For purposes of determining whether an income or resource standard or methodology is more restrictive than the standard or methodology under the State plan in effect on June 1, 1997, we would compare it to the standard or methodology that was actually being applied under the plan on June 1, 1997. For purposes of this section, a pending Medicaid State plan amendment that would establish a more restrictive standard or methodology, but that has an effective date later than June 1, 1997, would not be considered ''in effect'' on June 1, 1997, regardless of when it was submitted. Also, although a State that adopted more restrictive income or resource standards or methodologies than those in effect on June 1, 1997 would not be eligible for enhanced FMAP, we believe that, if a State drops an optional eligibility group entirely, this prohibition against receiving enhanced FMAP does not apply.

The enhanced FMAP discussed in this section will be used to determine the Federal share of State expenditures for services provided to three groups of children. The first group for whom the enhanced FMAP is available is the new optional eligibility group of ''optional targeted low-income children'' described in the new § 435.229.

The second group is children who meet the definition of ''targeted low-income children'' and who would not be eligible under the Medicaid policies in effect under the State plan on March 31, 1997. Thus, a State need not necessarily adopt the new optional group of ''optional targeted low-income children'' to receive the enhanced FMAP for targeted low-income children. The State may receive the enhanced FMAP for these children by covering them under expansions of existing Medicaid groups, as long as the children meet the definition of ''targeted low-income children,'' including the requirement that they be uninsured. (The State may claim its regular FMAP for children with creditable health insurance who are covered under the expansion.)

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

Concerning the second group above, we do not believe that Congress intended to provide enhanced FMAP for services provided to children who, although not eligible under the policies in effect in the Medicaid State plan in effect on March 31, 1997, became eligible after that date due solely to a Federal statutory change or a scheduled periodic cost-of-living increase. We believe that such changes are inherent

in the State plan policies in effect on March 31, 1997. Enhanced FMAP will be available only when children are made eligible because a State elects to adopt an optional policy.

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

2. Optional Targeted Low-income Children

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

Section 1905(u)(2)(B), defines an optional targeted low-income child as a child who meets the definition of a targeted low-income child in section 2110(b)(1) of the Act (see § 457.310(a)) and who would not qualify for Medicaid under the Medicaid State plan as in effect on March 31, 1997.

The very specific cross reference in section 1905(u)(2)(B) to section 2110(b)(1) for the definition of an optional targeted low-income child indicates that the Medicaid definition of an optional targeted low-income child is based only on section 2110(b)(1). Thus, the Medicaid definition does not include the exclusions described in section 2110(b)(2) that would by contrast apply in a separate child health program. Specifically, the exclusions from the definition of targeted low-income children that apply in a separate child health program but not in Medicaid are (1) children who are inmates of public institutions and patients in institutions for mental diseases (IMD), and (2) children of State employees, as outlined in section 2110(b)(2).

Under normal Medicaid eligibility rules, there is no eligibility exclusion of children who are inmates of a public institution, patients in an institution for mental diseases, or members of a family eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State (although restrictions on Federal financial participation may apply under some circumstances). Restrictions on Federal financial participation under Medicaid, however, apply for services provided to inmates of public institutions and patients in institutions for mental diseases. This means no payment can be made for services to individuals residing in an IMD. We note that under Medicaid, FFP is available for services furnished to children in psychiatric facilities for individuals under age 21 that meet certain standards and conditions (see § 441.150ff).

The definition of optional targeted low-income child at section 1905(u)(2)(B) of the Act excludes a child who would have been eligible for Medical assistance under the State plan on March 31, 1997 on any basis including medically needy. This exclusion applies to all children eligible for Medicaid including those eligible under States' medically needy groups. We propose to interpret the exclusion in the following manner. Children who are eligible for Medicaid only after paying a spenddown would not be excluded, because they are not eligible under title XIX until the spenddown is met. However, a child who is medically needy without a spenddown is eligible for Medicaid and therefore cannot be an optional targeted low-income child. Thus, if a child would have qualified for Medicaid as medically needy without a spenddown under the State's March 31, 1997 Medicaid State plan, even if not eligible under current rules, the child could not be covered as an optional targeted low-income child.

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

States that choose to cover the group of optional targeted low-income children are not required to provide coverage to all children who meet the definition of an optional targeted low-income child. As with the current Medicaid program, eligibility can be limited to a reasonable group or reasonable groups of such children. We do not consider it reasonable to limit a group by geographic location because of the requirement in section 1902(a)(1) of the Act that a State plan be in effect in all political subdivisions of the State. Also, we do not consider it reasonable to limit a group by age other than those specified by Congress in section 1905(a)(1) and referenced in section 1902(a)(10)(A)(ii). We believe that if Congress intended to allow use of age to establish a reasonable category, the statutory language would not have specified any ages. We note that in the case of the optional targeted low-income children, a State does not have the option to have a reasonable category of children under age 21 or 20, because the group itself is limited to children under age 19. Although a State may not define a reasonable group by age, the income standard used to determine eligibility under the optional targeted low-income children's group because it is related to income standards used for existing poverty level groups, may be different for infants, children under age 6, and children who have attained age 6 but have not attained age 19, if the State's Medicaid applicable income levels for these age groups differ. Eligibility standards for optional targeted low-income children must be uniform throughout the State. A State is required to provide all services covered under the plan, including EPSDT services, to optional targeted low-income children and apply all regular Medicaid rules, including those pertaining to immigration status.

We are not proposing to require States to apply eligibility-related substitution provisions such as periods of uninsurance to the ''optional targeted low-income children'' group because we believe that such eligibility conditions are inconsistent with the entitlement nature of Medicaid.

A State is obligated to continue to provide services to eligible optional targeted low-income children after the title XXI allotment is exhausted, unless the Medicaid State plan is amended to drop the group of optional targeted low-income children. Once the title XXI allotment is exhausted, Medicaid matching funds are available for these children at the regular matching rate rather than the enhanced rate.

3. Furnishing a Social Security Number

Section 1137(a)(1) of the Social Security Act requires applicants and recipients of Medicaid to furnish the State with their social security number(s) as a condition of eligibility. While the United States Supreme Court in *Bowen* v. *Roy*, 476 U.S. 693 (1986) upheld this requirement, it did so in a plurality decision in which some of the Justices held that the challenge was moot since the claimant had obtained a social security number. That decision did foreclose a challenge to the requirement by an individual who had not already secured a social security number and had religious objections to applying for a number. The Religious Freedom Restoration Act of 1993 also raised questions about the requirements of section 1137(a) of the Act in these cases. Thus, in 1995 HCFA announced a policy which permits States to obtain or assign alternative identifiers to eligible individuals who object to obtaining an SSN on religious grounds. This policy was adopted in order to enable States to administer Medicaid in the most efficient manner possible. While, in 1997, a portion of the Religious Freedom Restoration Act was held to be unconstitutional, that portion only involved the applicability of that Act to State and local officials. The proposed rule seeks to accommodate the purpose of section 1137(a) with the Constitution's protection of freedom of religion and the dictates of the 1993 Act by permitting alternative identifiers.

4. Exemption From the Limitation on FFP

Section 162 of Public Law 105–100 amended section 1903(f)(4) of the Act to add the optional group of targeted low-income children and other children for whom enhanced FMAP is available under § 456.622 (or would be available except for the fact that the title XXI allotment is exhausted) to the list of those who are exempt from the limitations on FFP found in section 1903(f). All previous citations in section 1903(f) were references to Medicaid eligibility groups, whereas this new provision adds not an eligibility group but children on whose behalf enhanced FMAP is available.

With certain exceptions, section 1903(f) limits FFP to families whose income does not exceed 133⅓ percent of the amount that would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments under the program of Aid to Dependent Children. As explained in § 435.1007, this provision effectively limits the use of the authority under section 1902(r)(2) to expand eligibility through the use of more liberal income and resource methodologies for those groups that are not exempt from the limitation. However, to the extent that section 162 of Public law 105–100 resulted in the exemption from the FFP limitation of children other than those in the optional eligibility group of optional targeted low-income children or in other groups already exempt from the FFP limitation, a conflict with the comparability requirements of section 1902(a)(17) of the Act and § 435.601(d)(4) of the Medicaid regulations would arise. We would continue to require that all children within a given group be treated comparably. Therefore, the FFP limitations described in § 435.1007 would continue to apply to all children who are covered as medically needy, and to those covered under an optional categorically needy group other than the new group of optional targeted low-income children or the optional categorically needy groups which are already exempt. However, Federal matching may be available at the enhanced rate for some children in the group.

5. Presumptive Eligibility for Children

Section 4912 of the BBA added a new section 1920A to the Act to allow States to provide services to children during a period of presumptive eligibility. Under section 1920A, services are available to children under age 19 prior to a formal determination of Medicaid eligibility. Under the statutory provisions, a qualified entity, as defined in section 1920A(b)(3)(A), determines whether a child is presumptively eligible for Medicaid on the basis of preliminary information about the child's family income. At the time of the determination, the qualified entity must refer the child to the Medicaid agency. The State must provide the qualified entity with application forms for Medicaid and information about how to assist in completing and filing an application for regular Medicaid. If an application for regular Medicaid is filed, the Medicaid agency will establish whether or not the child is eligible for regular Medicaid. We propose to require that if a State chooses to provide services to children during a period of presumptive eligibility, the State must make presumptive eligibility available Statewide to all children. We considered whether to allow States to limit the availability of presumptive eligibility to certain jurisdictions or certain groups of children but found no indication in the statute or legislative history that such a limitation should be allowed. Although we consider presumptive eligibility a special status, we believe that the requirements pertaining to Statewideness and comparability which apply to the provision of regular Medicaid should apply here as well.

In some respects, the provisions of section 1920A mirror the provisions related to section 1920, which provide for presumptive eligibility for pregnant women. Where this is the case, we propose policies associated with section 1920A that are consistent with the March 23, 1994 notice of proposed rulemaking related to presumptive eligibility for pregnant women (59 FR 13666). We make one exception. The proposed regulations pertaining to presumptive eligibility for pregnant women would require that States use gross income alone to determine presumptive eligibility. We propose here that in determining presumptive eligibility for children, States be permitted to request some additional information and to apply simple disregards as explained later in this section.

In accordance with section 1920A(b)(2), the period of presumptive eligibility begins on the day that a qualified entity makes a determination that a child is presumptively eligible. The child then has until the last calendar day of the following month to file a regular Medicaid application with the Medicaid agency. If the child does not file a regular Medicaid application by that last day, presumptive eligibility ends on that last day. If the child files an application for regular Medicaid, presumptive eligibility ends on the date that a determination is made on the regular Medicaid application.

Although section 1920A places no restrictions on the number of periods of presumptive eligibility for a child, we believe it is unreasonable to provide a child with unrestricted number of periods of presumptive eligibility. Such a policy would effectively allow continuous eligibility for children who never file an application for regular Medicaid and are never determined to be eligible for regular Medicaid. Also, by reinforcing the ability to establish immediate short term eligibility for medical assistance, such an approach could be counter productive to efforts to promote the use of preventive and primary care and effective management of care for children. At the same time, we also believe that it is unreasonable to limit a child to one period of presumptive eligibility in a lifetime. Therefore, we propose to allow States to establish reasonable methods of limiting the number of periods of presumptive

eligibility that can be authorized for a child in a given time frame. We are particularly seeking comments on what would constitute a reasonable limitation and whether specific limitations on the number of periods of presumptive eligibility should be imposed by regulation.

In implementing the provisions of section 1920A that specify that determinations of presumptive eligibility must be based on family income, we would provide limited flexibility to States in calculating income for this purpose. We would also allow States to require that qualified entities request and use general information other than about income, as long as the information is relatively simple to obtain and is requested in a fair and nondiscriminatory manner. In States that adopt the most conservative approach to presumptive eligibility, the qualified entity would use gross family income. The qualified entity would compare family income to the highest income eligibility standard established under the plan that is most likely to be used to establish the regular Medicaid eligibility of a child of the age involved. As a result, there may not be a single income standard for all children. For example, the standards for presumptive eligibility might be 133 percent of the Federal poverty level (FPL) for children under 6 and 100 percent FPL for children age 6 through 19, if these were the highest standards applicable to children of the specified ages under a State's Medicaid plan.

We would specifically allow a State to require that qualified entities apply simple income disregards, such as the general $90 earned income disregard. However, we would not allow a State to require that qualified entities deduct the costs of incurred medical expenses in order to reduce income to the allowed income level. We believe that Congress intended by the use of the term ''applicable level'' to require qualified entities to make simple calculations and not complicated adjustments of income such as those involved in applying spenddown rules or in disregarding certain types of income. To impose detailed and complicated calculations on qualified entities would be administratively burdensome and contrary to efficient administration because of the short-term nature of presumptive eligibility and because no eligibility requirements other than income need be considered.

We do not believe that we are imposing an undue hardship on a child by not allowing spenddown or not disregarding certain income. If a qualified entity decides that the child does not ''appear'' to meet the income criteria, the child has a right to apply for regular Medicaid and have a formal eligibility determination made. We are specifically seeking comments on whether States should be allowed to require that qualified entities make certain adjustments to gross income and ways that these adjustments could be limited.

Section 1920A(b)(3)(A) of the Act defines qualified entity as an entity that:

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

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

(3) Is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990; or

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

(5) Is determined by the agency to be capable of making determinations of presumptive eligibility for children.

Section 1920A(b)(3)(B) authorizes the Secretary to issue regulations further limiting those entities that may become qualified entities. We have not proposed any further limitations at this time. We have also found no authority to expand those entities that may be designated qualified entities.

