DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 93.767 CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

I. PROGRAM OBJECTIVES

Title XXI of the Social Security Act (Act) authorizes the Children's Health Insurance Program (CHIP) to assist state efforts in initiating and expanding 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 specific requirements, (2) expanding benefits under the state's Medicaid plan under Title XIX of the Act, or (3) a combination of both.

II. PROGRAM PROCEDURES

A. Overview

The following paragraphs are intended to provide a high-level, overall description of how CHIP generally operates. It is not practical to provide a complete description of program procedures because CHIP operates under both federal and state laws and regulations and states are afforded flexibility in program administration. Accordingly, the following paragraphs are not intended to be used in lieu of or as a substitute for the federal and state laws and regulations applicable to this program.

Administration

Title XXI authorizes grants to states that initiate or expand health insurance programs for low-income, uninsured children. Under Title XXI, CHIP 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 can design their CHIP program in one of three ways:

1. Separate CHIP: a program under which a state receives federal funding to provide child health assistance to uninsured, low-income children that meets the requirements of section 2103 of the Social Security Act.

2. Medicaid Expansion CHIP: a program under which a state receives federal funding to expand Medicaid eligibility to optional targeted low-income children that meets the requirements of section 2103 of the Social Security Act.

3. Both a Separate CHIP and a Medicaid Expansion: a state receives federal funding to implement both a Medicaid expansion and a separate CHIP.

CHIP provides an allotment of funds to states on a matched basis. 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.

To be eligible for funds under this program, states must submit a state child health plan (CHIP state plan). CHIP state plans and amendments to those plans are approved by CMS on behalf of the secretary of the Department of Health and Human Services. The amendments are reviewed by an intra-departmental team, which must decide whether to approve or disapprove the amendment within a 90-day period. This "90-day clock" can be stopped by CMS sending the state a formal written request for additional information from the state and can be restarted at the same point when a response is formally received from the state. Copies of CHIP state plans are available on Medicaid.gov at https://www.medicaid.gov/chip/state-program-information/index.html.

Pursuant to section 2107(e)(1)(B) of the Act, cross referencing Title XIX requirements at 1902(a)(25) of the Act, states must take reasonable measures to determine the legal liability of third parties to pay for services furnished under the CHIP state plan. Such reasonable measures could include:

- Collect health insurance information during the initial eligibility application process and the redetermination process.
- Conduct diagnosis and a trauma code edits to identify specific codes which could denote trauma related injury.
- Conduct data exchanges with:
  - state wage information collection agencies,
  - SSA wage and earnings files,
  - state title IV-A agencies,
  - state motor vehicle accident report files, and
  - state workers' compensation or Industrial Accident Commission files.

Waivers

The state may apply for a waiver of CHIP federal requirements under section 1115 of the Social Security Act. Waivers are intended to provide flexibility needed to enable states to try experimental, pilot, or demonstration projects that, in the judgment of the secretary, are likely to assist in promoting the objectives of the CHIP program. Where approved by the secretary, and subject to specific safeguards for the protection of enrollees and the program, waivers allow exceptions to CHIP state plan requirements that permit the state to implement innovative programs or activities on a time-limited basis, permit states to try new or different approaches to the efficient and cost-effective delivery of health care services to children or adapt their programs to the special needs of particular areas or groups of enrollees. The secretary will approve only demonstration projects that are consistent with key principles of the CHIP statute. States' waiver authority is found at

section 2107(e)(2)(A) of the Act (42 USC 1397gg(e)(2)(A)), which extends to CHIP the Medicaid waiver authority at section 1115 of the Act (42 USC 1315).

Addendum for the Public Health Emergency (PHE)

Medicaid and the CHIP play a critical role in helping states and territories respond to public health emergencies (PHEs) and disasters, including the outbreak of the Novel Coronavirus Disease 2019 (COVID-19). Over the course of the PHE for COVID-19, state Medicaid and CHIP agencies adopted many flexibilities to respond effectively to local outbreaks, including changes to modify eligibility requirements and benefit packages. In addition, states made program changes to comply with the requirements of the Families First Coronavirus Response Act (FFCRA) (Pub. L. No. 116-127), as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. No. 116-136). Section 6008 of the FFCRA provides states with a temporary 6.2 percentage increase to the Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Social Security Act (the Act) for certain Medicaid expenditures if states meet certain conditions, including a continuous enrollment requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020. The temporary FMAP increase and accompanying requirements are not applicable to separate CHIPs.

CMS provided for program flexibilities and federal matching funds for certain services that should be considered when planning single audits, as described below. In some instances, certain audit steps compliance requirements may not be relevant during this review period in light of the flexibilities offered to states. The flexibilities are unique to individual states and follow the typical documentation process, including CMS approval of state plans and waivers, in accordance with regulations and guidance. During the Public Health Emergency for COVID-19, which is available online at: https://www.medicaid.gov/state-resource-center/downloads/covid-19-tech-factsheet-ifc-433400.pdf, provides additional information on these changes. Further details were also provided by CMS stakeholder calls following issuance of the IFC; transcripts of these calls are available at https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html.

