§ 457.224 FFP: Conditions relating to cost sharing.

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

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

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

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

§ 457.226 Fiscal policies and accountability.

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

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

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

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

(d) Retain records for nonexpendable property acquired under a Federal grant for 3 years from the date of final disposition of that property.

§ 457.228 Cost allocation.

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

§ 457.230 FFP for State ADP expenditures.

FFP is available for State ADP expenditures for the design, development, or installation of mechanized claims processing and information retrieval systems and for the operation of certain systems. Additional HHS regulations and CMS procedures regarding the availability of FFP for ADP expenditures are in 45 CFR part 74, 45 CFR part 95, subpart F, and part 11, State Medicaid Manual.

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

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

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

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

§ 457.236 Audits.

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

§ 457.238 Documentation of payment rates.

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

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

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

§ 457.300 Basis, scope, and applicability.

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

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

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

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

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

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

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

(c) *Applicability.* The requirements of this subpart apply to child health assistance provided under a separate child health program. Regulations relating to eligibility, screening, applications and enrollment that are applicable to a Medicaid expansion program are found at §§ 435.4, 435.229, 435.905 through 435.908, 435.1102, 435.940 through 435.958, 435.1200, 436.3, 436.229, and 436.1102 of this chapter.

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

§ 457.301 Definitions and use of terms.

As used in this subpart—

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

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

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

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

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

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

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

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

Public agency means a State, county, city or other type of municipal agency, including a public school district, transportation district, irrigation district, or any other type of public entity.

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

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

(2) Is authorized to determine eligibility of a child to participate in a