In accordance with section 1920A(c)(1), we would require States to provide qualified entities with regular Medicaid application forms and information on how to assist parents, guardians, and other persons in completing and filing such forms. As provided by section 1920A(c)(3), the application provided may be an application developed by the State for use by children who wish to apply as low-income children described in section 1902(l)(1) of the Act. We would not require States to provide any other application forms. The date that the regular Medicaid application form is received by the Medicaid State agency is the Medicaid filing date for Medicaid eligibility unless State agency staff are located on site at the qualified entity, in which case the Medicaid filing date is the date that the onsite State agency staff person receives the completed form. However, even though State agency staff can receive and process applications for regular Medicaid, they cannot make presumptive eligibility determinations unless they themselves meet the definition of ''qualified entity'' under section 1920A(b)(3) of the Act.

Since we are considering presumptive eligibility a special status, we propose not to apply to a decision on presumptive eligibility the notification requirements that a State must meet when it makes a decision on a regular Medicaid application. Existing regulations under §§ 435.911 and § 435.912 and part , subpart E, require Medicaid agencies to send Medicaid applicants written notice within a specified period of time of the agency's decision on a regular Medicaid application, and if eligibility is denied the reasons for the denial, the regulatory basis for it, and an explanation of rights to a hearing. Although we propose not to apply these requirements to presumptive eligibility determinations, we are proposing to require that the qualified entity inform the parent or custodian of the child, in writing, of the presumptive eligibility decision at the time of the determination. In a case of a denial of presumptive eligibility, the qualified entity would be required to inform the parent or custodian of the child, in writing, of the reason for the denial and his/her right to apply for regular Medicaid.

In accordance with section 1920A(c)(2) of the Act, we propose to require the qualified entity to provide written information to the parent or custodian of a child who is determined presumptively eligible, indicating that a regular Medicaid application must be filed on the child's behalf by the last day of the following month if the child wishes to continue to receive services after that date. The qualified entity must also inform the parent or custodian of the child, in writing, that if an application for regular Medicaid is not filed on the child's behalf by the last day of the month following the month of the determination of presumptive eligibility, the presumptive eligibility will end on that date. However, if an application is filed on the child's behalf, the child will remain presumptively eligible until a determination of the child's eligibility for regular Medicaid has been made. Under section 1920A(c)(2), the qualified entity also must notify the State agency within 5 working days after the date on which the entity determines that the child is presumptively eligible.

We considered defining ''custodian'' for purposes of presumptive eligibility but have decided to allow States flexibility to determine who is a child's custodian. We expect that some States

will consider any interested adult who has the child in his/her care at the moment to be the custodian for purposes of presumptive eligibility under section 1920A. We expect that other States will only consider an adult to be a child's custodian if the adult has a legal responsibility for the child.

Because we do not consider presumptive eligibility to be eligibility for Medicaid *per se*, and because termination of presumptive eligibility occurs automatically after specified time periods, we propose not to apply the existing provisions of the regulations that require Medicaid agencies to provide timely written notice of reduction or termination of Medicaid benefits and rights to appeal of an adverse action (part , subpart E and § 435.919). As indicated earlier, we propose to require a qualified entity to provide written notice of the date that the child can expect the presumptive eligibility to end. However, we propose not to grant rights to appeal a denial or termination of services under a presumptive eligibility decision because it is not considered to be a determination of Medicaid eligibility. If a regular Medicaid application is filed on the child's behalf and is denied, the child would have the right to appeal that denial.

We do not believe that we are imposing an undue burden on qualified entities by requiring that notification be in writing. We do not foresee that this written notice will necessarily be individual personal letters. We considered requiring States to supply qualified entities with preprinted notices. However, we decided to allow States the flexibility to determine how best to arrange for this notification within each State program.

Existing regulations at § 435.914 permit States to provide Medicaid for an entire month when the individual is eligible for Medicaid under the plan at any time during the month. We propose not to permit States to provide full-month eligibility for presumptive eligibility periods because by definition a presumptive determination is not a determination of Medicaid eligibility but eligibility for a special status. In addition, section 1920A(b)(2) of the Act expressly defines the period of presumptive eligibility.

Since presumptive eligibility is a special status, we considered whether States should be required to provide all services to presumptively eligible children or should be required or allowed to limit the services provided. For example, we considered allowing States to limit services to ambulatory care. Although presumptive eligibility for pregnant women includes a statutory restriction on services, there is no similar statutory restriction pertaining to presumptive eligibility for children. We propose to require that States provide all services covered under the State plan, including EPSDT, to presumptively eligible children. We believe most presumptively eligible children will be found retroactively eligible for Medicaid during what was a presumptive eligibility period, and complete and adequate medical care should not be delayed pending the decision on the regular Medicaid application.

Section 4912 of the BBA provides that, for purposes of Federal financial participation, services that are covered under the plan, furnished by a provider that is eligible for payment under the plan, and furnished to a child during a period of presumptive eligibility, will be treated as expenditures for medical assistance under the State plan. See § 447.88 and § 457.616 for a discussion of the options for claiming FFP payment related to presumptive eligibility.

Other than payments made for children during a presumptive eligibility period, section 4912 of the BBA does not hold States harmless for Medicaid payments made for services provided to ineligible children. However, HCFA and the States share a mutual commitment to enrolling uninsured children in Medicaid. An estimated 4 million children are eligible for Medicaid but remain uninsured due partly to the complexities associated with outreach and enrollment efforts. A basic strategy for overcoming this problem is simplification of States' Medicaid applications for children, and the removal of other enrollment barriers, such as burdensome documentation requirements.

For eligibility groups that are new, States often have no eligibility determination experience, and may be reluctant to ease the documentation and verification requirements because they can help ease Medicaid eligibility quality control concerns until experience has been gained. To remove this potential barrier to simplification, and to encourage States to simplify the Medicaid application process and enroll uninsured children, HCFA is asserting its policy to waive MEQC eligibility errors resulting from the coverage of children under new eligibility groups added by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the BBA, including the optional group of optional targeted low-income children described in section 1902(a)(10)(A)(ii)(XIV) of the Act. If a State has an error rate over three percent, the State is subject to a disallowance of FFP. The State can appeal this disallowance through a waiver process outlined in § .865. As part of this waiver process error cases and associated claims identified by the State as directly attributable to the enrollment of children in these groups will be excluded from the error rate calculation.

L. Medicaid Disproportionate Share Hospital (DSH) Expenditures

Section 4911 of the BBA amended section 1905(b) of the Act to require that for expenditures for section 1905(u)(2)(A)(medical assistance expenditures of optional targeted low-income children) or section 1905(u)(3) (Waxman children), the Federal medical assistance percentage is equal to the *enhanced* FMAP described in section 2105(b)of the Act to the extent of the available title XXI allotment. In other words, under the statute, States that provide health insurance coverage to children as an expansion of their Medicaid programs may receive enhanced match for services provided to the Medicaid expansion population.

Under the authority of section 1902(a)(13)(A)(iv) of the Act, States are required to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs when developing rates for Medicaid inpatient hospital services. Medicaid disproportionate share hospital (DSH) expenditures are defined as payments made for hospital services rendered to Medicaid eligibles and the uninsured. Some of the expenditures may be identifiable as expenditures for services for a child in a CHIP-related Medicaid expansion program. Those identifiable payments may qualify for the enhanced FMAP.

Proposed § 433.11 sets forth provisions regarding the enhanced FMAP rate available for State expenditures related to services provided to children under an expansion to the State's current Medicaid program. Paragraph (a)(3) specifies that the enhanced FMAP rate determined in accordance with the proposed regulation at section 457.622 will be used to determine the Federal share of State expenditures for disproportionate share hospital expenditures as they relate to children eligible for health insurance coverage under an expansion to the State's current Medicaid program.

Any DSH payments that are calculated at the enhanced matching rate will be counted against the CHIP allotment, the Federal DSH allotments

as published in section 4721 of the BBA, and the disproportionate share hospitals amount of uncompensated care cost limits as required under section 1923(g) of the Act.

The State should work with the HCFA Regional Office to develop an appropriate methodology to allocate a portion of the DSH payments to the Medicaid expansion group so that these expenditures are appropriately claimed at the enhanced FMAP and counted against the State's title XXI allotment. Federal payments for such DSH expenditures will also be counted against the State's Medicaid DSH allotment.

We understand that questions have been raised concerning the interaction of title XXI allotments, Federal DSH payment allotments (as enacted in section 4721 of the BBA) and DSH payments for services rendered to 1905(u)(2) and 1905(u)(3) children in Medicaid. Specifically, there is concern about whether enhanced matching rates should apply to DSH payments. We believe a statutory change would be needed not to apply enhanced FMAP. However, since any such statutory changes would be completed following the publication of this proposed regulation, we have developed this proposed regulation text in accordance with current law.

M. Vaccines for Children Program

As discussed in the letter to State Health Officials of May 11, 1998, under the authority of section 1928(b)(2) of the Act, children covered under a CHIP program that is a Medicaid expansion are Federally vaccine-eligible under the Vaccines for Children (VFC) program. Children served by a separate State child health program are not Federally vaccine eligible because they are neither entitled to Medicaid nor uninsured, as required in section 1928(b)(2) of the Act. Under the authority of section 1928(b)(3), States may elect to obtain vaccine for children enrolled in a separate child health program at the Federal discount price (plus an amount to cover the costs of administrative overhead and distribution). States may want to use this authority given the existence of the VFC program and its potential to save money.

Under section 1928 of the Social Security Act and section 317 of the Public Health Service Act, the Centers for Disease Control and Prevention (CDC) contracts with vaccine manufacturers to purchase vaccines, usually at a substantial discount from retail prices. These vaccines are furnished to State health departments, as grantees of CDC, for distribution to providers that participate in the VFC program, and other providers authorized to administer vaccines under section 317. Because the immunization program of the State health department is the CDC grantee, and has sole authority to order and distribute vaccine purchased under the CDC discount contracts, a State that elects to obtain these vaccines for its separate child health program population must negotiate a memorandum of agreement between its separate child health program and the State immunization program, to order vaccines and distribute them to CHIP providers. As part of that agreement, the separate child health program must agree to reimburse the immunization program for the cost of each dose of vaccine, including a pro rata share of administrative overhead and distribution costs. Providers who receive vaccine must agree to comply with reporting and other requirements of the State immunization program, in order to assure that vaccine distributed is accounted for appropriately.

States electing to purchase vaccine at the Federal discount price must retain overall responsibility for the required health benefits coverage package, under the requirements of § 457.490 (a)(1), ''Methods of Administration.'' However, the State may subcontract for any and all other services, with the exception of vaccine products, provided under its separate child health program, including professional services required to immunize eligible children.

If HCFA establishes that the State has retained overall responsibility for the provision of services and if the State Immunization program has established one price per dose which includes all charges for vaccine, the cost of vaccines will be treated as part of the required health benefits coverage package and will not be subject to 10 percent cap on other expenditures of title XXI funds. Moreover, these costs are eligible for the enhanced match.

III. Regulatory Impact Analysis

A. Impact Statement

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

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States based enterprises to compete with foreign based enterprises in domestic and export markets.

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

We have examined the impacts of this proposed rule as required by Executive Order 12866, the Unfunded Mandate Reform Act of 1995 (Public Law 104–4), and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulations are necessary, to select regulatory approaches that maximize net benefits (including potential economic environments, public health and safety, other advantages, distributive impacts, and equity).

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

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain rural counties adjacent to urban areas, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and we certify, that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

For purposes of the RFA, we prepare a regulatory flexibility analysis unless

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

B. Cost Benefit Analysis

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

CHIP is the largest single expansion of health insurance coverage for children since the creation of Medicaid in 1965. CHIP was designed to reach children from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. As discussed in detail below, this initiative set aside $24 billion over five years for States to provide new health coverage for millions of children. To date, plans prepared by all 50 States, 5 U.S. territories, and the District of Columbia have been approved. States expect to enroll an estimated 2.6 million children by September 2000. The implementation of CHIP has significantly reduced the number of uninsured children nationwide. Previously uninsured children now have access to a range of health care services including well baby and well child care, immunizations, and emergency services. In addition to the obvious benefit of providing access to health care coverage for millions of children, as discussed in detail below, CHIP will also have a beneficial impact on the private sector.

1. Disbursement of Federal Funds

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

TOTAL AMOUNT OF ALLOTMENTS

Fiscal year	Amount
1998	$4,295,000,000
1999	4,275,000,000
2000	4,275,000,000
2001	4,275,000,000
2002	3,150,000,000
2003	3,150,000,000
2004	3,150,000,000
2005	4,050,000,000
2006	4,050,000,000
2007	5,000,000,000

Under Public Law 105–277, an additional $32 million was appropriated for allotment only to the Commonwealths and Territories, and only for FY 1999. In addition, we note that there was an additional allocation of $20 million in FY 1998, which increases the FY 1998 total allotment amount to $4.295 billion. Also, for each of the first five years, $60 million of the allotment must be used for the special diabetes programs. We note that the Federal spending levels for the CHIP program are based entirely on the spending and allocation formulas contained in the statute. The Secretary has no discretion over these spending levels and initial allotments of funds allocated to States. Both direct program and administrative costs are covered by the allotments.

2. Impact on States

CHIP is a State-Federal program under which funds go directly to States, which have great flexibility in designing their programs. Specifically, within broad Federal guidelines, each State determines the design of its program, eligible groups, benefit packages, payment levels for coverage and administrative and operating procedures. As such, it is difficult to quantify the economic impact on States. As stated above, the total Federal payments available to States are specified in the statute and are allocated according to a statutory formula based on the number of uninsured, low-income children for each State, and a geographic adjustment factor. For qualifying expenditures, States will receive an enhanced Federal matching rate equal to its current FMAP increased by 30 percent of the difference between its regular matching rate and 100 percent, except that the enhanced match cannot exceed 85 percent.

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

FISCAL YEAR OUTLAYS

[In $billions]

	1999	2000	2001	2002	2003
Federal Share	1.4	1.9	2.8	3.5	4.3
State Share	0.6	0.8	1.2	1.5	1.9
Total	2.0	2.7	4.0	5.0	6.2

Note: These estimates are based on State and Federal budget projections and have been included in the President's FY 2000 budget.