It is important for auditors to be aware of the requirements and flexibilities implemented by the state Medicaid or CHIP agency in response to the PHE for COVID-19 so that a state is not determined to be out of compliance with requirements that would have been in place absent the PHE.

Background

On January 31, 2020, the secretary of Health and Human Services (HHS) declared a PHE, effective as of January 27, 2020, for the entire United States to aid the nation's health care community in responding to COVID-19. On March 13, 2020, the president declared the ongoing COVID-19 pandemic of sufficient severity and magnitude to warrant an emergency declaration for all states, tribes, territories, and the District of Columbia pursuant to section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 USC 5121-5207 (the "Stafford Act"), with a retroactive effective date of March 1, 2020. Furthermore, the current PHE was renewed effective

January 21, 2021, for an additional 90 days. During a PHE or disaster, CMS can rely on various legal authorities to grant states emergency flexibilities critical to ensuring that states can respond to the crisis expeditiously to protect and serve the general public.

On December 22, 2020, CMS issued State Health Official letter #20-004, entitled Planning for the Resumption of Normal State Medicaid, CHIP, and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency (https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf). This State Health Official letter provides guidance on returning to regular operations, including ending temporary authorities when the PHE concludes, making temporary changes permanent where legally permissible and otherwise appropriate, ending the expiring FFCRA provisions, and addressing pending eligibility and enrollment actions that developed during the PHE. States should have documentation available to describe the temporary changes made to their programs.

Some of the major areas to note include the following:

a. **Telehealth**

Federal telehealth requirements provide states with significant flexibility, and states have broad variability in their approaches to incorporating telehealth into their Medicaid and CHIP programs. CMS also recognizes that, in many circumstances, states have adopted Medicaid and CHIP telehealth policies that mirror Medicare telehealth policies, for which regulatory flexibilities have been provided during the COVID-19 PHE. To assist states with understanding the flexibilities regarding Medicaid and CHIP telehealth policy as it relates to COVID-19, CMS issued a COVID-19 Telehealth Toolkit, which was updated on October 14, 2020, that highlighted policy and operational questions that a state may consider when designing their approach (State Medicaid and CHIP Telehealth Toolkit, *Policy Considerations for States Expanding Use of Telehealth - COVID-19 Version* https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf)(State Medicaid and CHIP Telehealth Toolkit, *Policy Considerations for States Expanding Use of Telehealth - COVID-19 Version*: Supplement #1. https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf). To support health care delivery while minimizing face-to-face encounters during the COVID-19 PHE, many states have significantly accelerated adoption of telehealth, including through telephonic modalities, across a wide variety of disciplines.

b. **Beneficiary Eligibility and Enrollment**

States are facing a number of challenges due to the ongoing COVID-19 PHE that will leave many states with large volumes of outstanding eligibility and enrollment actions when the PHE ends. Different states have utilized different eligibility and enrollment flexibilities available during the PHE**.** As each state determines which flexibilities to maintain and which flexibilities to end, states are expected to develop an operational plan that documents and tracks compliance, including the timelines for making changes to application and renewal processing and verifications. Additional information is provided

in SHO letter #20-004 on planning for the resumption of normal operations at the conclusion of the PHE, which is available on Medicaid.gov at https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf.

The flexibilities afforded to states as they respond to the PHE related to beneficiary eligibility and enrollment could lead to unintended vulnerabilities and risks. CMS reiterates the importance of states considering the appropriate program integrity activities related to beneficiary eligibility and enrollment.

c. **Managed Care**

As previously described in CMS guidance (https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf (page 77)), if a benefit or other identified flexibility is covered under a state plan, waiver, or demonstration, CMS encourages states to amend their managed care plan contracts, if not already included, to extend the same flexibilities to the managed care plans during the COVID-19 PHE. States may also amend their managed care contracts and assess if changes are needed to capitation rates to account for the PHE for COVID-19.

d. **Other Benefits and Changes**

In response to COVID-19 PHE, many states have implemented emergency measures to ensure that Medicaid and CHIP beneficiaries continue to have access to essential health services. Specific to CHIP, states have submitted disaster relief state plan amendments (SPAs) to suspend, add, and revise policies that could prevent enrollees from accessing needed care during the PHE.

Payment Error Rate Measurement (PERM) Program

The PERM program is utilized by HHS to calculate national improper payment rates for Medicaid and CHIP. The regulations at 42 CFR Part 431, Subpart Q, specify requirements for estimating improper payments in Medicaid and CHIP. The PERM program annually measures the national Medicaid and CHIP improper payment rates and uses a 17-state, three-year rotation process. The national Medicaid and CHIP improper payment rates include findings from the most recent three cycle measurements so that all states are captured in one rate. The national improper payment rates comprise three components: fee-for-service, managed care, and eligibility. States are expected to issue corrective action plans to address the root cause of errors and deficiencies.

