SUBCHAPTER C—MEDICAL ASSISTANCE PROGRAMS

PART 430—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

Subpart A—Introduction; General Provisions

Subpart B—State Plans

Subpart C—Grants; Reviews and Audits; Withholding for Failure To Comply; Deferral and Disallowance of Claims; Reduction of Federal Medicaid Payments

Subpart D—Hearings on Conformity of State Medicaid Plans and Practice to Federal Requirements

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Subpart A—Introduction; General Provisions

§ 430.0 Program description.

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

§ 430.1 Scope of subchapter C.

The regulations in subchapter C set forth State plan requirements, standards, procedures, and conditions for obtaining Federal financial participation (FFP). Each part (or subpart of section) in the subchapter describes the specific statutory basis for the regulation. However, where the basis is the Secretary's general authority to issue regulations for any program under the Act (section 1102 of the Act), or his general authority to prescribe State plan requirements needed for proper and efficient administration of the plan (section 1902(a)(4)), those statutory provisions are simply cited without further description.

§ 430.2 Other applicable Federal regulations.

Other regulations applicable to State Medicaid programs include the following:

(a) 5 CFR part 900, subpart F, Administration of the Standards for a Merit System of Personnel Administration.

(b) The following HHS Regulations in 45 CFR subtitle A:

Part 16—Procedures of the Departmental Appeals Board.
Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.
Part 80—Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services: Effectuation of Title VI of the Civil Rights Act of 1964.
Part 81—Practice and Procedure for Hearings Under 45 CFR part 80.
Part 84—Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting From Federal Financial Assistance.
Part 95—General Administration—grant programs (public assistance and medical assistance).

[53 FR 36571, Sept. 21, 1988, as amended at 56 FR 8845, Mar. 1, 1991; 81 FR 3011, Jan. 20, 2016]

§ 430.3 Appeals under Medicaid.

Four distinct types of disputes may arise under Medicaid.

(a) *Compliance with Federal requirements.* Disputes that pertain to whether a State's plan or proposed plan amendments, or its practice under the plan meet or continue to meet Federal requirements are subject to the hearing provisions of subpart D of this part.

(b) *FFP in Medicaid expenditures.* Disputes that pertain to disallowances of FFP in Medicaid expenditures (mandatory grants) are heard by the Departmental Appeals Board (the Board) in accordance with procedures set forth in 45 CFR part 16.

(c) *Discretionary grants disputes.* Disputes pertaining to discretionary grants, such as grants for special demonstration projects under sections 1110 and 1115 of the Act, which may be awarded to a Medicaid agency, are also heard by the Board. 45 CFR part 16, appendix A, lists all the types of disputes that the Board hears.

(d) *Imposition of suspensions of procedural disenrollments and civil money penalties under section 430.49 of this part.* Disputes that pertain to CMS' imposition of suspensions of procedural disenrollments and civil money penalties under § 430.49(c) of this part are heard by the Board in accordance with procedures set forth in 45 CFR part 16.

(e) Disputes that pertain to disapproval of written approval by CMS of State directed payments under 42 CFR 438.6(c)(2)(i) are also heard by the Board in accordance with procedures set forth in 45 CFR part 16. 45 CFR part 16, appendix A, lists all the types of disputes that the Board hears.

[53 FR 36571, Sept. 21, 1988, as amended at 56 FR 8845, Mar. 1, 1991; 88 FR 84733, Dec. 6, 2023; 89 FR 41267, May 10, 2024]

§ 430.5 Definitions.

As used in this subchapter, unless the context indicates otherwise—

Contractor means any entity that contracts with the State agency, under the State plan, in return for a payment, to process claims, to provide or pay for medical services, or to enhance the State agency's capability for effective administration of the program.

Federal redetermination requirements means, for the purposes of § 430.49, Federal requirements applicable to eligibility redeterminations outlined in 42 CFR 435.916, including renewal strategies authorized under section 1902(e)(14)(A) of the Social Security Act or other alternative processes and procedures approved by CMS under section 1902(e)(14)(A) of the Act or section 6008(f)(2)(A) of the Families First Coronavirus Response Act.

Procedural disenrollment means, for the purposes of § 430.49 and 45 CFR part 16, a *termination* of a beneficiary's Medicaid eligibility after advance notice under subpart E of part 431 for reasons that are unrelated to a State's determination of whether the individual meets eligibility criteria to qualify for coverage, including for failure to return a renewal form or documentation needed by the State to make a determination of eligibility.

Representative has the meaning given the term by each State consistent with its laws, regulations, and policies.