3. Impact on the Private Sector

We note that due to the flexibility that States have in designing and implementing their CHIP programs it is not possible to determine the impact on individual providers groups of providers, insurers, health plans, or employers. However, we anticipate that the CHIP program will benefit the private sector in a number of ways. The program may have a positive impact on a number of small entities given that CHIP funding will filter down to health care providers and health plans that cover the CHIP population. Health plans that provide insurance coverage under the CHIP program will benefit to the extent that children are generally a

lower-risk population. That is, children tend to use fewer high-cost health care services than older segments of the population. Thus, by providing health insurance coverage for preventive care such as well-baby and well-child care and immunizations, CHIP may benefit health insurers by reducing the need to provide more costly health care services for serious illnesses. Additionally, because CHIP provides health insurance coverage to children who were previously uninsured, health care providers will no longer have to absorb the cost of uncompensated care for these children. The private sector may also benefit from CHIP to the extent that children and families with health insurance coverage are more likely to use health care services. Thus, health care providers are likely to experience an increase in demand for their services. Small businesses that are unable to afford private health insurance for their employees will benefit to the extent that the employees, or their children qualify for CHIP.

4. Impact on Beneficiaries

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

Subpart E of this proposed rule sets forth provisions regarding the costs that beneficiaries may incur (cost sharing) under CHIP. In accordance with the statute, we proposed provisions concerning general cost sharing protection for lower income children and American Indians/Alaska Natives, cost sharing for children from families with certain income levels, and cumulative cost-sharing maximums. Section 457.555 sets forth maximum allowable cost sharing charges on targeted low-income children in families with income from 101 to 150 percent of the FPL. This section specifies maximum copayment amounts that may be imposed under fee-for-service delivery systems and managed care organizations. Additionally, regarding cumulative cost sharing maximums, § 457.560 provides that cost sharing for children with family income above 150 percent of the Federal poverty level may not exceed 5 percent of total family income for the year. For children with family income at or below 150 percent of the Federal poverty level, cost sharing may not exceed 2.5 percent of total family income for the year.

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

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

IV. Federalism

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

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

In the course of the State plan and amendment approval process, we consulted with State and local officials to discuss all aspects of the State's proposed plan or amendment. We discussed with each State provisions and policy decisions that arose from its proposed plans and amendments. In this process, States put forward their policy concerns and proposed statutory interpretations.

The proposed programmatic regulation incorporates much of the guidance that already has been issued to States. As the proposed regulation builds upon previously released guidance, most of the regulation represents policies that have been in operation for some time and are a result of the consultation process that is required as part of the implementation of CHIP; specifically, the State plan approval process.

To be more specific, the Department began issuing guidance to States within one month of enactment of the BBA. We provided information on each State's allotment through two **Federal Register** notices published on September 12, 1997 (62 FR 48098) and February 8, 1999 (64 FR 6102). We developed a model application template to assist State's in applying for title XXI funds. We provided over 100 answers to frequently asked questions. We issued policy guidance through a series of 23 letters to State health officials. All of this information is currently available on our website located on the Internet at http://www.hcfa.gov. We have also provided technical assistance to all States in development of CHIP applications.

In the exhaustive approval process, we listened to States' concerns. This proposed regulation builds upon previously released guidance and therefore, most of the regulation represents policies that have been in operation for some time. States and Territories have used this guidance to design and implement their programs.

In developing the interpretative policies set forth in this proposed rule, we also listened to the concerns of States through processes other than the State plan process as well, by attending conferences and meeting with various groups representing State and public interests.

As we continue to implement the program, however, we have identified a number of areas in which we further elaborate on previous guidance or propose new policies that have not yet been made public. In an attempt to highlight the key issues, a brief summary follows:

A. Subpart A—State Plan Requirements

The regulation would clarify several conditions under which States must submit amendments to approved CHIP plans. For example, we propose that States submit a plan amendment when the funding source of the State share changes, prior to such change taking effect. The purpose of this proposed

requirement is to ensure that programs are operated using only permissible sources of funding. In addition, amendments to impose cost-sharing on beneficiaries, increase existing cost-sharing charges, or increase the cumulative cost sharing maximum will be considered the same as amendments proposing a restriction in benefits. Therefore, we propose to require for these amendments that States adhere to the statutory requirements relating to prior public notice and retroactive effective dates.

B. Subpart C—Eligibility, Screening, Applications and Enrollment

Title XXI prohibits the participation of children of public agency employees who are eligible to participate in a State health benefits plan. We interpret this statutory prohibition to be triggered only when the employer makes more than a nominal contribution available for the child's health benefits coverage. We propose to clarify that when only a nominal contribution is available, children would not be considered eligible for health benefits coverage under a State health benefits plan and could be eligible for coverage through CHIP.

C. Subpart D—Coverage and Benefits

The proposed regulation provides some flexibility for States in updating the benefit package. States using the benchmark benefit package option are not required to submit an amendment each time the benchmark package changes. States need only submit amendments when proposing to make a change to the benefit package for the separate child health program. At that time, the State must compare their benefit package to the most recent benchmark coverage.

The proposed regulation also clarifies policy regarding the conditions under which abortion services are permitted under title XXI and proposes that, when States contract with managed care entities for CHIP services, those contracts cannot include abortion services. To the extent that a managed care entity furnishes these services, the managed care entity must do so under a separate contractual arrangement.

D. Subpart E—Beneficiary Financial Responsibilities

The statute places a 5 percent cap on cost-sharing expenditures for families with incomes greater than 150 percent of the Federal Poverty Level (FPL) who are enrolled in separate child health programs. In an attempt to preserve State flexibility, the proposed regulation gives States the option to use either gross or net family income when calculating the cost-sharing cap.

In addition, the regulation proposes to place a comparable limit of 2.5 percent on cost-sharing for families with incomes below 150 percent of the poverty line, in order to ensure that those families with lower incomes will not be forced to pay the same amount of cost-sharing as those with higher incomes. And States would have the option to apply cost-sharing imposed on adults in CHIP family coverage plans toward the cumulative maximum cap.

The regulation proposes that States must have a process in place that will protect beneficiaries by ensuring due process before beneficiaries can be disenrolled from the program for failure to pay cost-sharing. This preamble suggests that States may look for a pattern of nonpayment, provide clear notice and opportunities for late payment, and wait at least one billing cycle before taking action to disenroll.

Finally, title XXI includes provisions to ensure enrollment and access to health care services for American Indian and Alaska Native (AI/AN) children. The regulation incorporates our interpretation that in light of the unique Federal relationship with tribal governments, cost-sharing requirements for individuals who are members of a Federally recognized tribe are not consistent with this statutory requirement.

E. Subpart G—Strategic Planning, Reporting and Evaluation

The proposed regulation includes provisions intended to ensure compliance with both the statute, the elements of the State's title XXI plan and the onsite review of State programs. In addition, monitoring will enable tracking of CHIP data submissions, which will ultimately help ensure enrollment in both the CHIP and Medicaid programs.

In addition, the regulation proposes that States have additional flexibility in setting procurement standards more broadly than Medicaid. States could choose to base payment rates on public and/or private rates for comparable services, and where appropriate, establish higher rates in order to ensure sufficient provider participation.

Finally, this proposed regulation includes various beneficiary protections consistent with the President's directive regarding the *Consumer Bill of Rights and Responsibilities.* Provisions are included throughout the proposed regulation to ensure that beneficiaries are given the opportunity to participate in and make informed medical decisions, to have access to needed services, and to be treated with dignity and respect.

F. Subpart I—Program Integrity and Beneficiary Protections

This subpart is intended to underscore the importance of preserving program integrity in the Children's Health Insurance Program. The regulation proposes that States must have fraud and abuse protections in place, but provides flexibility to States in developing program integrity protections for separate child health programs. States are encouraged to utilize systems already existing for Medicaid, but are not required to do so.

F. Subpart J—Waivers

The proposed regulation discusses the circumstances under which States may obtain a waiver in order to provide title XXI coverage to entire families. We propose that in order to qualify for such a waiver, the State must meet several requirements, including a requirement that the proposal be cost effective. The proposed regulation would give States added flexibility by permitting alternate methods States can use to meet the cost effectiveness test. States would be able to compare the cost of coverage for the family to any child-only health benefits package that is available for purchase, even if it is not included under the State plan.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

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

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

of this document contain information collection requirements:

Section 457.50 State Plan

In summary, § 457.50 requires a State to submit a child health plan to HCFA for approval. The child health plan is a comprehensive written statement submitted by the State describing the purpose, nature, and scope of its Child Health Insurance Program and giving assurance that it will be administered in conformity with the specific requirements of title XXI, title XIX (as appropriate), and the regulations in this chapter. The State plan contains all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation in the State program.

The burden associated with this requirement is the time and effort for a State to prepare and submit its child health plan to HCFA for approval. These collection requirements are currently approved by OMB under OMB# 0938–0707, with a current expiration date of 6/30/2000.

Section 457.60 Amendments

In summary, § 457.60 requires a State to submit to HCFA for approval an amendment to its approved State plan, whenever necessary, to reflect any changes in (1) Federal law, regulations, policy interpretations, or court decisions, (2) State law, organization, policy or operation of the program, or (3) the source of the State share of funding.

The burden associated with this requirement is the time and effort for a State to prepare and submit any necessary amendments to its State plan to HCFA for approval. Based upon HCFA's previous experiences with State plan amendments we estimate that on average, it will take a State 80 hours to complete and submit an amendment. We estimate that 10 States/territories will submit an amendment on an annual basis for a total burden of 800 hours.

Section 457.70 Program Options

In summary, § 457.70 requires a State that elects to obtain health benefits coverage through its Medicaid plan to submit an amendment to the State's Medicaid State plan as appropriate, demonstrating that it meets the requirements in subparts A, and G of part 457 and the applicable Medicaid regulations.

The burden associated with this requirement is the time and effort for a State to prepare and submit the necessary amendment to its Medicaid State plan to HCFA for approval. Based upon HCFA's previous experiences with State Plan amendments we estimate that on average, it will take a State 2 hours to complete and submit an amendment for HCFA approval. We estimate that 28 States/territories will submit an amendment for a total one-time burden of 56 hours.

Section 457.350 Eligibility Screening

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

The burden associated with this requirement is the time and effort for a State to prepare and provide written notification to the family if the child is found not to be Medicaid eligible. The average burden upon the State to prepare the notice is a one time burden estimated to be 10 hours and that it will take 3 minutes for the State to provide and the family to read the information. We estimate that on average, that each State will be required to provide 1 million notices on an annual basis for a total annual burden of 50,000 hours, per State. Therefore, the total estimated burden is calculated to be 2,700,000 hours on an annual basis.

Section 457.360 Facilitating Medicaid Enrollment

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

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

Section 457.361 Application for and Enrollment in CHIP

In summary, § 457.361(b) requires a State to inform applicants, in writing and orally if appropriate, about the eligibility requirements and their rights and obligations under the program.

The burden associated with this requirement is the time and effort for a State to inform each applicant in writing and orally if appropriate, about the eligibility requirements and their rights and obligations under the program. We estimate the average burden upon the State to disseminate a standard notice to the family is estimated to be 3 minutes. We estimate that on average, each State will be required to provide 1 million notices on an annual basis for a total annual burden of 50,000 hours, per State. Therefore, the total estimated burden is calculated to be 2,700,000 hours on an annual basis.

In summary, § 457.361(c) requires a State to send each applicant a written notice of the agency's decision on the application, and if eligibility is denied or terminated, the specific reason or reasons for the action and an explanation of the right to request a hearing within a reasonable time.

The burden associated with this requirement is the time and effort for a State to prepare and provide written notice to each applicant of the agency's decision on the application, and if eligibility is denied or terminated, the specific reason or reasons for the action and an explanation of the right to request a hearing within a reasonable time. We estimate that on average, it will take each State 3 minutes to prepare each notice and that each State will be required to provide 1 million notices on an annual basis for a total annual burden of 50,000 hours, per State. Therefore, the total estimated burden is calculated to be 2,700,000 hours on an annual basis.

Section 457.431 Actuarial Report for Benchmark-Equivalent Coverage

In summary, § 457.431 requires a State that wants to obtain approval for benchmark-equivalent benefits coverage described under § 457.430, to submit to HCFA an actuarial report that; (1) compares the actuarial value of coverage of the benchmark package to the State-designed benchmark-equivalent benefit package, (2) demonstrates through an actuarial analysis of the benchmark-equivalent package that coverage requirements under § 457.430 are met, and (3) meets the requirements of § 457.431(b).

The burden associated with this requirement is the time and effort for a State that wants to obtain approval for benchmark-equivalent benefits coverage described under § 457.430, to prepare and submit its actuarial report to HCFA for approval. We estimate that on

average, it will take a State 40 hours to prepare and submit a report for HCFA approval. We estimate that 6 States/territories will submit a plan for a total burden of 240 hours.

Section 457.525 Public Schedule

In summary, § 457.505 requires a State to make the public schedule available to: (1) CHIP beneficiaries (enrolled and non-enrolled) before the imposition of the charges, (2) CHIP applicants at the time of application, (3) all CHIP participating providers, (4) the general public.

The burden associated with this requirement is the time and effort for a State to prepare and make available its public schedule available to these four groups. We estimate that on average, it will take each State/Territory 120 minutes to prepare its public schedule and 3 minutes to disseminate no more than 20,000 copies of its schedule on an annual basis for a total annual burden of 1000 hours, per State/Territory. Therefore, the total estimated burden is calculated to be 54,000 hours on an annual basis.

Section 457.740 State Expenditure and Statistical Reports

In summary, § 457.740 requires a State to submit a report to the Secretary that contains quarterly program expenditures and statistical data, no later than 30 days after the end of each quarter of the federal fiscal year. The burden associated with this requirement is the time and effort for a State to prepare and submit its report to the Secretary. These collection requirements are currently approved by under OMB approval number OMB# 0938–0731, with a current expiration date of 1/31/2002.