Source of Governing Requirements

This program is authorized by Section 490l(a) of the Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, as amended by Pub. L. No. 105-100, which added Title XXI to the Social Security Act (Act) and made subsequent amendments to Title XXI. Title XXI authorizes CHIP to assist state efforts to initiate and expand the provision of child health assistance to uninsured,

low-income children. Title XXI is codified at 42 USC 1397aa-1397jj. The regulations for this program are found at 42 CFR Part 457.

The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA 2009) (Pub. L. No. 111-3) reauthorized CHIP through fiscal year (FY) 2013. The Patient Protection and Affordable Care Act (ACA) (Pub. L. No. 111-148) reauthorized CHIP through 2019 and extended CHIP funding through FY 2015. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Pub. L. No. 114-10) extended CHIP funding through FY 2017. Most recently, Congress extended federal funding for the CHIP through September 30, 2027, through the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (referred to as the HEALTHY KIDS Act and included in Pub. L. No. 115-120) and the Advancing Chronic Care, Extenders and Social Services Act (referred to as the ACCESS Act and included in Pub. L. No. 115-123).

This program is subject to the requirements of 45 CFR Part 75 (the HHS implementation of 2 CFR Part 200) and 45 CFR Part 95.

Availability of Other Program Information

States and other interested parties can access information on the department's policies on this and other issues at http://www.medicaid.gov/.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, "Matrix of Compliance Requirements"), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a "Y" in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as "N," it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an "N." See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment/ Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement Suspension & Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	Y	N	Y	Y	N	N	Y	N	Y

A. Activities Allowed or Unallowed

1. *Activities Allowed*

States have general flexibility in allocating their individual allotments toward activities needed to operate the CHIP (section 2105 of the Act (42 USC 1397ee(a)). In addition to expenditures for child health assistance under the plan for targeted low-income children, other allowable activities, to the extent permitted by 42 USC 1397ee(c), include payment of other child health assistance for targeted low-income children; expenditures for health services initiatives for improving the health of children (targeted and other low income) under the plan; expenditures for outreach activities; expenditures for translation and interpretation services in connection with the enrollment, retention, and use of services under Title XXI by individuals for whom English is not their primary language (as found necessary by the secretary for the proper and efficient administration of the chip state plan); and other reasonable costs incurred by the state to administer the plan (42 USC 1397ee).

Managed Care

A state may use managed care for the delivery of some or all its CHIP benefits and services for either all or a subset of the CHIP populations served under the CHIP state plan. Under managed care, the delivery of benefits and services are through contracted arrangements between state CHIP agencies and managed care plans that accept a set per member per month capitation payment for the services.

States must comply with the managed care regulations at 42 CFR Part 457, Subpart L, for utilization of a managed care delivery system. These regulations align CHIP rules with those of other health insurance coverage programs, such as Medicaid and the Marketplace, to reflect how states purchase managed care for beneficiaries, and to strengthen the consumer experience and key consumer protections.

CHIP managed care guidance can be found at https://www.medicaid.gov/chip/managed-care/index.html.

Health Services Initiatives (HSI)

Under section 2105(a)(1)(D)(ii) of Title XXI of the Act (42 USC 1397ee(a)(1)(D)(ii)), states have the option to develop state-designed health services initiatives (HSIs) that improve the health of low income and targeted low-income children. Under regulations at 42 CFR 457.10, HSIs must include activities that protect the public health, protect the health of individuals, improve or promote a state's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals related to improving the health of children. HSIs may also be directed at low-income pregnant women or parents; however, HSIs may only provide services for adults if the project directly improves the health of children.

Federal funding for HSIs is expended from a state's available CHIP allotment for a fiscal year. Under section 2105(c)(2)(A) of the Act (42 USC 1397ee(c)(2)(A)) , claims for HSIs and certain other expenditures such as administrative expenses cannot exceed 10 percent of the total amount of title XXI funds claimed by the state each quarter. States must fund all CHIP state plan benefits before using allotment for HSIs.

HSIs are implemented through an amendment to the CHIP state plan. States' approved HSI programs are described in section 2.2 of the CHIP state plan template. HSI budget information is provided at section 9.10 of the CHIP state plan.

Premium Assistance

A state may pay premiums for employer sponsored insurance on behalf of a CHIP beneficiary if it is cost effective to do so. When providing premium assistance, states must ensure that children have access to all mandatory benefits provided under the CHIP state plan, and that they are not required to incur greater out-of-pocket costs for premiums, deductibles, co-payments or similar cost sharing charges than under the CHIP state plan. Individual state premium assistance programs are described in the CHIP state plan.

2. *Activities Unallowed*

Federal funds may not be expended under the CHIP state plan to pay for any abortion or to assist in the purchase, in whole or in part, of health coverage that includes coverage of abortion, except, if necessary, to save the life of the mother or if the pregnancy is the result of incest or rape (Section 2105(e) of the Act (42 USC 1397ee(c)).

