be authorized for pregnant women is one per pregnancy.

(b) If the agency provides Medicaid during a presumptive eligibility period to children under §435.1102 or to pregnant women under paragraph (a) of this section, the agency may also apply the terms of §§435.1101 and 435.1102 to the individuals described in one or more of the following sections of this part, based on the income standard established by the state for such individuals and providing the benefits covered under that section: §§435.110 (parents and caretaker relatives), 435.119 (individuals aged 19 or older and under age 65), 435.150 (former foster care children), and 435.218 (individuals under age 65 with income above 133 percent FPL).

(c)(1) The terms of §§435.1101 and 435.1102 apply to individuals who may be eligible under §435.213 of this part (relating to individuals with breast or cervical cancer) or §435.214 of this part (relating to eligibility for limited family planning benefits) such that the agency may provide Medicaid during a presumptive eligibility period following a determination by a qualified entity described in paragraph (c)(2) of this section that—

(i) The individual meets the eligibility requirements of §435.213; or

(ii) The individual meets the eligibility requirements of §435.214, except that coverage provided during a presumptive eligibility period to such individuals is limited to the services described in §435.214(d).

(2) Qualified entities described in this paragraph include qualified entities which participate as providers under the State plan and which the agency determines are capable of making presumptive eligibility determinations.

[77 FR 42304, July 15, 2012]

§435.1110 Presumptive eligibility determined by hospitals.

(a) *Basic rule.* The agency must provide Medicaid during a presumptive eligibility period to individuals who are determined by a qualified hospital, on the basis of preliminary information, to be presumptively eligible subject to the same requirements as apply to the State options under §§435.1102 and 435.1103, but regardless of whether the agency provides Medicaid during a presumptive eligibility period under such sections.

(b) *Qualified hospitals.* A qualified hospital is a hospital that—

(1) Participates as a provider under the State plan or a demonstration under section 1115 of the Act, notifies the agency of its election to make presumptive eligibility determinations under this section, and agrees to make presumptive eligibility determinations consistent with State policies and procedures;

(2) At State option, assists individuals in completing and submitting the full application and understanding any documentation requirements; and

(3) Has not been disqualified by the agency in accordance with paragraph (d) of this section.

(c) *State options for bases of presumptive eligibility.* The agency may—

(1) Limit the determinations of presumptive eligibility which hospitals may elect to make under this section to determinations based on income for all of the populations described in §435.1102 and §435.1103; or

(2) Permit hospitals to elect to make presumptive eligibility determinations on additional bases approved under the State plan or an 1115 demonstration.

(d) *Disqualification of hospitals.* (1) The agency may establish standards for qualified hospitals related to the proportion of individuals determined presumptively eligible for Medicaid by the hospital who:

(i) Submit a regular application, as described in §435.907, before the end of the presumptive eligibility period; or

(ii) Are determined eligible for Medicaid by the agency based on such application.

(2) The agency must take action, including, but not limited to, disqualification of a hospital as a qualified hospital under this section, if the agency determines that the hospital is not—

(i) Making, or is not capable of making, presumptive eligibility determinations in accordance with applicable state policies and procedures; or

(ii) Meeting the standard or standards established by the agency under paragraph (d)(1) of this section.

(3) The agency may disqualify a hospital as a qualified hospital under this

paragraph only after it has provided the hospital with additional training or taken other reasonable corrective action measures to address the issue.

[77 FR 42304, July 15, 2012]

Subpart M—Coordination of Eligibility and Enrollment Between Medicaid, CHIP, Exchanges and Other Insurance Affordability Programs

SOURCE: 77 FR 17212, Mar. 23, 2012, unless otherwise noted.

§ 435.1200 Medicaid agency responsibilities.

(a) *Statutory basis and purpose.* This section implements sections 1943 and 2102(b)(3)(B) of the Affordable Care Act to ensure coordinated eligibility and enrollment among insurance affordability programs.

(b) *General requirements.* The State Medicaid agency must—

(1) Fulfill the responsibilities set forth in paragraphs (d) and (e) and, if applicable, paragraph (c) of this section in partnership with other insurance affordability programs.

(2) Certify for the Exchange and other insurance affordability programs the criteria applied in determining Medicaid eligibility.

(3) Enter into and, upon request, provide to the Secretary one or more agreements with the Exchange and the agencies administering other insurance affordability programs as are necessary to fulfill the requirements of this section, including a clear delineation of the responsibilities of each program to—

(i) Minimize burden on individuals;

(ii) Ensure compliance with paragraphs (d) through (f) of this section and, if applicable, paragraph (c) of this section;

(iii) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under § 435.912, based on the date the application is submitted to any insurance affordability program.

(c) *Provision of Medicaid for individuals found eligible for Medicaid by another insurance affordability program.* If the agency has entered into an agreement in accordance with § 431.10(d) of this subchapter under which the Exchange or other insurance affordability program makes final determinations of Medicaid eligibility, for each individual determined so eligible by the Exchange or other program, the agency must—

(1) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of Medicaid eligibility;

(2) Comply with the provisions of § 435.911 of this part to the same extent as if the application had been submitted to the Medicaid agency; and

(3) Comply with the provisions of § 431.10 of this subchapter to ensure it maintains oversight for the Medicaid program.

(d) *Transfer from other insurance affordability programs to the State Medicaid agency.* For individuals for whom another insurance affordability program has not made a determination of Medicaid eligibility, but who have been screened as potentially Medicaid eligible, the agency must—

(1) Accept, via secure electronic interface, the electronic account for the individual;

(2) Not request information or documentation from the individual already provided to another insurance affordability program and included in the individual's electronic account or other transmission from the other program.

(3) Promptly and without undue delay, consistent with timeliness standards established under § 435.912, determine the Medicaid eligibility of the individual, in accordance with § 435.911 of this part, without requiring submission of another application.

(4) Accept any finding relating to a criterion of eligibility made by such program, without further verification, if such finding was made in accordance with policies and procedures which are the same as those applied by the agency or approved by it in the agreement described in paragraph (b) of this section;

(5) Notify such program of the receipt of the electronic account.

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