In addition § 457.740 requires a State to submit an annual report, thirty days after the end of the Federal fiscal year, of an unduplicated count for the Federal fiscal year of children who are enrolled in the title XIX Medicaid program, and the separate child health and Medicaid-expansion programs, as appropriate, by age, service delivery, and income categories described in paragraphs (a) and (b) of this section.

The burden associated with this requirement is the time and effort for a State to prepare and submit its annual report to the Secretary. We estimate that on average, it will take a State 40 hours to complete and submit their report. We estimate that 54 States/territories will submit a plan for a total burden of 2160 hours.

Section 457.750 Annual Report

In summary, § 457.750 requires a State to submit a report to the Secretary by January 1 following the end of each preceding federal fiscal year, on the results of the State's assessment of operation of the State child health plan.

The burden associated with this requirement is the time and effort for a State to prepare and submit its annual report on the results of the State's assessment of operation of the State child health plan. We estimate that on average, it will take a State 40 hours to complete and submit their report. We estimate that 54 States/territories will submit a plan for a total burden of 2160 hours.

Section 457.760 State Evaluations

In summary, § 457.760 requires a State to submit by March 31, 2000, an evaluation to the Secretary that includes all of the elements referenced in paragraphs (a) through (g) of this section.

The one time burden associated with this requirement is the time and effort for a State to prepare and submit an evaluation to the Secretary that includes all of the elements referenced in paragraphs (a) though (g) of this section. We estimate that on average, it will take a State 40 hours to complete and submit their evaluation. We estimate that 54 States/territories will submit a plan for a total burden of 2,160 hours.

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

In summary, § 457.810(d) requires a State that uses title XXI funds to provide premium subsidies under employer-sponsored group health plans to collect information to evaluate the amount of substitution that occurs as a result of the subsidies and the effect of subsidies on access to coverage.

The burden associated with this requirement is the time and effort for a State to collect the necessary data to evaluate the amount of substitution that occurs as a result of the subsidies and the effect of subsidies on access to coverage. We estimate that on average, it will take a State 20 hours to collect the necessary data for their evaluation. We estimate that 54 States/territories will submit a plan for a total burden of 1,080 hours.

Section 457.965 Documentation

In summary, § 457.965 requires a State to include in each applicant's record facts to support the State's determination of the applicant's eligibility for CHIP. While this requirement is subject to the PRA, we believe that the burden associated with this requirement is exempt from the PRA as defined in 5 CFR 13203(b)(3), because this requirement would be imposed in the absence of a Federal requirement.

Section 457.985 Enrollee Rights To File Grievances and Appeals

In summary, § 457.985(b) requires a State to establish and maintain written procedures for grievances and appeals that adhere to generally acceptable industry practices within the State and comply with State-specific grievance and appeal requirements currently in effect for commercially licensed health care related businesses. While this requirement is subject to the PRA, we believe that the burden associated with this requirement is exempt from the PRA, as defined in 5 CFR 1320.3(b)(3), because this requirement would be imposed in the absence of a Federal requirement.

Section 457.1005 Waiver for Cost-Effective Coverage Through a Community-Based Health Delivery System

In summary, § 457.1005 requires a State requesting a waiver for cost-effective coverage through a community-based health delivery system, to submit documentation to HCFA that demonstrates that they meet the requirements of § 457.1005(b)(1) and (b)(2).

The burden associated with this requirement is the time and effort for a State that wants to obtain a waiver to prepare and submit the necessary documentation to HCFA that demonstrates that they meet the requirements of § 457.1005.

We estimate that on average, it will take a State 24 hours to prepare and submit a waiver request for HCFA approval. We estimate that 10 States/territories will submit a request for a total burden of 240 hours.

Section 457.1015 Cost Effectiveness

In summary, § 457.1015 requires a State to report to HCFA in its annual report the amount it spent on family coverage and the number of children it covered. While this requirement is subject to the PRA, the burden associate with this requirement is captured in § 457.750 (Annual report).

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements in §§ 457.50, 457.60, 457.70, 457.350, 457.360, 457.431, 457.525, 457.555, 457.740, 457.750, 457.760, 457.810, 457.965, 457.985, 457.1005, and

457.1015. These requirements are not effective until they have been approved by OMB.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and 3 copies directly to the following:

Health Care Financing Administration, Office of Information Services, Standards and Security Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850. Attn: John Burke HCFA–2006–P.

And,

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

VI. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

List of Subjects

42 CFR Part 431

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

42 CFR Part 433

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

42 CFR Part 435

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

42 CFR Part 457

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

42 CFR chapter IV would be amended as set forth below:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

A. Part 431 is amended as follows:

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

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

§ 431.865 [Amended]

2. In § 431.865(b), the definition of ''erroneous payment'' is amended by adding the sentence, ''The term does not include payments made for care and services covered under the State plan and furnished to children during a presumptive eligibility period as described in § 435.1102 of this chapter.'' at the end of paragraph (3) of the definition.

PART 433—STATE FISCAL ADMINISTRATION

B. Part 433 is amended as follows:

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

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

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

§ 433.10 Rates of FFP for program services.

* * * * *

(c) *Special provisions.* * * *

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

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

§ 433.11 Enhanced FMAP rate for children.

(a) Subject to the conditions in paragraph (b) of this section, enhanced FMAP determined in accordance with § 457.622 of this chapter will be used to determine the Federal share of State expenditures for—

(1) Services provided to optional targeted low-income children described in § 435.229(b) of this chapter; and

(2) Services provided to children born before October 1, 1983 who would be described in section 1902(l)(1)(D) of the Act (poverty-level-related children's groups) if—

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

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

(3) Disproportionate share hospital expenditures identified as payment for services provided to children described in paragraphs (a)(1) and (a)(2) of this section.

(b) Enhanced FMAP is not available if—

(1) A State adopts income and resource standards and methodologies for purposes of determining a child's eligibility under the Medicaid State plan that are more restrictive than those applied under the State plan in effect on June 1, 1997; or

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

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

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

C. Part 435 is amended as set forth below:

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

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

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

§ 435.229 Optional targeted low-income children.

(a) An optional targeted low-income child is a child who:

(1) Is a targeted low-income child as defined in § 457.310(a) of this chapter; and

(2) Would not be eligible for Medicaid under the policies of the State plan in effect on March 31, 1997.

(b) The State agency may provide Medicaid to:

(1) Individuals under age 19 who are optional targeted low-income children described in paragraph (a) of this section; or

(2) Reasonable categories of these individuals.

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

§ 435.910 Use of social security number.

* * * * *

(h) *Exception.* (1) An applicant who, because of well established religious objections, refuses to obtain a Social Security Number (SSN) may be given a Medicaid identification number by the State. Such a number may be either an SSN obtained by the State on the applicant's behalf or another unique identifier.

(2) The term ''well established religious objections'' means that the applicant:

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

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

(3) An alternative number established by the State to identify such an individual shall be used to the same extent as an SSN is used by the State as described in paragraph (b)(3) of this section.

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

§ 435.1001 FFP for administration.

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

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

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

* * * * *

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

§ 435.1002 FFP for services.

* * * * *

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

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

(2) During a period of presumptive eligibility;

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

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

§ 435.1007 [Amended]

6. In paragraph (a), the second sentence is amended by adding ''and 1905(u)'' between ''(X)'', and ''of the Act;''.

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

Subpart L—Option for Coverage of Special Groups

Sec.
435.1100 Scope.

Presumptive Eligibility for Children

435.1101 Definitions related to presumptive eligibility period for children.
435.1102 General Rules.

§ 435.1100 Scope.

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

Presumptive Eligibility for Children

§ 435.1101 Definitions related to presumptive eligibility period for children.

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

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

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

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

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

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

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

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

(3) Is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990; or

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

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

§ 435.1102 General rules.

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

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

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

(2) Establish procedures to ensure that qualified entities—

(i) Notify the agency that a child is presumptively eligible within 5 working days after the date that the determination is made;

(ii) In writing at the time that a determination is made, inform the parent or custodian of a child determined to be presumptively eligible that if a Medicaid application is not filed by the last day of the following month, the presumptive eligibility will end on that last day and that if a Medicaid application is filed by the last day of the following month, the child's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(iii) In writing at the time that a determination is made, inform the parent or custodian of a child determined not to be presumptively eligible of the reason for the determination and that he/she may file an application for Medicaid on the child's behalf;

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

(4) Make determinations of presumptive eligibility available Statewide to all children.

(c) The agency may establish reasonable methods of determining the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

D. Subchapter D is redesignated as subchapter F; and Parts 462, 466, 473, and 476 are redesignated as parts 475, 476, 478 and 480, respectively.

E. Subchapter E is redesignated as subchapter G.

F. A new subchapter D consisting of part 457 is added to read as follows:

SUBCHAPTER D—CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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 Duration of State plans and plan amendments.
457.70 Program options.
457.80 Current State child health insurance coverage and coordination.
457.90 Outreach.
457.110 Enrollment assistance and information requirements.
457.120 Public involvement in program development.
457.125 Provision of child health assistance to American Indian and Alaska Native children
457.130 Civil rights assurance.
457.135 Assurance of compliance with other provisions.
457.140 Budget.
457.150 HCFA review of State plan material.
457.160 Notice and timing of HCFA action on State plan material.
457.170 Withdrawal process.
457.190 Administrative and judicial review of action on State plan material.

Subpart B—[Reserved]

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.
457.320 Other eligibility standards.
457.340 Application.
457.350 Eligibility screening.
457.360 Facilitating Medicaid enrollment.
457.361 Application for and enrollment in CHIP.
457.365 Grievances and appeals.

Subpart D—Coverage and Benefits: General Provisions

457.401 Basis, scope, and applicability.
457.402 Child health assistance and other definitions.
457.410 Health benefits coverage options.
457.420 Benchmark health benefits coverage.
457.430 Benchmark-equivalent health benefits coverage.
457.431 Actuarial report for benchmark-equivalent coverage.
457.440 Existing comprehensive State-based coverage.
457.450 Secretary-approved coverage.
457.470 Prohibited coverage.
457.475 Limitations on coverage: Abortions.
457.480 Preexisting condition exclusions and relation to other laws.
457.490 Delivery and utilization control systems.
457.495 Grievances and appeals.

Subpart E—State Plan Requirements: Beneficiary 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.
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/Alaska Natives.
457.540 Cost sharing charges for children in families at or below 150 percent of the Federal poverty line (FPL).
457.545 Cost sharing for children in families above 150 percent of the FPL.
457.550 Restriction on the frequency of cost sharing charges on targeted low-income children in families at or below 150 percent of the FPL.
457.555 Maximum allowable cost sharing charges on targeted low-income children at or below 150 percent of the FPL.
457.560 Cumulative cost sharing maximum.
457.565 Grievances and appeals.
457.570 Disenrollment protections.

Subpart F—[Reserved]

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 State plan requirement: State annual reports and evaluation.
457.735 State plan requirement: State assurance of the quality and appropriateness of care.
457.740 State expenditures and statistical reports.
457.750 Annual report.
457.760 State evaluations.

Subpart H—Substitution of Coverage

457.800 Basis, scope, and applicability.
457.805 State plan requirements: Private coverage substitution.
457.810 Premium assistance for employer-sponsored group health plans: Required protections against substitution.

Subpart I—Program Integrity and Beneficiary Protections

457.900 Basis, scope, and applicability.
457.902 Definitions.
457.910 State program administration.
457.915 Fraud detection and investigation.
457.920 Accessible means to report fraud and abuse.
457.925 Preliminary investigation.
457.930 Full investigation, resolution, and reporting requirements.
457.935 Sanctions and related penalties.
457.940 Procurement standards.
457.945 Certification for contracts and proposals.
457.950 Contract and payment requirements including certification of payment-related information.
457.955 Conditions necessary to contract as a managed care entity (MCE).
457.960 Reporting changes in eligibility and redetermining eligibility.
457.965 Documentation.
457.970 Eligibility and income verification.
457.975 Redetermination intervals in cases of suspected enrollment fraud.
457.980 Verification of enrollment and provider services received.
457.985 Enrollee rights to file grievances and appeals.
457.990 Privacy protections.
457.995 Consumer Bill of Rights and Responsibilities.

Subpart J—Allowable Waivers: General Provisions

457.1000 Basis, scope, and applicability.
457.1005 Waiver for cost-effective coverage through a community-based health delivery system.
457.1010 Waiver for purchase of family coverage.
457.1015 Cost-effectiveness.

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

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

§ 457.1 Program description.

Title XXI of the Social Security Act, enacted in 1997 by the Balanced Budget Act, authorizes Federal grants to States for provision of child health assistance to uninsured, low-income children. The program is jointly financed by the Federal and State governments and administered by the States. Within broad Federal rules, each State decides eligible groups, types and ranges of services, payment levels for benefit coverage, and administrative and operating procedures.

§ 457.2 Basis and scope of subchapter D.

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

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

§ 457.10 Definitions and use of terms.

For purposes of this part the following definitions apply:

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

(1) A member of a Federally recognized Indian tribe, band, or group or a descendant in the first or second degree of any such member;

(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.;*

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

(4) A person who is determined to be an Indian under regulations promulgated by the Secretary.

Child means an individual under the age of 19.

Child health assistance has the meaning assigned in § 457.402.

Children's Health Insurance Program (CHIP) means a program established and administered by a State, but 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 of both.

Combination program means a program under which a State provides child health assistance through both a Medicaid expansion program and a separate child health program.

Contractor has the meaning assigned in § 457.902.

Cost-effectiveness has the meaning assigned in § 457.1015.

Creditable health coverage has the meaning given the term ''creditable coverage'' at 45 CFR 146.113.

Emergency medical condition has the meaning assigned at § 457.402.

Emergency medical services has the meaning assigned at § 457.402.

Employment with a public agency has the meaning assigned in § 457.301.

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

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

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

Grievance has the meaning assigned at § 457.902.

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

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

Health benefits coverage has the meaning assigned in § 457.402.

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

Legal obligation has the meaning assigned in § 457.555.

