

(ix) Individuals who become ineligible for AFDC because of the collection or increased collection of child or spousal support, but, in accordance with section 406(h) of the Act, remain eligible for Medicaid for four more months; and

(x) Individuals who become ineligible for AFDC because they are no longer eligible for the disregard of earnings of \$30 or of \$30 plus one-third of the remainder, but, in accordance with section 402(a)(37) of the Act, are considered as receiving AFDC for a period of 9 to 15 months.

(3) No FFP is available in State Medicaid expenditures that could have been paid for under Medicare Part B but were not because the person was not enrolled in Part B. This limit applies to all recipients eligible for enrollment under Part B, whether individually or through an agreement under section 1843(a) of the Act. However, FFP is available in expenditures required by §§ 435.914 and 436.901 of this subchapter for retroactive coverage of recipients.

[43 FR 45188, Sept. 29, 1978, as amended at 44 FR 17935, Mar. 23, 1979; 52 FR 47933, Dec. 17, 1987; 53 FR 657, Jan. 11, 1988]

§ 431.630 Coordination of Medicaid with QIOs.

(a) The State plan may provide for the review of Medicaid services through a contract with a QIO designated under Part 462 of this chapter. Medicaid requirements for medical and utilization review are deemed to be met for those services or providers subject to review under the contract.

(b) The State plan must provide that the contract with the QIO—

(1) Meets the requirements of § 434.6(a) of this part;

(2) Includes a monitoring and evaluation plan by which the State ensures satisfactory performance by the QIO;

(3) Identifies the services and providers subject to QIO review;

(4) Ensures that the review activities performed by the QIO are not inconsistent with QIO review activities of Medicare services and includes a description of whether and to what extent QIO determinations will be considered conclusive for Medicaid payment purposes.

[50 FR 15327, Apr. 17, 1985]

§ 431.635 Coordination of Medicaid with Special Supplemental Food Program for Women, Infants, and Children (WIC).

(a) *Basis.* This section implements sections 1902(a)(11)(C) and 1902(a) (53) of the Act, which provide for coordination of Medicaid with the Special Supplemental Food Program for Women, Infants, and Children (WIC) under section 17 of the Child Nutrition Act of 1966.

(b) *Definitions.* As used in this section, the terms *breastfeeding women*, *postpartum women*, and *pregnant women* mean women as defined in section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)).

(c) *State plan requirements.* A State Plan must provide for—

(1) Coordinating operation of the Medicaid program with the State's operation of the Special Supplemental Food Program for Women, Infants, and Children;

(2) Providing timely written notice of the availability of WIC benefits to all individuals in the State who are determined to be eligible (including presumptively eligible) for Medicaid and who are:

- (i) Pregnant women;
- (ii) Postpartum women;
- (iii) Breastfeeding women; and
- (iv) Children under the age of 5.

(3) Referring individuals described under paragraphs (c)(2) (i) through (iv) of this section to the local agency responsible for administering the WIC program.

(d) *Notification requirements.* (1) The agency must give the written notice required under paragraph (c) of this section as soon as the agency identifies the individual (e.g., at the time of an eligibility determination for Medicaid) or immediately thereafter (e.g., at the time of notice of eligibility).

(2) The agency, no less frequently than annually, must also provide written notice of the availability of WIC benefits, including the location and telephone number of the local WIC agency or instructions for obtaining further information about the WIC program, to all Medicaid recipients (including those found to be presumptively eligible) who are under age 5 or who are women who might be pregnant, postpartum, or breastfeeding as

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described in paragraphs (c)(2) (i) through (iv) of this section.

(3) The agency must effectively inform those individuals who are blind or deaf or who cannot read or understand the English language.

[57 FR 28103, June 24, 1992]

§ 431.636 Coordination of Medicaid with the State Children's Health Insurance Program (SCHIP).

(a) *Statutory basis.* This section implements—

(1) Section 2102(b)(3)(B) of the Act, which provides that children who apply for coverage under a separate child health plan under title XXI, but are found to be eligible for medical assistance under the State Medicaid plan, must be enrolled in the State Medicaid plan; and

(2) Section 2102(c)(2) of the Act, which requires coordination between a State child health program and other public health insurance programs.

(b) *Obligations of State Medicaid Agency.* The State Medicaid agency must adopt procedures to facilitate the Medicaid application process for, and the enrollment of children for whom the Medicaid application and enrollment process has been initiated in accordance with §457.350(f) of this chapter. The procedures must ensure that—

(1) The applicant is not required to provide information or documentation that has been provided to the State agency responsible for determining eligibility under a separate child health program under title XXI and forwarded by such agency to the Medicaid agency on behalf of the child in accordance with § 457.350(f) of this chapter;

(2) Eligibility is determined in a timely manner in accordance with §435.911 of this chapter;

(3) The Medicaid agency promptly notifies the State agency responsible for determining eligibility under a separate child health program when a child who was screened as potentially eligible for Medicaid is determined ineligible or eligible for Medicaid; and

(4) The Medicaid agency adopts a process that facilitates enrollment in a State child health program when a child is determined ineligible for Med-

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icaid at initial application or redetermination.

[66 FR 2666, Jan. 11, 2001]

Subpart N—State Programs for Licensing Nursing Home Administrators

§ 431.700 Basis and purpose.

This subpart implements sections 1903(a)(29) and 1908 of the Act which require that the State plan include a State program for licensing nursing home administrators.

§ 431.701 Definitions.

Unless otherwise indicated, the following definitions apply for purposes of this subpart:

Agency means the State agency responsible for licensing individual practitioners under the State's healing arts licensing act.

Board means an appointed State board established to carry out a State program for licensing administrators of nursing homes, in a State that does not have a healing arts licensing act or an agency as defined in this section.

Licensed means certified by a State agency or board as meeting all of the requirements for a licensed nursing home administrator specified in this subpart.

Nursing home means any institution, facility, or distinct part of a hospital that is licensed or formally recognized as meeting nursing home standards established under State law, or that is determined under §431.704 to be included under the requirements of this subpart. The term does not include—

(a) A religious nonmedical institution as defined in §440.170(b) of this chapter; or

(b) A distinct part of a hospital, if the hospital meets the definition in §440.10 or §440.140 of this subchapter, and the distinct part is not licensed separately or formally approved as a nursing home by the State even though it is designated or certified as a skilled nursing facility.

Nursing home administrator means any person who is in charge of the general administration of a nursing home whether or not the person—