B. Allowable Costs/Cost Principles

1. CHIP regulations under 42 CFR 457.628(a) make the Medicaid requirements at 42 CFR sections 433.50 through 433.74 regarding sources of nonfederal share and Health Care-Related Taxes and Provider Related Donations applicable to CHIP in the same manner as they apply to state Medicaid programs. Before calculating the amount of FFP, certain revenues received by a state will be deducted from the state's medical assistance expenditures. The revenues to be deducted are (1) donations made by health care providers or related entities (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of out-stationed eligibility workers); and (2) impermissible health care-related taxes that exceed a specified limit (Section 1903(w) of the Act (42 USC 1396b(w)); 42 CFR section 433.57).

   (a) "Provider-related donations" are any donations or other voluntary payments (in-cash or in-kind) made directly or indirectly to a state or unit of local government by: (1) a health care provider, (2) an entity related to a health care provider, or (3) an entity providing goods or services under the CHIP state plan and paid as administrative expenses. "Bona fide provider-related donations" are donations that have no direct or indirect relationship to payments made under Title XIX (42 USC 1396 et seq.) to (1) the donating provider, (2) providers furnishing the same class of items and services as the donating provider, or (3) any related entity (42 CFR sections 433.58(d) and 433.66(b)).

   (b) Permissible health care-related taxes are those taxes that are broad-based; are uniformly applied to a class of health care items, services, or providers; and do not hold a taxpayer harmless for the costs of the tax. A tax program for which CMS has granted a waiver may also be considered permissible health care-related taxes. Health care-related taxes that do not meet these requirements are impermissible health care-related taxes (42 CFR section 433.68(b)).

   These provisions apply to all 50 states and the District of Columbia, except those states whose entire Medicaid program is operated under a waiver granted under Section 1115 of the Social Security Act (42 CFR Part 433).

2. The 42 CFR 457.628(b) makes 45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (except as specifically excepted) applicable to the CHIP program.

3. The 42 CFR 457.1203 requires each Medicaid managed care plan to calculate and report a MLR for rating periods starting on or after July 1, 2017 and require each CHIP managed care plan to calculate and report a MLR for rating periods in CHIP managed care contracts as of the state fiscal year beginning on or after July 1, 2018. If a state elects to mandate a minimum MLR, that minimum MLR must be at least 85 percent. The regulation cross-references 42 CFR section

438.8(e)(4), which incorporates the standards adopted for the private insurance market MLR (45 CFR section 158.150) for the treatment of fraud prevention expenses in the numerator of the MLR calculation. The MLR is reported for a rating period, using data from that rating period.

With regard to capitation rate setting for CHIP managed care plans, under 42 CFR 457.1203(a), states must use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at Section 457.10. In addition, for both Medicaid and CHIP managed care plans, the rates must be developed so that the managed care plan is projected to meet an 85 percent MLR (42 CFR 457.1203(c)(1)).

E. Eligibility

Auditors may combine III.A, "Activities Allowed or Unallowed," III.B, "Allowable Costs/Cost Principles," and III.E, "Eligibility." Therefore, compliance requirements related to amounts provided to, or on behalf of, eligible individuals and presumptively eligible individuals may be combined with III.A, "Activities Allowed or Unallowed" and III.B, "Allowable Costs/Cost Principles" such as, was the service incurred during the period the individual was eligible to receive benefits and was the provider paid the correct amount for the service billed."

The state verifies the financial and nonfinancial factors of eligibility, with two exceptions described below, by checking electronic data sources in accordance with federal requirements at 42 CFR 457.380 and state requirements as documented in the CHIP state plan, verification plan and eligibility manual). The state is required (as described at 42 CFR 457.965) to maintain facts in the case file to support the eligibility determination. When data sources used by the state are not available to the auditor, or information is not required to be available for the period under audit, auditors would not be expected to test verification other than the requirement to maintain information in the case file. For states that accept applicant self-attestation for household size or income, and do not require further verification or documentation, the auditors are not expected to test beyond the requirements of the state.

The exceptions to the verification process described above are eligibility determinations made by an Exchange, either the Federally Facilitated Exchange (FFE) or a state-based Exchange, elements of a determination made by an express lane agency, and presumptive eligibility determinations made by qualified entities. In states that have an agreement with the FFE or state-based exchange, through which the Exchange determines CHIP eligibility, the state relies on the verifications conducted by the Exchange and auditors are not expected to test verification. When express lane eligibility is used, the CHIP agency relies upon elements of a determination made by an express lane agency. For presumptive eligibility determinations, the qualified entity accepts attestation of all needed information and states may not require verification or documentation of any eligibility criteria. When testing a presumptive eligibility determination, auditors are not expected to test verification.

1. Eligibility for Individuals

a. Eligibility Determination

(1) Eligibility for CHIP is based on the application of modified adjusted gross income and household definition, in additional to other permissible eligibility standards, for example standards relating to geographic area, age (up to, but not including age 19), and insurance status. States have flexibility in determining eligibility levels for individuals for whom the state will receive enhanced matching funds within the guidelines established under the Act. Generally, a state may not cover children with higher family income without covering children with a lower family income, nor deny eligibility based on a child having a preexisting medical condition. States are required to include in their CHIP state plans a description of the standards used to determine eligibility of targeted low-income children. CHIP state plans should be consulted for specific information concerning individual eligibility requirements (42 CFR 457.315 and 457.320, 42 USC 1397bb(b)).