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

Managed care entity (MCE) has the meaning assigned in § 457.902.

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

Medicaid expansion program means a program where a State receives Federal funding at the enhanced matching rate available for expanding eligibility to targeted low-income children.

Post-stabilization services has the meaning assigned in § 457.402.

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 for employer-sponsored group health plans means State payment of part or all of premiums for group health plan or group health insurance coverage of an eligible child or children.

Public agency has the meaning assigned in § 457.301.

Separate child health program means a program under which a State receives Federal funding from its title XXI of the Act allotment under an approved plan that obtains child health assistance through obtaining coverage that meets the requirements of section 2103 of the Act.

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

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

State plan means the approved or pending title XXI State child health plan.

State program integrity unit has the meaning assigned in § 457.902.

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

Uncovered 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 and children as defined by the State. For purposes of cost sharing, the term has the meaning assigned at § 457.520.

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

(a) *Statutory basis.* This subpart is based on the following sections of the Act:

(1) Section 2101(a) of the Act specifies that the purpose of title XXI of the Act is to provide to States funds to enable them to initiate and expand child health assistance to uninsured low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

(2) Section 2101(b) requires that the State submit a State plan.

(3) Section 2102(a) sets forth requirements regarding the contents of the State plan.

(4) Section 2102(c) 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 specifies the process for submission, approval, and amendment of State plans.

(6) Section 2107(c) 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) requires that the State plan include a description of the budget for the plan.

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

(b) *Scope.* This subpart sets forth provisions governing the administration of a 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 of the Act.

§ 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 of the Act (as appropriate), and the

regulations in this chapter. HCFA monitors the operation of the approved State plan and plan amendments to ensure compliance with the requirements of title XXI, title XIX of the Act (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, the State officials who are responsible for program administration and financial oversight.

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

§ 457.50 State plan.

The State plan is a comprehensive written statement submitted by the State to HCFA for approval, which describes the purpose, nature, and scope of the State's CHIP and gives assurance that the program is administered in conformity with the specific requirements of title XXI, title XIX of the Act (as appropriate), and the regulations in this chapter. The State plan contains all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

§ 457.60 Amendments.

(a) *Submittal of plan amendments.* A State may amend its approved State plan in whole or in part at any time through the submission of an amendment to HCFA. A State must amend its State plan whenever necessary to reflect—

(1) Changes in Federal law, regulations, policy interpretations, or court decisions;

(2) Changes in State law, organization, policy, or operation of the program; and

(3) Changes in the source of the State share of funding.

(b) *Budget amendment.* When the State plan amendment makes any modification to the approved budget, a State must include an amended budget that describes the State's planned expenditures for a three year period.

§ 457.65 Duration of State plans and plan amendments.

(a) *Effective date in general.* (1) A State plan or plan amendment takes effect on the day specified in the plan but no earlier than October 1, 1997. The effective date is no earlier than the date on which the State begins to incur costs to implement its State plan or plan amendment.

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

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

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

(2) The public notice was published before the requested effective date of 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 § 457.555 is considered an amendment that restricts benefits and must meet the requirements in paragraph (b) of this section.

(d) *Amendments relating to source of State funding.* (1) A State must submit a plan amendment to HCFA before any change in the source of the State share of funding from the source reflected in the approved State plan can take effect.

(2) A State is not required to submit a plan amendment for changes in the type of non-health care related revenues used to generate general revenue.

(e) *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; or

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

§ 457.70 Program options.

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

(1) A Medicaid expansion program;

(2) A separate child health program; or

(3) A combination program.

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

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

(1) Meet the requirements of the following subparts of this part—

(i) Subpart A;

(ii) Subpart B (if the State claims administrative costs under title XXI of the Act;

(iii) Subpart C (with respect to the definition of a targeted low-income child only);

(iv) 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 of the Act only);

(v) Subpart G;

(vi) Subpart H (if the State elects the eligibility group for optional targeted low-income children and elects to pay for employer-sponsored insurance); and

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

(2) Submit an approvable amendment to the State's Medicaid State plan as appropriate.

(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;

(c) Procedures the State uses to accomplish coordination of CHIP with other public and private health insurance programs, including procedures designed to increase the number of children with creditable health coverage and to ensure that only eligible targeted low-income children are covered under CHIP.

§ 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.

§ 457.110 Enrollment assistance and information requirements.

(a) *Information disclosure.* The State must make accurate, easily understood information available to families of targeted low-income children and provide assistance to these families in making informed health care decisions about their health plans, professionals, and facilities.

(b) *Required information.* The State must have a mechanism in place to ensure that the following information is made available to applicants and beneficiaries in a timely manner:

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

(2) Names and locations of current participating providers.

§ 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; and

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

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

(a) *Enrollment.* A State must include a description of procedures used to ensure the provision of child health assistance to American Indian and Alaska Native children. HCFA requests that the State official responsible for CHIP consult with Federally recognized Tribes and other Indian tribes and organizations in the State on the development and implementation of these procedures.

(b) *Exemption from cost sharing.* HCFA will not approve a State plan that imposes cost sharing on American Indian and Alaska Native children.

§ 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 as required at § 457.60(b), must include a budget that describes the State's planned expenditures for a 3-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.

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

§ 457.150 HCFA review of State plan material.

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

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

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

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

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

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

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

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

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

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

(i) Written notice of disapproval; or

(ii) Written notice of additional information it needs in order to make a final determination.

(2) A State plan or plan amendment is considered received when the

designated official or individual, as determined in § 457.150(d) and (e), receives an electronic, fax or paper copy of the complete material.

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

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

(ii) Resumes on the next calendar day after the HCFA designated individual receives an electronic, fax, or hard copy from the State of all the requested additional information, unless the information is received after 5 p.m. eastern 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, HCFA will consider the 90th day to be the next business day.

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

§ 457.170 Withdrawal process.

A State may withdraw its State plan or plan amendment at any time during the review process by providing written notice to HCFA of the withdrawal.

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

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

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

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

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

(e) *Judicial review.* Judicial review of a final determination made under this subchapter is governed by § 430.38 of this chapter.

Subpart B—[Reserved]

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

§ 457.300 Basis, scope, and applicability.

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

(1) Section 2102(b) of the Act, which relates to eligibility standards and methodologies;

(2) Section 2105(c)(6)(B) of the Act, which relates to no payment for expenditures for child health assistance provided to children eligible for coverage under other Federal health care programs other than programs operated or financed by the Indian Health Service; and

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

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

(c) *Applicability.* The requirements of this subpart apply to child health assistance provided under a separate child health program and apply to a Medicaid expansion program only with respect to the definition of a targeted low-income child.

§ 457.301 Definitions and use of terms.

As used in this subpart—

Employment with a public agency includes employment with an entity under a contract with a public agency;

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;

State health benefits plan means a 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 separately run county, city, or other public agency plan or a plan that provides coverage only for a specific type of care, such as dental or vision care.

§ 457.305 State plan provisions.

The State plan must include a description of standards consistent with § 457.310 and § 457.320 used to determine the eligibility of children for coverage under the State plan.

§ 457.310 Targeted low-income child.

(a) *Definition.* A targeted low-income child is a child who meets the standards set forth in paragraph (b) of this section and other eligibility standards established by the State under § 457.320.

(b) *Standards.* A targeted low-income child must meet the following standards:

(1) *Financial need.* A child who resides in a State with a Medicaid applicable income level must have a family income at or below 200 percent of the Federal poverty line or family income that—

(i) Exceeds the Medicaid applicable income level but not by more than 50 percentage points (expressed as a percentage of the Federal poverty line); or

(ii) Does not exceed the Medicaid applicable income level calculated using June 1, 1997 instead of March 31, 1997.

(2) *No other coverage.* A targeted low-income child must not be—

(i) Found eligible for Medicaid (determined either through the Medicaid application process or the screening process described at § 457.350); or

(ii) Covered under a group health plan or under health insurance coverage, unless the 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 would not be considered covered under a group health plan if the child did not have reasonable access to care under that plan.

(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 a member of a family 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. A contribution over $10

towards the cost of dependent coverage is considered more than nominal.

(iii) The contribution with respect to the child is calculated by deducting amounts only available to an adult employee from the total State or public agency contribution.

(2) *Residents of an institution.* A child must not be an inmate of a public institution or a patient in an institution for mental diseases as defined at § 435.1009 of this chapter, at the time of initial application or any redetermination of eligibility.

§ 457.320 Other eligibility standards.

(a) 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 (not to exceed 18 years);

(3) Income;

(4) Resources;

(5) Spenddowns;

(6) Disposition of resources;

(7) Residency;

(8) Disability status;

(9) Access to or coverage under other health coverage; or

(10) Duration of eligibility (as long as eligibility is determined at least every 12 months).

(b) In establishing eligibility standards, a State may *not*—

(1) Cover children with higher family income without covering children with a lower family income within any defined group of covered targeted low-income children;

(2) Deny eligibility based on a preexisting medical condition;

(3) Restrict eligibility based on disability status;

(4) Require that any individual provide a social security number, including the social security number of the child or that of a family member whose income or resources might be used in making the child's eligibility determination;

(5) Exclude American Indian or Alaska Native children based on eligibility for, or access to, medical care funded by the Indian Health Service;

(6) Violate any other Federal laws or regulations pertaining to eligibility for CHIP, including laws that require exclusion of certain income or resources from all consideration and laws that require verification of certain items or statuses;

(7) Exclude individuals based on citizenship or nationality, to the extent that the children are U.S. citizens, U.S. nationals or qualified aliens (except to the extent that 8 U.S.C. 1613(a) precludes them from receiving Federal means-tested public benefits).

(c) In establishing eligibility for CHIP coverage, States must obtain proof of citizenship (including nationals of the U.S.) and verify qualified alien status in accordance with section 432 of PRWORA, as amended (8 U.S.C. 1642).

§ 457.340 Application.

(a) *Opportunity to apply.* The State must afford every individual the opportunity to apply for child health assistance without delay.

(b) *Application forms.* The application form used to apply for child health assistance may be—

(1) A joint application for both Medicaid and CHIP; or

(2) A separate application for CHIP only.

§ 457.350 Eligibility screening.

(a) *State plan requirement.* The State plan must include a description of the screening procedures that the State will use, at intake and any follow-up eligibility determination, including any periodic redetermination, to ensure that only targeted low-income children are furnished child health assistance under the plan.

(b) *Screening with joint application.* A State that uses a joint application for Medicaid and CHIP must use the screening procedures described in paragraphs (c) and (d) of this section for children who apply for CHIP.

(c) *Screening objectives.* Except as described in paragraph (e) of this section, a State must use screening procedures to identify, at minimum, any child who—

(1) Is potentially eligible for Medicaid under one of the poverty level related groups described in section 1902(l) of the Act; or

(2) If the State has not extended eligibility in the groups described in paragraph (c)(1) of this section to children of a particular age, is potentially eligible for Medicaid because the child meets the highest categorical income standards used under Medicaid to establish eligibility for non-disabled children of that age.

(d) *Eligibility test.* To identify the children in paragraph (c) of this section, at a minimum, States must either initially apply a gross income test described in paragraph (d)(1) of this section and then use an adjusted income test described in paragraph (d)(2) of this section for applicants whose State-defined income exceeds the initial test, or use only the adjusted income test for all applicants.

(1) *Initial gross income test.* Under this test, a State initially screens for Medicaid eligibility by comparing gross family income to the appropriate Medicaid income standard.

(2) *Adjusted income test.* Under this test, a State screens for Medicaid eligibility by comparing adjusted family income to the appropriate Medicaid income standard. The State must apply all Medicaid policies relating to income for the particular Medicaid eligibility group, including—

(i) Income standards;

(ii) Income exclusions and disregards; and

(iii) Methodologies for determining countable income and resources including State Medicaid policies and procedures for deeming of income.

(e) *Treatment of children found potentially eligible for Medicaid.* After applying the appropriate eligibility tests, the State must—

(1) Find ineligible for CHIP a child whose State-defined income or adjusted family income is below the applicable Medicaid income standard, or who is found potentially eligible for Medicaid under any other tests that the State has chosen to apply, unless a completed Medicaid application for that child is denied;

(2) Redetermine eligibility for a child found ineligible for CHIP through the screening process if—

(i) An application for Medicaid is completed for the child and the child is found ineligible for Medicaid; or

(ii) The child's circumstances change and another screening shows that the child is ineligible for Medicaid; and

(3) Provide that the child found ineligible for CHIP remains ineligible for CHIP unless the child's circumstances change even if the child refuses to apply for Medicaid or does not complete the Medicaid application process for any reason.

(f) *Treatment of child found potentially ineligible for Medicaid.* If the State uses a screening procedure other than a full determination of Medicaid eligibility under all possible groups, and the screening reveals that the child is ineligible for Medicaid, the State must provide the child's family the following in writing:

(1) A statement that, based on an initial review, the child does not appear eligible for Medicaid, but Medicaid eligibility can only be determined based on review of a full Medicaid application.

(2) Information about Medicaid benefits (if that information was not already furnished).

(3) Information about how and where to apply for Medicaid.

§ 457.360 Facilitating Medicaid enrollment.

(a) *State Plan requirement.* The State plan must include a description of reasonable procedures, including the

procedures described in paragraphs (b) and (c) of this section, to ensure that children found through the screening process described in § 457.350 to be eligible for Medicaid actually apply for and are enrolled in Medicaid.

(b) The State must establish procedures through which the State initiates the Medicaid enrollment process for children found through eligibility screening to be potentially Medicaid eligible consistent with the following requirements:

(1) States that use a separate Medicaid application must either—

(i) Provide Medicaid application assistance at the CHIP office to the extent permitted under Medicaid law and regulations;

(ii) Send information obtained through the screening process to the appropriate Medicaid office or to Medicaid staff, to begin the Medicaid application process; or

(iii) Use other reasonable procedures designed to ensure application and enrollment in Medicaid.

(2) States that use a joint Medicaid and CHIP application must send the application to the appropriate Medicaid office or to Medicaid staff to make the Medicaid eligibility determination.