[67 FR 41094, June 14, 2002, as amended at 88 FR 84733, Dec. 6, 2023]

Subpart B—State Plans

§ 430.10 The State plan.

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

§ 430.12 Submittal of State plans and plan amendments.

(a) *Format.* A State plan for Medicaid consists of a standardized template, issued and updated by CMS, that includes both basic requirements and individualized content that reflects the characteristics of the State's program. The Secretary will periodically update the template and format specifications for State plans and plan amendments through a process consistent with the requirements of the Paperwork Reduction Act.

(b) *Governor's review*—(1) *Basic rules.* Except as provided in paragraph (b)(2) of this section—

(i) The Medicaid agency must submit the State plan and State plan amendments to the State Governor or his designee for review and comment before submitting them to the CMS regional office.

(ii) The plan must provide that the Governor will be given a specific period of time to review State plan amendments, long-range program planning projections, and other periodic reports on the Medicaid program, excluding periodic statistical, budget and fiscal reports.

(iii) Any comments from the Governor must be submitted to CMS with the plan or plan amendment.

(2) *Exceptions.* (i) Submission is not required if the Governor's designee is the head of the Medicaid agency.

(ii) Governor's review is not required for preprinted plan amendments that are developed by CMS if they provide absolutely no options for the State.

(c) *Plan amendments.* (1) The plan must provide that it will be amended whenever necessary to reflect—

(i) Changes in Federal law, regulations, policy interpretations, or court decisions; or

(ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program. For changes related to advance directive requirements, amendments must be submitted as soon as possible, but no later than 60 days from the effective date of the change to State law concerning advance directives.

(2) Prompt submittal of amendments is necessary—

(i) So that CMS can determine whether the plan continues to meet the requirements for approval; and

(ii) To ensure the availability of FFP in accordance with § 430.20.

[53 FR 36571, Sept. 21, 1988, as amended at 60 FR 33293, June 27, 1995; 81 FR 86447, Nov. 30, 2016]

§ 430.14 Review of State plan material.

CMS regional staff reviews State plans and plan amendments, discusses any issues with the Medicaid agency, and consults with central office staff on questions regarding application of Federal policy.

§ 430.15 Basis and authority for action on State plan material.

(a) *Basis for action.* (1) Determinations as to whether State plans (including plan amendments and administrative practice under the plans) originally meet or continue to meet the requirements for approval are based on relevant Federal statutes and regulations.

(2) Guidelines are furnished to assist in the interpretation of the regulations.

(b) *Approval authority.* The Regional Administrator exercises delegated authority to approve the State plan and plan amendments on the basis of policy statements and precedents previously approved by the Administrator.

(c) *Disapproval authority.* (1) The Administrator retains authority for determining that proposed plan material

is not approvable or that previously approved material no longer meets the requirements for approval.

(2) The Administrator does not make a final determination of disapproval without first consulting the Secretary.

§ 430.16 Timing and notice of action on State plan material.

(a) *Timing.* (1) A State plan or plan amendment will be considered approved unless CMS, within 90 days after receipt of the plan or plan amendment in the regional office, sends the State—

(i) Written notice of disapproval; or

(ii) Written notice of any additional information it needs in order to make a final determination.

(2) If CMS requests additional information, the 90-day period for CMS action on the plan or plan amendment begins on the day it receives that information.

(b) *Notice of final determination.* (1) The Regional Administrator or the Administrator notifies the Medicaid agency of the approval of a State plan or plan amendment.

(2) Only the Administrator gives notice of disapproval of a State plan or plan amendment.

§ 430.18 Administrative review of action on State plan material.

(a) *Request for reconsideration.* Any State dissatisfied with the Administrator's action on plan material under § 430.15 may, within 60 days after receipt of the notice provided under § 430.16(b), request that the Administrator reconsider the issue of whether the plan or plan amendment conforms to the requirements for approval.

(b) *Notice and timing of hearing.* (1) Within 30 days after receipt of the request, the Administrator notifies the State of the time and place of the hearing.

(2) The hearing takes place not less than 30 days nor more than 60 days after the date of the notice, unless the State and the Administrator agree in writing on an earlier or later date.

(c) *Hearing procedures.* The hearing procedures are set forth in subpart D of this part.

(d) *Decision.* A decision affirming, modifying, or reversing the Administrator's original determination is made in accordance with § 430.102.

(e) *Effect of hearing decision.* (1) Denial of Federal funds, if required by the Administrator's original determination, will not be delayed pending a hearing decision.

(2) However, if the Administrator determines that his or her original decision was incorrect, CMS pays the State a lump sum equal to any funds incorrectly denied.