States have the option to extend eligibility to low-income targeted pregnant women. There is no income eligibility level for pregnant women in CHIP that is lower than the state's Medicaid level, and states must cover pregnant women up to 185 percent of the federal poverty level before they can elect the option to include pregnant women in its CHIP state plan (Section 2112(b) of the Act).

(2) CHIP beneficiaries must either be US citizens or qualified noncitizens (aliens). Qualified aliens, as defined at 8 USC 1641, who entered the United States on or after August 22, 1996, are not eligible for a separate child health program under Title XXI (CHIP) for a period of five years, beginning on the date the alien became a qualified alien, unless the alien is exempt from this five-year bar under the terms of 8 USC 1613, or unless the state has adopted the option to provide coverage to these lawfully residing children, as authorized under Section 214 of CHIPRA (42 USC 1396b(v)(4)(ii)). States must provide coverage under a separate child health program under Title XXI to all other otherwise eligible qualified aliens who are not barred from coverage under 8 USC 1613 (42 CFR section 457.320(b)(6)).

States may elect to provide medical assistance, notwithstanding section 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, to children and pregnant women who are lawfully residing in the United States and who are otherwise eligible for such assistance. This optional

coverage in CHIP is only applicable if the state has elected to apply this allowance with respect to such category of children or pregnant women under Title XIX (Pub. L. No. 111-3, Section 214 (codified at section 2107(e)(1)(N) of the Act, cross referencing section 1903(v)(4) of the Act (42 USC 1396b(v)(4)).

(3) States must accept applications submitted online, by telephone, via mail, or in person. This includes electronic, telephonically recorded, and handwritten signatures and handwritten signatures. The CHIP agency must have facts in the case record to support the agency's eligibility determination, including a record of verification of income and citizenship or satisfactory immigration status for each individual. The state must provide notice of its decision concerning eligibility and provide timely and adequate notice of the basis for discontinuing assistance (42 CFR sections 457.330, 457.340).

(4) States are directed, at 42 CFR 457.340(d), to determine eligibility promptly and without undue delay. The determination of eligibility may not exceed 45 days.

(5) Regulations 42 CFR 457.348 and 457.350 require coordination between the CHIP agency and other insurance affordability programs, including the federal and state exchanges. Typically, electronic accounts must be transferred from the CHIP agency to the exchange and vice versa. States utilizing the FFE must enter into an agreement in which the FFE makes either a determination or an assessment of CHIP eligibility and sends the individual's electronic account to the agency for enrollment (FFE determination) or a final determination and enrollment (FFE assessment). Additional information may be found in the July 25, 2016 CMCS Informational Bulletin on Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace (https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib072516.pdf).

(6) When determining eligibility for a child, the CHIP agency may rely on elements of a determination made by an express lane agency (as defined in Section 4 of the CHIP state plan template) as to whether a child satisfies one or more requirements of CHIP eligibility. The CHIP agency may use an income determination from an express lane agency without regard to differences in budget unit, income disregards, deeming, or other differences in methodology between the express lane agency and CHIP. Auditors are not expected to test verification of express lane determinations relied upon by the CHIP Agency. This policy is set out at sections

2107(e)(1)(H) and 1902(e)(13) of the Social Security Act (42 USC 1397gg(e)(1)(H) and 1396a(e)(13) respectively); more information is available in state Health Official Letter #10-003, issued on February 4, 2010 (https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10003.pdf).

b. Eligibility Verification

(1) States must request information from reliable electronic data sources, including other agencies in the state and other state and federal programs to the extent that such information is determined useful in verifying the financial eligibility of an individual. As described in the state's verification plan and in state policies and procedures, this may include information from agencies such as the state Wage Information Collection Agency, the Social Security Administration, and the Internal Revenue Service. States may also use information related to eligibility or enrollment from other state programs such as the Supplemental Nutrition Assistance Program. If information provided by or on behalf of an individual is reasonably compatible with information obtained from the electronic data sources, as described in the state's verification plan, then the agency must determine or renew eligibility based on such information and may not require the individual to provide any further documentation. If the information is not reasonably compatible, then the agency must provide the individual with a reasonable period of time to explain the discrepancy or furnish additional information (42 CFR 457.380; 42 CFR 435.952).

(2) States may choose to accept self-attestation of information needed to determine or renew eligibility except with respect to income and citizenship or immigration status. When self-attestation is accepted, further information, including documentation, cannot be required from the individual. In such cases, the auditor would not be expected to test documentation other than required by the state. States must follow the requirements described at 42 CFR 457.380, for verification and documentation of income and citizenship and immigration status.

c. Periodic Renewal

As required at 42 CFR 457.343, states must renew enrollees' CHIP eligibility once every 12 months and no more frequently than once every 12 months. When renewing eligibility, states must first attempt to renew based on reliable information available to the agency without requiring information from the individual. If sufficient information is not available to complete a renewal, or if the state has information that suggests that the beneficiary is ineligible, the state

must provide the beneficiary with a prepopulated renewal form and inform the individual of any additional information or documentation needed to determine eligibility. Additional information may be found in the CMCS Informational Bulletin on Medicaid and CHIP renewal requirements issued on December 4, 2020 and available on Medicaid.gov at https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.

d. Presumptive Eligibility

Presumptive eligibility (PE) is a state option to facilitate enrollment and immediate access to services for children who are likely eligible for CHIP without having to wait for a full application to be processed. CHIP regulations at 42 CFR 457.355 outline the requirements for establishing a program of presumptive eligibility for children. The options elected by each state are described in the CHIP state plan.