(c) *Informed application decisions.* A State must ensure that a decision by a family not to apply for Medicaid or not to complete the Medicaid application process represents an informed decision by providing full and complete information, in writing, about—

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

(2) The effect on eligibility for CHIP of neither applying for Medicaid nor completing the Medicaid application process.

§ 457.361 Application for and enrollment in CHIP.

(a) *Application assistance.* A State must afford families a reasonable opportunity to complete the application process and must offer assistance to families in understanding and completing applications and in obtaining any required documentation.

(b) *Notice of rights and responsibilities.* A State must inform applicants, in writing and orally if appropriate, about the eligibility requirements, their obligations under the program, and their right to file grievances and appeals in accordance § 457.985.

(c) *Notice of decision concerning eligibility.* The State must send each applicant a written notice of the decision on the application and, if eligibility is denied or terminated, the specific reason or reasons for the action and an explanation of the right to request a hearing within a reasonable time.

(d) *Timely determinations of eligibility.* The State must establish time standards for determining eligibility and inform the applicant of those standards. These standards may not exceed forty-five calendar days.

(1) In applying the time standards, the State must count each calendar day from the day of application to the day the agency mails notice of its decision to the applicant.

(2) The agency must determine eligibility within the standards except in unusual circumstances, for example—

(i) When the agency cannot reach a decision because the applicant delays or fails to take a required action; or

(ii) When there is an administrative or other emergency beyond the agency's control.

(3) The agency must not use the time standards—

(i) As a waiting period before determining eligibility; or

(ii) As a reason for denying eligibility (because it has not determined eligibility within the time standards).

(e) *Effective date of eligibility.* The State must specify in its approved state plan a method for determining the effective date of CHIP eligibility, which can be determined based on the date of application or through any other reasonable method.

§ 457.365 Grievances and appeals.

The State must provide enrollees in separate child health programs with an opportunity to file grievances and appeals for denial, suspension or termination of eligibility in accordance with § 457.985.

Subpart D—Coverage and Benefits: General Provisions

§ 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 certain types of care;

(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 Child health assistance and other definitions.

(a) *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:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) Physician services and surgical services.

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

(5) 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.

(6) Over-the-counter medications.

(7) Laboratory and radiological services.

(8) Prenatal care and prepregnancy family planning services and supplies.

(9) Inpatient mental health services, other than services described in paragraph (a)(17) of this section but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

(10) Outpatient mental health services, other than services described in paragraph (a)(18) of this section but including services furnished in a State-operated mental hospital and including community-based services.

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

(12) Disposable medical supplies.

(13) 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.)

(14) 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.

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

(16) Dental services.

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

(18) Outpatient substance abuse treatment services.

(19) Case management services.

(20) Care coordination services.

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

(22) Hospice care.

(23) 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—

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

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

(iii) 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.

(24) Premiums for private health care insurance coverage.

(25) Medical transportation.

(26) 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.

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

(b) *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.

(c) *Emergency services* means covered inpatient or outpatient services that are—

(1) Furnished by any provider qualified to furnish emergency services without requirement for prior authorization; and

(2) Needed to evaluate or stabilize an emergency medical condition.

(d) *Post-stabilization services* means medically necessary non-emergency services furnished to an enrollee after he or she is stabilized related to the emergency medical condition.

(e) *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.

§ 457.410 Health benefits coverage options.

(a) *Types of health benefits coverage.* States may choose to provide 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 under paragraph (a) of this section that the State chooses to obtain, the State must obtain coverage for—

(1) Well-baby and well-child care;

(2) Immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP); and

(3) Emergency services as defined in § 457.402(c).

§ 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 packages:

(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.* The 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 must have 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 services.* 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.

(4) Well-baby and well-child care, including age-appropriate immunizations provided in accordance with the recommendations of the ACIP.

(c) *Additional services.* (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, the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the value of the coverage for such a category or service in the benchmark plan used for comparison by the State.

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

§ 457.431 Actuarial report for benchmark-equivalent coverage.

(a) To obtain approval for benchmark-equivalent health benefits coverage described under § 457.430, the State must submit to HCFA an actuarial report that contains an actuarial opinion that the health benefits coverage meets the actuarial requirements under § 457.430. The report must also specify the benchmark coverage used for comparison.

(b) The actuarial report must state that it was prepared—

(1) By an individual who is a member of the American Academy of Actuaries;

(2) Using generally accepted actuarial principles and methodologies of the American Academy of Actuaries;

(3) Using a standardized set of utilization and price factors;

(4) Using a standardized population that is representative of privately insured children of the age of those expected to be covered under the State plan;

(5) Applying the same principles and factors in comparing the value of different coverage (or categories of services);

(6) Without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

(7) Taking into account the ability of a State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing under that coverage.

(c) The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of this section.

(d) The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by HCFA, to replicate the State's result.

§ 457.440 Existing comprehensive State-based coverage.

(a) *General requirements.* Existing comprehensive State-based health benefits coverage must—

(1) Include coverage of a range of benefits;

(2) Be administered or overseen by the State and receive funds from the State;

(3) Be offered in the State of New York, Florida or Pennsylvania; and (4) Have been 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; and

(2) 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.

A State may provide health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population of targeted low-income children covered under the program. Secretary-approved coverage, for which no actuarial analysis is required, may include—

(a) Coverage that is the same as the coverage provided under the Medicaid State plan;

(b) Comprehensive coverage offered by the State under a Medicaid demonstration project approved by the Secretary under section 1115 of the Act that either includes coverage for the full Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit or that the State has extended to the entire Medicaid population in the State;

(c) Coverage that includes benchmark coverage, as specified in § 457.420, plus any additional coverage; or

(d) Coverage, including coverage under an employer-sponsored group health plan purchased by the State, that the State demonstrates to be substantially equivalent to benchmark coverage, as specified in § 457.420, through use of a benefit-by-benefit comparison of the coverage demonstrating that each benefit meets or exceeds the corresponding benefit in the benchmark.

§ 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 of the Act even if any benchmark package includes coverage for that item or service.

§ 457.475 Limitations on coverage: Abortions.

(a) *General rule.* FFP under title XXI of the Act 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 paragraphs (b)(1) and (b)(2) 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 to be paid with State-only funds, or append riders, attachments or addenda to existing contracts to separate the additional abortion services from the other services covered by the contract.

(3) Nothing in this section affects the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than those expended under the State plan) for any abortion services or for health benefits coverage that includes coverage of abortion services.

§ 457.480 Preexisting condition exclusions and relation to other laws.

(a) *Preexisting condition exclusions.* (1) Subject to paragraph (a)(2) of this section, the State child health insurance plan may not permit the imposition of any pre-existing condition exclusion for covered benefits under the plan.

(2) If the State obtains health benefits coverage through payment for, or a contract with, a group health plan or group health insurance coverage, the State may permit the imposition of a pre-existing condition exclusion but only to the extent that the exclusion is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (ERISA) and title XXVII of the Public Health Service Act.

(b) *Relation of title XXI to other laws.* (1) *ERISA.* Nothing in this title affects or modifies section 514 of ERISA with respect to a group health plan as defined by section 2791(a)(1) of the Public Health Service Act.

(2) *Health Insurance Portability and Accountability Act (HIPAA).* Health benefits coverage provided under a State plan and coverage provided as a cost-effective alternative, as described in subpart J of this part, is creditable coverage for purposes of part 7 of subtitle B of title II 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).* A State plan under this subpart 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).* A State plan under this subpart must comply with the requirements of the NMHPA of 1996

regarding requirements for minimum hospital stays for mothers and newborns in accordance with 45 CFR 146.130 and 148.170.

§ 457.490 Delivery and utilization control systems.

A State that elects to obtain health benefits coverage through a separate child health program must include in its State plan a description of the child health assistance provided under the plan for targeted low-income children, including a description of the proposed methods of delivery and utilization control systems. A State must—

(a) Describe the methods of delivery of child health assistance including the choice of financing and the methods for assuring delivery of the insurance products to the children, including any variations; and

(b) Describe utilization controls systems designed to ensure that children use only appropriate and medically necessary health care approved by the State or its subcontractor.

§ 457.495 Grievances and appeals.

States must provide enrollees in a separate child health program the right to file grievances or appeals for reduction or denial of services as specified in § 457.985.

Subpart E—State Plan Requirements: Beneficiary Financial Responsibilities

§ 457.500 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart implements section 2103(e) of the Act, which sets forth provisions regarding State plan requirements for cost sharing limitations and options.

(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 child health assistance provided under a separate child health program and, with respect to the mandatory cost sharing waiver for AI/AN children only, a Medicaid expansion program.

§ 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 beneficiaries, applicants, providers and the general public of the cost sharing charges, the cumulative cost sharing maximum, and any changes to these amounts; and

(c) When States purchase coverage through, or provide premium assistance for, employer sponsored group health plans—

(1) The procedures the State uses to ensure that beneficiaries are not charged copayments, coinsurance, deductibles or similar fees on well-baby and well-child care as defined in § 457.520. A procedure that primarily relies on a refund given by the State for overpayment by a beneficiary is not an acceptable procedure.

(2) The procedures to ensure that AI/AN children are not charged premiums, copayments, coinsurance, deductibles, or similar fees as required in § 457.535. A procedure that primarily relies on a refund given by the State for overpayment by a beneficiary is not an acceptable procedure.

(3) The procedures to ensure that beneficiaries are not charged cost sharing in excess of the cumulative cost sharing maximum specified in § 457.555. A procedure that primarily relies on a refund given by the State for overpayment by a beneficiary is not an acceptable procedure.

§ 457.510 Premiums, enrollment fees, or similar fees: State plan requirements.

When a State imposes premiums, enrollment fees, or similar fees on CHIP beneficiaries, the State plan must describe—

(a) The amount of the premium, enrollment fee or similar fee imposed on beneficiaries;

(b) The time period for which the charge is imposed;

(c) The group or groups that are subject to the premium, enrollment fees, or similar charges;

(d) The consequences for a beneficiary who does not pay a charge; and

(e) A methodology to ensure that total cost sharing liability for a family does not exceed the cumulative cost sharing maximum specified in § 457.560. A methodology that primarily relies on a refund given by the State for overpayment by a beneficiary is not an acceptable methodology.

§ 457.515 Co-payments, coinsurance, deductibles, or similar cost sharing charges: State plan requirements.

To impose copayments, coinsurance, deductibles or similar charges on beneficiaries, the State plan must describe—

(a) The service for which the charge may be imposed;

(b) The amount of the charge;

(c) The group or groups that may be subject to the cost sharing charge;

(d) The consequences for a beneficiary who does not pay a charge; 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. A methodology that primarily relies on a refund given by the State for overpayment by a beneficiary is not an acceptable methodology.

(f) An assurance that—

(1) Enrollees will not be held liable for additional costs, beyond the copayment amounts specified in the State plan, that are associated with emergency services provided at a facility that is not a participating provider in the enrollee's managed care network; and

(2) The State will not charge different copayment amounts for emergency services, based upon the location (in network or out of network) at which those services were provided.

§ 457.520 Cost sharing for well-baby and well-child care.

(a) The State plan may not impose copayments, deductibles, coinsurance or other cost sharing with respect to well-baby and well-child care services as defined by the State in either the managed care delivery setting or the fee-for-service delivery setting.

(b) For the purposes of this subpart, any of the following services covered under the State plan are well-baby and well-child care services:

(1) All healthy newborn inpatient physician visits, including routine screening whether provided on an inpatient or outpatient basis.

(2) Routine physical examinations.

(3) Laboratory tests.

(4) Immunizations and related office visits as recommended and updated in 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.''

(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) Beneficiary groups subject to the charges.

(3) Cumulative cost sharing maximums.

(4) The consequences for a beneficiary who does not pay a charge.

(b) The State must make the public schedule available to the following groups:

(1) CHIP beneficiaries, at the time of enrollment, and when cost sharing charges and cumulative cost sharing maximums are revised.

(2) CHIP applicants, at the time of application.

(3) All CHIP participating providers.

(4) The general public.

§ 457.530 General cost sharing protection for lower income children.

The State may vary premiums, deductibles, coinsurance, copayments or any other cost sharing based on family income only in a manner that does not favor children from families with higher income over children from families with lower income.

§ 457.535 Cost sharing protection to ensure enrollment of American Indians/ Alaska Natives.

States must exclude from premiums, deductibles, coinsurance, copayments or any other cost sharing charges those children who are American Indians and Alaska Natives, members of a Federally recognized tribe, and enrolled in a separate child health program.

§ 457.540 Cost sharing charges for children in families at or below 150 percent of the Federal poverty line (FPL).

The State may impose premiums, enrollment fees, deductibles, copayments, coinsurance, cost sharing and other similar charges for children whose family income is at or below 150 percent of the FPL as long as—

(a) Aggregate monthly enrollment fees, premiums, or similar charges imposed on a family are less than or equal to the maximum monthly charges described in § 447.52 of this chapter for a Medicaid eligible family of the same size and income;

(b) For children whose family income is at or below 100 percent of the FPL, any copayments, coinsurance, deductibles or similar charges are equal to or less than the amounts permitted under § 447.54 of this chapter;

(c) For children whose family income is 101 percent to 150 percent of the FPL, any copayments, coinsurance, deductibles or similar charges are equal to or less than the amounts permitted under § 457.555;

(d) The frequency of cost sharing charges is consistent with § 457.550; and

(e) 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(d).

§ 457.545 Cost sharing for children in families above 150 percent of the FPL.

The State may impose premiums, enrollment fees, copayments, deductibles, coinsurance, cost sharing and similar charges on children in families above 150 percent of the FPL, as long as 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 § 457.555(c).

§ 457.550 Restriction on the frequency of cost sharing charges on targeted low-income children in families at or below 150 percent of the FPL.

(a) The State plan may not impose more than one type of cost sharing charge (deductible, copayment, or coinsurance) on a service.