When electing the PE option, states designate qualified entities, such as health care providers, community-based organizations, and schools to make PE determinations. These qualified entities are trained on the state's PE screening process and state-specific requirements for PE. In many states, qualified entities also help individuals to complete the full application process. A qualified entity is responsible for collecting and recording all information necessary to make a PE determination.

To be determined presumptively eligible, an individual must meet the basic requirements of eligibility as a targeted low-income child, including household income at or below the standard established by the state. In addition to the basic requirements of the eligibility group, states may, but are not required to, consider state residency and US citizenship or eligible immigration status when making a PE determination. Other information that would be collected on a full application, cannot be required for a PE determination. In addition, individuals attest to all information needed for a PE determination. States may not require verification or documentation of any eligibility criteria as a condition of presumptive eligibility.

The PE period begins the day on which the qualified entity makes the PE determination. The end date varies depending on whether or not the individual submits a CHIP application. If the individual submits a CHIP application by the last day of the month following the month in which PE was determined, the PE period will continue until full CHIP eligibility is either approved or denied. If the individual does **not** submit a CHIP application, the PE period ends on the last day of the month following the month in which PE was determined. States must adopt reasonable standards regarding the number of PE periods that will be authorized for an individual.

2. Eligibility for Group of Individuals or Area of Service Delivery

Not Applicable

3. Eligibility for Subrecipients

Not Applicable

G. Matching, Level of Effort, Earmarking

1. Matching

a. The state matching rate for its CHIP expenditures is determined in accordance with the federal matching rate for such expenditures, referred to as the enhanced federal medical assistance percentage (Enhanced FMAP) for a state. That is, the CHIP state matching rate is calculated by subtracting the 1905(b) of the Social Security Act Medicaid FMAP rate from 100, taking 30 percent of the difference, and then adding it to the 1905(b) Medicaid FMAP rate. The Enhanced FMAP is calculated in accordance with section 2105(b) of the Act, 42 USC 1397ee(b), which provides that the Enhanced FMAP for a state shall not exceed 85 percent except during the periods of October 1, 2015 through September 30, 2019, where the enhanced FMAP was increased by 23 percentage points (not to exceed 100 percent) and October 1, 2019 through September 30, 2020, where the enhanced FMAP is reduced to an increase of 11.5 percentage points (not to exceed 100 percent). The increase to the enhanced FMAP does not apply to certain categories of expenditures as described in the last sentence of 42 USC 1397ee(b). Calculated FMAPs and enhanced FMAPs may be found at http://www.aspe.hhs.gov/health/fmap.htm (42 USC 1397ee(a) and (b)). Because the EFMAP under section 2105(b) of the Act is calculated using the 1905(b) FMAP as a "base," in general, any fluctuations to the 1905(b) FMAP amount for a period will affect the EFMAP determination under 2105(b) of the Act for such period unless otherwise precluded in statute.

b. A qualifying state as described under section 2105(g) of the Act, 42 USC 1397ee(g) may elect to be paid from the state's allotment for any of FYs 2009 through 2027, an amount equal to the additional amount that would have been paid to the state under Title XIX with respect to expenditures if the enhanced FMAP had been substituted for the FMAP (section 2105(g)(4) of the Act (42 USC 1397ee(g)(4)). The qualifying states are Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin (as determined by CMS on the basis of the criteria in Pub. L. No. 108-74, Section 1(g)(2) and Pub. L. No. 108-127, Section 1).

2. Level of Effort

2.1 Level of Effort – *Maintenance of Effort*

a. In order to receive federal matching funds for CHIP expenditures at the enhanced matching rate, each state must continue to maintain its Medicaid eligibility standards and the methodologies that were applied in its Medicaid state plans as of June 1, 1997 (42 USC 1397ee(d)(1) and 1397jj(b)).