(b) The State plan may not impose more than one copayment for multiple services furnished during one office visit.

(c) For targeted low-income children whose family income is from 101 to 150 percent of the FPL, a standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in paragraphs (b) and (c) of this section to the State's average or typical payment for that service.

§ 457.555 Maximum allowable cost sharing charges on targeted low-income children in families with income from 101 to 150 percent of the FPL.

(a) *Non-institutional services.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State plan must provide that for non-institutional services—

(1) Any copayment or similar charge the State imposes under a fee-for-service delivery system does not exceed the following amounts:

Payment for the service	Maximum amount chargeable to beneficiary
$15.00 or less	$1.00
$15.01 to $40	2.00
$40.01 to $80	3.00
$80.01 or more	5.00

(2) Any copayment that the State imposes under a managed care organization may not exceed $5.00 per visit;

(3) Any coinsurance rate the State imposes may not exceed 5 percent of the payment the State directly or through contract makes for the service; and

(4) Any deductible the State imposes may not exceed $3.00 per month, per family for each period of CHIP eligibility.

(b) *Institutional services.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the maximum deductible, coinsurance or copayment charge for each institutional admission may not exceed 50 percent of the payment the State makes directly or through contract for the first day of care in the institution.

(c) *Nonemergency use of the emergency room.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State may charge up to twice the charge for non-institutional services, up to a maximum amount of $10.00, for services furnished in a hospital emergency room if those services do not result from an emergency medical condition.

(d) *Emergency room services provided outside of the enrollee's managed care network.* States must assure that enrollees will not be held liable for additional costs associated with emergency services provided at a facility that is not a participating provider in the enrollee's managed care network beyond the specified co-payment amount.

§ 457.560 Cumulative cost sharing maximum.

(a) *Legal obligation* means liability to pay amounts a provider actually charges and any other amounts for which payment may be required under applicable State law for covered services to eligible children, even if payment is never actually made.

(b) *General rules.* (1) The State plan may set cumulative cost sharing maximum levels lower than the maximum levels specified in paragraphs (c) and (d) of this section, but may not set maximum levels in excess of the specified levels.

(2) A State must count cost sharing amounts that the family has a legal obligation to pay in computing whether a family has met the cumulative cost sharing maximum.

(c) *Children with family incomes above 150 percent of the FPL.* For targeted low-income children with family income above 150 percent of the FPL, the State plan may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost sharing charges that, in the aggregate, exceed 5 percent of total family income for a year (or 12 month eligibility period).

(d) *Children with family incomes at or below 150 percent of the FPL.* For targeted low-income children with family income at or below 150 percent of the FPL, the plan may not impose premiums, deductibles, copayments, coinsurance, enrollment fees, or similar cost sharing charges that, in the aggregate, exceed 2.5 percent of total family income for the year.

§ 457.565 Grievances and appeals.

The State must provide enrollees in a separate child health program the right to file grievances and appeals as specified in § 457.985 for disenrollment from the program due to failure to pay cost sharing.

§ 457.570 Disenrollment protections.

The State must establish a process that gives beneficiaries reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

Subpart F—[Reserved]

Subpart G—Strategic Planning, Reporting, and Evaluation

§ 457.700 Basis, scope, and applicability.

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

(1) Sections 2102(a)(7)(A) and (B) of the Act, which relate to assurances of quality and appropriateness of care, and access to covered services;

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

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

(b) *Scope.* This subpart sets forth requirements for strategic planning, monitoring, reporting and evaluation under title XXI of the Act.

(c) *Applicability.* The requirements of this subpart apply to separate child health programs and Medicaid expansion programs.

§ 457.710 State plan requirements: Strategic objectives and performance goals.

(a) *Plan description.* A State plan must include a description of—

(1) The strategic objectives as described in paragraph (b) of this section;

(2) The performance goals as described in paragraph (c) of this section; and

(3) The performance measurements, as described in paragraph (d) of this section, that the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health benefits coverage for other low-income children and children generally in the State.

(b) *Strategic objectives.* The State plan must identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children.

(c) *Performance goals.* The State plan must specify one or more performance goals for each strategic objective identified.

(d) *Performance measurements.* The State plan must describe how performance under the plan is—

(1) Measured through objective, independently verifiable means; and

(2) Compared against performance goals.

§ 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.

§ 457.730 State plan requirement: State annual reports and evaluation.

A State plan must include a description of the State's strategy for the submission of the annual reports required under § 457.750, and the evaluation required by § 457.760.

§ 457.735 State plan requirement: State assurance of the quality and appropriateness of care.

(a) 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, particularly with respect to—

(1) Well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations; and

(2) Access to covered services, including covered emergency services and covered post-stabilization services as defined at § 457.402.

(b) States must assure appropriate and timely procedures to monitor and treat enrollees with complex and serious medical conditions, including access to specialists.

§ 457.740 State expenditures and statistical reports.

(a) *Required quarterly reports.* A State must submit a report to HCFA that contains quarterly program expenditures and statistical data no later than 30 days after the end of each quarter of the Federal fiscal year. Territories are excepted from the definition of ''State'' for the purposes of quarterly reporting. A State must collect required data beginning on the date of implementation of the approved State plan. The quarterly reports must include data on—

(1) Program expenditures; and

(2) 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) Service delivery system (managed care, fee-for-service, and primary care case management).

(iii) Family income as a percentage of the Federal poverty level as described in paragraph (b) of this section.

(b) *Reportable family income categories.* (1) A State that does not impose cost sharing or a State that only imposes cost-sharing based on a fixed percentage of income must report by two family income categories:

(i) At or below 150 percent of FPL.

(ii) Over 150 percent of FPL.

(2) A State that imposes cost sharing at one or more poverty levels must report by poverty level categories that match the poverty level categories used for purposes of cost sharing in the separate child health program and in the Medicaid-expansion program.

(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 are enrolled in the Medicaid program, the separate child health program, and the Medicaid-expansion program, as appropriate, by age, service delivery, and poverty level categories described in paragraphs (a) and (b) of this section.

§ 457.750 Annual report.

(a) *Report required for each Federal fiscal year.* A State must report to HCFA by January 1 following the end of each Federal fiscal year, on the results of the State's assessment of the operation of the State plan.

(b) *Contents of annual report.* In the annual report required under paragraph (a) of this section, a State must—

(1) Describe the State's progress in reducing the number of uncovered, low-income children and in meeting other strategic objectives and performance goals identified in the State plan;

(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 agreed to periodically monitor and assess;

(5) Provide an updated budget for the current Federal fiscal year with details on the planned use of funds and any changes in the sources of the non-Federal share of State plan expenditures; and

(6) Identify the total State expenditures for family coverage and total number of children and adults covered by family coverage during the preceding Federal fiscal year.

(c) *Methodology for estimate of number of uninsured, low-income children.* (1) To report on the progress made in reducing the number of uncovered, 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 and to provide an annual estimate of changes in this number at two poverty levels, 200 percent FPL and at the current upper eligibility level of the State's program. A State may base the estimate on data from—

(i) The March supplement to the Current Population Survey (CPS);

(ii) A State-specific survey;

(iii) A statistically adjusted CPS; or

(iv) Another appropriate source.

(2) A State must submit a description of the methodology used to develop the initial baseline estimate and the rationale for its use unless the State bases the estimate on data from the March supplement to the CPS.

§ 457.760 State evaluations.

By March 31, 2000, a State that has an approved State plan must submit to HCFA a report on the operation of its Medicaid-expansion program, separate child health program, or combination program. The report must provide an evaluation of the State plan that includes the following:

(a) An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage.

(b) A report on progress made in meeting other strategic objectives and performance goals identified by the State plan.

(c) A description and analysis of the effectiveness of elements of the State plan, including—

(1) The characteristics of the children and families assisted under the State plan, including age of the children, family income, and the assisted children's access to coverage or coverage by other health insurance prior to the State plan and after eligibility for coverage under the State plan ends;

(2) The quality of health coverage provided, including the results or the plans to assess the results of any monitoring or other methods used to assure quality and appropriateness of care;

(3) The amount and level of assistance (including payment of part or all of any premiums, copayments, or enrollment fees) provided by the State;

(4) The service area of the State program;

(5) The time limits for coverage of a child under the program;

(6) The extent of substitution of public coverage for private coverage and the State's effectiveness in designing policies that discourage substitution.

(7) The State's choice of health benefits coverage, including the types of benefits provided and the scope and range of these benefits, and other methods used for providing child health assistance; and

(8) The sources of non-Federal funding used in the program.

(d) A State that subsidizes children's coverage through employer-sponsored group health plans must provide an assessment of the effectiveness of its substitution prevention strategies.

(e) An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.

(f) A review and assessment of State activities to coordinate the program with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.

(g) An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.

(h) A description of any plans the State has for improving the availability of health insurance and health care for children.

(i) Recommendations for improving the program.

Subpart H—Substitution of Coverage

§ 457.800 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements section 2102(b)(3)(C) of the Act, which provides that the State plan must include a description of procedures the State uses to ensure that insurance 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 employer-sponsored group health plans.

(c) *Applicability.* The requirements of this subpart apply to separate child health programs.

§ 457.805 State plan requirements: Private coverage substitution.

The State plan must include a description of reasonable procedures to ensure that coverage provided under the plan does not substitute for coverage under group health plans as defined at § 457.10.

§ 457.810 Premium assistance for employer-sponsored group health plans: Required protections against substitution.

If a State obtains health benefits coverage through employer-sponsored group health plans, the State must provide the protections against substitution of CHIP coverage for private coverage specified in this section. States must describe these provisions in their State plan, annual reports, and State evaluations.

(a) *Minimum period without employer-sponsored group health coverage.* (1) As a condition of eligibility for CHIP payment for employer-sponsored group health coverage, a child must not have had employer-sponsored group health coverage for a period of at least 6 months and not more than 12 months prior to application for CHIP.

(2) States may permit exceptions to the minimum period without employer-sponsored group health coverage if a child's coverage during the minimum period was involuntarily terminated by an employer.

(3) A newborn is not required to have a period without insurance as a condition of eligibility for CHIP payment for employer-sponsored group health coverage.

(b) *Employer contribution.* As a condition of eligibility for CHIP payment for employer-sponsored group health coverage—

(1) The employee who is eligible for the coverage must apply for the full premium contribution available from the employer; and

(2) The employer must make a substantial contribution to the cost of family coverage equal to—

(i) 60 percent of the total cost; or

(ii) A lower amount if the State can show that the average contribution in the State is lower than 60 percent.

(c) *Cost effectiveness.* The State's payment for coverage for a child under an employer-sponsored group health plan must not be greater than the cost of other CHIP coverage.

(d) *State evaluation.* The State must evaluate the amount of substitution that occurs as a result of payments for employer sponsored group health plans and the effect of those payments on access to coverage.

Subpart I—Program Integrity and Beneficiary Protections

§ 457.900 Basis, scope and applicability.

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

(1) Section 2101(a) of the Act, which provides 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; and

(2) Section 2107(e) of the Act, which provides that certain title XIX and title XI provisions, including the following, apply to States under title XXI in the same manner as they apply to a State under title XIX:

(i) Section 1902(a)(4)(C) of the Act, relating to conflict of interest standards.

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

(iii) Section 1903(w) of the Act, relating to limitations on provider taxes and donations.

(iv) Section 1124 of the Act, relating to disclosure of ownership and related information.

(v) Section 1126 of the Act, relating to disclosure of information about certain convicted individuals.

(vi) Section 1128 of the Act, relating to exclusions.

(vii) Section 1128A of the Act, relating to civil monetary penalties.

(viii) Section 1128B(d) of the Act, relating to criminal penalties for certain additional charges.

(ix) Section 1132 of the Act, relating to periods within which claims must be filed.

(b) *Scope.* This subpart sets forth requirements, options, and standards for program integrity assurances that must be included in the approved State plan.

(c) *Applicability.* This subpart only applies to States that implement separate child health programs. States that implement Medicaid expansion programs are subject to the program integrity rules and requirements specified under title XIX of the Act.

§ 457.902 Definitions.

As used in this subpart—

Contractor means any individual or entity that enters into a contract, or a subcontract to provide, arrange, or pay for services under title XXI of the Act. This definition includes, but is not limited to, managed care organizations, prepaid health plans, primary care case managers, and fee-for-service providers and insurers.

Fee-for-service entity means any entity that furnishes services, under the program on a fee-for-service basis, including health insurance services.

Grievance means a written communication, submitted by or on behalf of an enrollee in a child health program, expressing dissatisfaction with any aspect of a State, a managed care or fee-for-service entity, or a provider's operations, activities or behavior that pertains to—

(1) The availability, delivery, or quality of health care services, including utilization review decisions that are adverse to the enrollee;

(2) Payment, treatment, or reimbursement of claims for health care services; or

(3) Issues unresolved through the complaint process established in accordance with § 457.985(e).

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.

State program integrity unit means a part of an organization designated by the State (at its option) to conduct program integrity activities for separate child health programs.

§ 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 (hereafter referred to as the ''State program integrity unit''),

(c) *Program coordination.* The State must develop and implement procedures for referring suspected fraud and abuse cases to the State program integrity unit and to law enforcement officials. Law enforcement officials include, but are not limited to 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.

§ 457.920 Accessible means to report fraud and abuse.

The State agency must establish and provide access to a mechanism for communication between the State and the public about potentially fraudulent and abusive practices by and among contractors, beneficiaries, and other entities. This communication mechanism may include a toll-free telephone number.

§ 457.925 Preliminary investigation.

If the State agency receives a complaint of fraud or abuse from any source or identifies any questionable practices, the State agency must conduct a preliminary investigation or take otherwise appropriate action 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, when requested to do so by that unit.

(b) Conduct a full investigation; or

(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 contractor 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 of the Act, in the same manner as these provisions and regulations apply to a State under title XIX:

(1) Part 455, subpart B of this chapter.

(2) Section 1124 of the Act pertaining to disclosure of ownership and related information.