b. The maintenance of effort (MOE) provisions at section 2105(d)(3) and sections 1902(a)(74) and 1902(gg)(2) of the Act (42 USC 1397ee(d)(3) and 1396a(a)(74) and (gg)(2)) specify that as a condition of receiving federal funding for CHIP or Medicaid (with certain exceptions), states must maintain Medicaid and CHIP "eligibility standards, methodologies, and procedures" for children that are no more restrictive than those in effect on March 23, 2010. The MOE requirement was first implemented under the American Recovery and Reinvestment Act (ARRA) and extended by the Patient Protection and Affordable Care Act (ACA). Section 3002 of the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (referred to as the HEALTHY KIDS Act and included in Pub. L. No. 115-120) extends the MOE requirements for children in CHIP and Medicaid through FY 2023, and Section 50101 of the Advancing Chronic Care, Extenders and Social Services Act (referred to as the ACCESS Act and included in Pub. L. No. 115-123), extends the MOE requirements for children in CHIP and Medicaid through FY 2027. Section 3002 of the HEALTHY KIDS Act amends the MOE provisions such that starting in FY 2020 and through FY 2027, the MOE provision is applicable to children in families with incomes that do not exceed 300 percent of the FPL. States with eligibility levels above 300 percent of the Federal Poverty Level (FPL) will have the option of maintaining or reducing existing coverage levels to 300 percent FPL at that time.

2.2 Level of Effort – *Supplement Not Supplant*

Not Applicable

3. Earmarking

Expenditures not directly related to providing child health insurance assistance under the plan are limited to 10 percent of the state's total expenditures through CHIP. The following expenditures are subject to the 10 percent limit: (a) payment for other child health assistance for targeted low-income children; (b) expenditures for health services initiatives under the state child health assistance

plan for improving the health of children; (c) expenditures for outreach activities; (d) expenditures for translation and interpretation services in connection with the enrollment, retention, and use of services under Title XXI by individuals for whom English is not their primary language (as found necessary by the secretary for the proper and efficient administration of the CHIP state plan); and (e) other reasonable costs incurred by the state to administer the state child health assistance plan (42 USC 1397ee(c)). States may apply for a waiver, or variance of this 10 percent cap under 42 USC 1397ee(c)(2). If applicable, information regarding such a waiver is in the CHIP state plan.

The 10 percent limit is applied on an annual fiscal-year basis and is calculated based on (a) the total amounts of expenditures, and (b) the quarter in which such expenditures are claimed by the state for the fiscal year (42 USC 1397ee).

H. Period of Performance

The availability of allotment amounts determined under section 2104(m) of the Social Security Act (the Act) for FY 2009 and each fiscal year thereafter, shall remain available for expenditure by the state through the end of the succeeding fiscal year as provided under section 2104(e) of the Act. (i.e., the year of award and one subsequent fiscal year) (42 USC 1397dd(e)).

L. Reporting

1. Financial Reporting

a. *SF-270, Request for Advance or Reimbursement* – Not Applicable

b. *SF-271, Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable

c. *SF-425, Federal Financial Report* – Applicable for cash status; Not Applicable for expenditure reporting

d. *CMS-21, Quarterly Children's Health Insurance Program Statement of Expenditures for Title XXI (OMB No. 0938-0731)*

Key Line Items – The following line items contain critical information:

1. *CMS-21 Base* – The CMS-21 consists of three parts: CMS-21 Base, CMS-21B, and CMS-21C. Only CMS-21 Base is expected to be tested for compliance.

2. Performance Reporting

Not Applicable

3. Special Reporting

Not Applicable

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

N. Special Tests and Provisions

1. Provider Eligibility (Screening and Enrollment)

Compliance Requirements In order to receive CHIP payments, CHIP providers must: (1) be licensed in accordance with federal, state, and local laws and regulations to participate in the CHIP program (42 CFR 457.900); (2) screened and enrolled in accordance with 42 CFR Part 455, Subpart E (sections 455.400 through 455.470); and make certain disclosures to the state (42 CFR 457.990(a), cross referencing 455.107). CHIP managed care network providers are subject to the same disclosure, screening, enrollment, and termination requirements that apply to Medicaid fee-for-service providers in accordance with 42 CFR Part 438, Subpart H.

Providers who have been barred from participation by the OIG exclusion list are not eligible to be enrolled in the CHIP program (42 CFR 457.990, 42 CFR 455 Subpart E). Lists may be found at https://oig.hhs.gov/exclusions/?utm_source=oigNewsletter&utm_medium=oig-nl-nav&utm_campaign=leie-nl.

Audit Objectives Determine whether CHIP providers of medical services have the required medical licenses and are eligible to participate in CHIP in accordance with federal, state, and local laws and regulations.

Suggested Audit Procedures

a. Obtain an understanding of the CHIP state plan's provisions for licensing and entering into agreements with providers.

b. Select samples from both CHIP fee-for-service providers and managed care network providers to ascertain if the:

   (1) The provider is screened, licensed, and enrolled in accordance with the CHIP state plan and the requirement of 42 CFR 455 Subpart E.

   (2) The provider complied with the requirements of the CHIP state plan.

   (3) The provider was not on the OIG's exclusion list at the time the services were provided.

2. Refunding of Federal Share of CHIP Overpayments to Providers

Compliance Requirements Federal regulations at 42 CFR 457.628 make the regulations at CFR 433.312-433.322 regarding overpayments applicable to CHIP. CMS rules at 42 CFR 433 Subpart F describe the requirements SMAs are to follow related to refunding the federal share of Medicaid overpayments made to providers. Pursuant to 1903(d)(2)(C) of the Social Security Act (the Act) (42 USC 1396b), states have up to one (1) year from the date of discovery of the overpayment to recover or attempt to recover the overpayment before the federal share must be refunded to CMS via Form CMS-64 Summary, Line 9C1- Fraud, Waste & Abuse Amounts, regardless of whether recovery is made from the provider, for which the federal share must be refunded to CMS via Form CMS-21 Summary, Line 4 - Adjustments Decreasing Claims - Collections. The state must credit the federal share to CMS as outlined under 42 CFR 433.320(a)(2) either in the quarter in which the recovery is made or in the quarter in which the one-year period ends following discovery, whichever is earlier, with limited exceptions. Under 42 CFR 433.316(d), for overpayments resulting from fraud, if not collected within one year of discovery, the SMA has until 30 days after the final judgment of a judicial or administrative appeals process to return the federal share.

Additionally, in accordance with 42 CFR 433.320(a)(4), the state will be charged interest for any non-recovered, non-refunded overpayment amounts. Any appeal rights offered to the provider does not extend the date of discovery per 42 CFR 433.316(h).

The repayment of the federal share is not required in cases where the state is unable to obtain recovery because the provider has filed for bankruptcy or the provider is otherwise out of business as outlined in 42 CFR 433.318.

The 42 CFR 433.320(c)(1) allows for downward adjustments previously credited to CMS if it is properly based on the approved CHIP state plan, federal law and regulations governing Medicaid, and the appeals resolution process specified in state administrative policies and procedures. States are not able to enter into settlement agreements with providers that reduces the federal share of the overpayment in order to avoid the expense of litigation. The Departmental Appeals Board (DAB) decision No. 1391 from February 19, 1993 (https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1993/dab1391.html), addressed overpayment settlements between the states and providers. This decision affirmed that states may not reduce the federal share by settling overpayment receivables for less than the actual amount of the overpayment based on anticipated success in litigation or made simply to avoid administrative costs or litigation expenses.

Audit Objectives Determine whether the SMA reported and returned CHIP provider overpayments in accordance the federal requirements.

Suggested Audit Procedures

a. Review applicable federal laws and regulation, including 1903(d)(2)(C) of the Act (42 USC 1396b), 42 CFR 433 Subpart F, and the Departmental Appeals Board Decision No. 1391.

b. Obtain an understanding of the process to identify overpayments.

c. Perform tests to ascertain if the federal share has been returned accurately in accordance with federal laws and regulations, including ensuring the full amount was refunded and any downward adjustments were made.

3. Medical Loss Ratio (MLR)

Compliance Requirements For all contracts, the state must ensure that each managed care organization (MCO), prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) submits a report with the data elements specified in 42 CFR 457.1203(e), cross-referencing 42 CFR 438.8(k) and 438.8(n). The report should contain the required 13 data elements in the regulation, reflect the correct reporting years, and contain an attestation of accuracy regarding the calculation of the MLR. The state should have a method to indicate when the report(s) are due from plans and should not accept multiple submissions from plans unless the capitation rates are revised retroactively.

Audit Objectives Determine whether the state's oversight of the content and submission of MLR reports meets the requirements.

Suggested Audit Procedures

a. Perform procedures to ascertain if the state obtained the required MLR reports;

b. Verify the 13 required elements are included;

c. Verify the reporting period covered is 12 months;

d. Verify the report contains an attestation statement to address accuracy;

e. Ascertain if the state did not permit plans to submit multiple MLR reports for a specific reporting year except when a state had retroactive changes to capitation payments.

4. Managed Care Financial Audit

Compliance Requirements Two types of audits are required for managed care:

1. Audited Financial Reports – The contract with each MCO, PIHP, and PAHP must require them to submit to the state an audited financial report specific to the Medicaid contract on an annual basis. These audits must be conducted in

accordance with generally accepted accounting principles and generally accepted auditing standards (42 CFR 457.1201(k)).

2. Periodic Audits – Effective no later than for rating periods for contracts starting on or after July 1, 2017, the state must periodically, but no less frequently than once every three years, conduct, or contract for an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of each MCO, PIHP, and PAHP and post the results of these audits on its website (42 CFR Part 438, Subpart H (as adopted in CHIP at 42 CFR 457.1285); May 6, 2016, *Federal Register* (81 FR 27497); OMB No. 0938-0920)).

Audit Objectives Determine whether the required audits were conducted and the audit reports for the Periodic Audits were posted on the state's website.

Suggested Audit Procedures

a. Review the state's policies and operating procedures for obtaining audited financial reports, conducting these required audits and for posting the Periodic Audits on the state's website.

b. Perform tests to ascertain if: (1) the state obtained annually the required Audited Financial Reports from each MCO, PIHP, and PAHP; and (2) the independent auditor's reports on the financial report stated the audit was conducted in accordance with generally accepted auditing standards.

c. Perform tests to ascertain if: (1) the state conducted or contracted for the required Periodic Audits for each MCO, PIHP, and PAHP at least once in the most recent three year period; and (2) the audits were posted on the state's website.