(3) Section 1126 of the Act pertaining to disclosure by institutions, organizations, and agencies of owners and certain other individuals who have been convicted of certain offenses.

(4) Section 1128 of the Act pertaining to exclusions.

(5) Section 1128A of the Act pertaining to civil monetary penalties.

(6) Section 1128B of the Act pertaining to criminal penalties for acts involving Federal health care programs.

(7) Section 1128E of the Act pertaining to the reporting of final adverse actions on liability findings made against health care providers, suppliers, and practitioners under the health care fraud and abuse data collection program.

§ 457.940 Procurement standards.

(a) A State must submit to HCFA a written assurance that title XXI services will be provided in an effective and efficient manner. The State must submit the assurance—

(1) With the initial State plan; or

(2) For States with approved plans, with the first request to amend the approved plan.

(b) A State must provide child health assistance in an effective and efficient manner by—

(1) Providing for free and open competition, to the maximum extent possible, in the bidding of all procurement contracts for coverage or other services in accordance with the procurement requirements of 45 CFR 74.43; or

(2) Basing title XXI payment rates on public and/or private payment rates for comparable services.

(c) 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 to enroll providers who demonstrate exceptional efficiency or quality in the provision of services.

(d) All contracts under this part must include provisions that define a sound and complete procurement contract, as required by 45 CFR part 74.

(e) The State must provide to HCFA, if requested, a description of the manner in which rates were developed in accordance with the requirements of paragraphs (a) or (b) of this section. HCFA may request this description either when a State—

(1) Determines its rates initially;

(2) Updates its rates; or

(3) Changes its reimbursement methodology.

§ 457.945 Certification for contracts and proposals.

Entities that contract with the State under a separate child health program must certify the accuracy, completeness, and truthfulness of information in contracts and proposals, including information on subcontractors, and other related documents as specified by the State.

§ 457.950 Contract and payment requirements including certification of payment-related information.

(a) *Managed care entity.* A State that makes payments to a managed care entity under a separate child health program, based on data submitted, must ensure that its contract requires the managed care entity to provide, under penalty of perjury —

(1) Enrollment information and other information required by the State;

(2) An attestation to the accuracy, completeness, and truthfulness of claims and payment data, upon penalty of perjury;

(3) Access for the State to enrollee health claims data and payment data, as determined by the State in conformance with the appropriate privacy protections in the State; and

(4) A guarantee that managed care entities will not avoid costs for services covered in its contract by referring beneficiaries to publicly supported health care resources.

(b) *Fee-for-service entities.* A State that makes payments to fee-for-service entities under a separate child health program must—

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

(2) Require, as a condition of participation, that fee-for-service entities provide the State with access to enrollee health claims data and claims payment data as determined necessary by the State.

§ 457.955 Conditions necessary to contract as a managed care entity (MCE).

(a) The State must assure that any entity seeking to contract as an MCE under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse.

(b) Unless otherwise provided for by State law, the State must ensure the arrangements or procedures required in paragraph (a) of this section —

(1) Enforce MCE compliance with all applicable Federal and State standards; and

(2) Include a mechanism for the MCE to report to the State, and to HCFA and/or the Office of Inspector General (OIG) information on violations of law by subcontractors or enrollees of an MCE and other individuals.

(c) With respect to enrollees, the reporting requirement in paragraph (b) of this section applies only to information on violations of law that pertain to enrollment in the plan, or the provision of, or payment for, health services.

(d) The State may inspect, evaluate, and audit MCEs at any time, as necessary, in instances where the State determines that there is a reasonable possibility of fraudulent and abusive activity.

§ 457.960 Reporting changes in eligibility and redetermining eligibility.

If the State requires reporting of changes in circumstances that may affect their eligibility for child health assistance, the State must:

(a) Establish procedures to ensure that beneficiaries make timely and accurate reports of any changes; and

(b) Promptly redetermine eligibility when the State has information about these changes.

§ 457.965 Documentation.

The State must include in each applicant's record facts to support the State's determination of the applicant's eligibility for CHIP.

§ 457.970 Eligibility and income verification.

(a) The State must establish procedures to ensure —

(1) The integrity of the eligibility determination process; and

(2) Compliance with verification and documentation requirements applicable to separate child health programs under other Federal laws and regulations.

(b) A State may use its discretion in establishing reasonable income and eligibility verification mechanisms.

(c) The State may choose to use the income and eligibility verification system requirements set forth in section 1137 of title XI of the Act at §§ 435.940 through 435.953 of this chapter.

(d) The State may terminate the eligibility of an applicant or beneficiary for ''good cause''.

(1) For purposes of this section, ''good cause'' exists if any information or other action makes the beneficiary fail to meet the requirements of income and eligibility verification or documentation as reasonably determined by the State.

(2) Beneficiaries terminated for good cause must be given notice of the termination decision that sets forth the reasons for termination and provides a reasonable opportunity to appeal the termination decision as specified in § 457.985.

§ 457.975 Redetermination intervals in cases of suspected enrollment fraud.

If a State suspects enrollment fraud, the State may, at its own discretion, perform eligibility redetermination at any frequency interval that is considered by the State to be in the best interest of the program.

§ 457.980 Verification of enrollment and provider services received.

(a) The State must establish methodologies to verify whether beneficiaries have received services for which providers are billed.

(b) The State must establish and maintain systems to identify, report, and verify those enrolled children that meet requirements of section 2105(a) of the Act, where enhanced Federal medical assistance percentage computations apply.

§ 457.985 Enrollee rights to file grievances and appeals.

(a) The State and its participating providers must give applicants and enrollees written notice of their right to file grievances and appeals in cases where the State or its contractors take actions to:

(1) Deny, suspend or terminate eligibility;

(2) Disenroll for failure to pay cost-sharing; or

(3) Reduce or deny services provided for in the benefit package.

(b) The State must establish and maintain written procedures for addressing grievances and appeal requests, including processes for internal review by the contractor and external review by an independent entity or the State agency, that comply with State-specific grievance and appeal requirements currently in effect for health insurance issuers (as defined in section 2791(b) of the Public Health Service Act) in the State. Such procedures must include a guarantee that resolution of grievances and appeal requests will be completed within a reasonable amount of time.

(c) The State may elect in its State plan to use the rules, systems, and procedures used in the Medicaid program such as—

(1) Part 431, subpart E of this chapter regarding fair hearings for Medicaid applicants and recipients; and

(2) Medicaid appeal procedures for Medicaid managed care entities.

(d) The State and its contractors must have in place a meaningful process for reviewing and resolving complaints that are submitted outside of the grievance and appeals procedures as part of the quality assurance process.

(e) The State must guarantee in all contracts for coverage and services, beneficiary access to information related to actions which could be subject to grievance or appeal in accordance with:

(1) Section 422.206 of this chapter, which prohibits interference with health care professionals' advice to enrollees; and

(2) Sections 422.208 and 422.210(a) and (b) of this chapter, related to limitations on physician incentives, or compensation arrangements that have the effect of reducing or limiting services, and information disclosure requirements respectively.

§ 457.990 Privacy protections.

(a) The State plan must assure that the program will be operated in compliance with the provisions of part 431, subpart F of this chapter related to safeguarding information on Medicaid applicants and recipients.

(b) The State plan must assure the protection of information and data pertaining to beneficiaries by providing that all contracts will include guarantees that—

(1) Original medical records are released only in accordance with Federal or State law, or court orders or subpoenas;

(2) Information from or copies of medical records are released only to authorized individuals;

(3) Medical records and other information are accessed only by authorized individuals;

(4) Confidentiality and privacy of minors is protected in accordance with applicable Federal and State law;

(5) Enrollees will have timely access to their records and to information that pertains to them;

(6) Beneficiary information is safeguarded in accordance with all Federal and State law relating to confidentiality and disclosure of mental health records, medical records, and other related information about the beneficiary; and

(7) Any electronic transmission of data to HCFA must comply with HCFA's policies and requirements regarding privacy and confidentiality of data transmissions. Data transmissions between providers, health plans and the State are also subject to these requirements.

(c) The State plan is subject to any Federal information disclosure safeguards as well as requirements mandated by the State including the use of the Internet to transmit CHIP data between the State and its providers.

(d) The State must assure that the program will be operated in compliance with all applicable State and Federal requirements to protect the confidentiality of information transmitted by electronic means, including the Internet.

§ 457.995 Overview of beneficiary rights.

In order to ensure that coverage and services are effectively and efficiently furnished to eligible beneficiaries, the following beneficiary protections are addressed in this part:

(a) *Information.* States are required to provide information to families of targeted low-income children regarding:

(1) Types of benefits, the amount, duration and scope of those benefits, and names and locations of current participating providers (§ 457.110(b));

(2) Either individually or through public notice, changes related to cost sharing or any other restrictions of eligibility or benefits (§§ 457.525 and 457.65);

(3) Enrollment assistance to potentially eligible children and their families (§ 457.360(d)) and information about beneficiary rights and obligations under the program (§ 457.360(e)); and

(4) Information must be accurate and easily understood and provide assistance to families in making informed health care decisions.

(b) *Choice of providers and plans.* States must provide enrollees assistance in making health care decisions and must assure appropriate and timely procedures to monitor and treat enrollees with complex and serious medical conditions including access to specialists in accordance with §§ 457.110 and 457.735(c) respectively.

(c) *Access to emergency services.* (1) States are required to provide an assurance of the quality and appropriateness of care, including access to covered services, including emergency services and covered post-stabilization services, as defined in § 457.402 and in accordance with § 457.735 respectively.

(2) States must assure that enrollees will not be held liable for additional costs, beyond the copayment amounts specified in the State plan, that are associated with emergency services provided by a facility that is not a

participating provider in the enrollee's managed care network (§ 457.515(f)).

(d) *Participation in treatment decisions.* Enrollees have the right to participate in their own care and to receive information on health plans, professionals, and facilities (§ 457.110 and § 457.985(e)). States must prohibit gag rules and establish principles for disclosure of physician financial arrangements that could affect treatment decisions (§ 457.985(e)).

(e) *Respect and nondiscrimination.* States must assure that families of targeted low-income children are treated with respect and nondiscrimination in accordance with applicable civil rights assurances and requirements found at § 457.130.

(f) *Confidentiality of health information.* States must ensure the confidentiality of a beneficiary's health information and provide beneficiaries access to medical records only in accordance with applicable Federal and State laws (§ 457.990).

(g) *Grievances and appeals.* (1) States and their participating contractors must ensure the family's right to file grievances and appeals by notifying beneficiaries of this right, and by having written procedures in place to afford applicants and enrollees the right to file grievances in cases where action is taken to—

(i) Deny, suspend or terminate eligibility in accordance with § 457.365;

(ii) Reduce or deny benefits provided for in the plan in accordance with § 457.495; or

(iii) Disenroll for failure to pay cost-sharing in accordance with § 457.560.

(2) Procedures for grievances, complaints and appeals must be conducted and resolved in a timely manner that is consistent with the standard health insurance practices in the State in accordance with § 457.985.

Subpart J—Allowable Waivers: General Provisions

§ 457.1000 Basis, scope, and applicability.

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

(1) Section 2105(c)(2)(B) of the Act, which sets forth the requirements for a waiver to permit a State to exceed the 10 percent cost limit on expenditures other than benefit package expenditures; and

(2) Section 2105(c)(3) of the Act, which permits a waiver for the purchase of family coverage.

(b) *Scope.* This subpart sets forth requirements for obtaining a waiver under title XXI of the Act.

(c) *Applicability.* The requirements of this subpart apply to child health assistance provided under a separate child health program and to a Medicaid expansion program only to the extent that the State claims administrative costs under title XXI and seeks a waiver of limitations such claims in light of a community-based health delivery system.

§ 457.1005 Waiver for cost-effective coverage through a community-based health delivery system.

(a) *Availability of waiver.* The Secretary may waive the requirements of § 457.618 regarding the 10 percent limit on expenditures not used for child health assistance in the form of health benefits coverage meeting 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 the coverage requirements of section 2103 of the Act and subpart D of this part; and

(2) The cost of such coverage, on an average per child basis, does not exceed the cost of coverage under the State plan.

(c) *Two-year approval period.* An approved waiver remains in effect for 2 years. A State may reapply for approval 3 months before the end of the 2-year period.

(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, and outreach; or

(2) Any reasonable costs necessary to administer the State's program.

§ 457.1010 Waiver for purchase of family coverage.

A State may purchase family coverage under a group health plan or health insurance 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 child otherwise meets the requirements of this part.

§ 457.1015 Cost-effectiveness.

(a) *Definition.* For purposes of this subpart, ''cost-effective'' means that the cost paid under the plan of purchasing family coverage under a group health plan or health insurance coverage that includes coverage for targeted low-income children is equal to or less than the State's cost of obtaining coverage under the 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 that meets the requirements of § 457.1010 to the cost of coverage only for the targeted low-income children under—

(1) The health benefits packages offered by the State under the State plan for which the child is eligible; or

(2) Any child-only health benefits package available for purchase in the State that meets the requirements of § 457.410, even if the State does not offer it under the State plan.

(c) *Individual or aggregate basis.* (1) The State may base its demonstration of the cost-effectiveness of family coverage on an assessment of cost-effectiveness 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. 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 subpart G of this part the cost of family coverage purchased under the waiver, and the number of children and adults covered under family coverage pursuant to the waiver.

PART 457—ALLOTMENTS AND GRANTS TO STATES

G. Part 457 is amended as follows:

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

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

2. Section 457.204(d)(2), as proposed at 64 FR 10428, March 4, 1999, is revised to read as follows:

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

* * * * *

(d) * * *

(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 beneficiaries will be treated equitably.

* * * * *

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

(Catalog of Federal Domestic Assistance Program No. 00.000, State Children's Health Insurance Program)

Dated: March 16, 1999.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: September 23, 1999.

Donna E. Shalala,

Secretary.

[FR Doc. 99–28693 Filed 11–1–99; 8:45 am]

BILLING CODE 4120–01–P