§ 430.20 Effective dates of State plans and plan amendments.

For purposes of FFP, the following rules apply:

(a) *New plans.* The effective date of a new plan—

(1) May not be earlier than the first day of the quarter in which an approvable plan is submitted to the regional office; and

(2) With respect to expenditures for medical assistance, may not be earlier than the first day on which the plan is in operation on a statewide basis.

(b) *Plan amendment.* (1) For a plan amendment that provides additional services to individuals eligible under the approved plan, increases the payment amounts for services already included in the plan, or makes additional groups eligible for services provided under the approved plan, the effective date is determined in accordance with paragraph (a) of this section.

(2) For a plan amendment that changes the State's payment method and standards, the rules of § 447.256 of this chapter apply.

(3) For other plan amendments, the effective date may be a date requested by the State if CMS approves it.

[53 FR 36571, Sept. 21, 1988, as amended at 56 FR 8845, Mar. 1, 1991]

§ 430.25 Waivers of State plan requirements.

(a) *Scope of section.* This section describes the purpose and effect of waivers, identifies the requirements that may be waived and the other regulations that apply to waivers, and sets forth the procedures that CMS follows in reviewing and taking action on waiver requests.

(b) *Purpose of waivers.* Waivers are intended to provide the flexibility needed

to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of beneficiaries. Waivers allow exceptions to State plan requirements and permit a State to implement innovative programs or activities on a time-limited basis, and subject to specific safeguards for the protection of beneficiaries and the program. Detailed rules for waivers are set forth in subpart B of part 431, subpart A of part 440, and subpart G of part 441 of this chapter.

(c) *Effect of waivers.* (1) Waivers under section 1915(b) allow a State to take the following actions:

(i) Implement a primary care case-management system or a specialty physician system.

(ii) Designate a locality to act as central broker in assisting Medicaid beneficiaries to choose among competing health care plans.

(iii) Share with beneficiaries (through provision of additional services) cost-savings made possible through the beneficiaries' use of more cost-effective medical care.

(iv) Limit beneficiaries' choice of providers (except in emergency situations and with respect to family planning services) to providers that fully meet reimbursement, quality, and utilization standards, which are established under the State plan and are consistent with access, quality, and efficient and economical furnishing of care.

(2) A waiver under section 1915(c) of the Act allows a State to include as ''medical assistance'' under its plan home and community based services furnished to beneficiaries who would otherwise need inpatient care that is furnished in a hospital, SNF, ICF, or ICF/IID, and is reimbursable under the State plan.

(3) A waiver under section 1916 (a)(3) or (b)(3) of the Act allows a State to impose a deduction, cost-sharing or similar charge of up to twice the ''nominal charge'' established under the plan for outpatient services, if—

(i) The outpatient services are received in a hospital emergency room but are not emergency services; and

(ii) The State has shown that Medicaid beneficiaries have actually available and accessible to them alternative services of nonemergency outpatient services.

(d) *Requirements that are waived.* In order to permit the activities described in paragraph (c) of this section, one or more of the title XIX requirements must be waived, in whole or in part.

(1) Under section 1915(b) of the Act, and subject to certain limitations, any of the State plan requirements of section 1902 of the Act may be waived to achieve one of the purposes specified in that section.

(2) Under section 1915(c) of the Act, the following requirements may be waived:

(i) Statewideness—section 1902(a)(1).

(ii) Comparability of services—section 1902(a)(10)(B).

(iii) Income and resource rules—section 1902(a)(10)(C)(i)(III).

(3) Under section 1916 of the Act, paragraphs (a)(3) and (b)(3) require that any cost-sharing imposed on beneficiaries be nominal in amount, and provide an exception for nonemergency services furnished in a hospital emergency room if the conditions of paragraph (c)(3) of this section are met.

(e) *Submittal of waiver request.* The State Governor, the head of the Medicaid agency, or an authorized designee may submit the waiver request.

(f) *Review of waiver requests.* (1) This paragraph applies to initial waiver requests and to requests for renewal or amendment of a previously approved waiver.

(2) CMS regional and central office staff review waiver requests and submit a recommendation to the Administrator, who—

(i) Has the authority to approve or deny waiver requests; and

(ii) Does not deny a request without first consulting the Secretary.

(3) A waiver request is considered approved unless, within 90 days after the request is received by CMS, the Administrator denies the request, or the Administrator or the Regional Administrator sends the State a written request for additional information necessary to reach a final decision. If additional information is requested, a new

90-day period begins on the day the response to the additional information request is received by the addressee.

(g) *Basis for approval*—(1) *Waivers under section 1915 (b) and (c).* The Administrator approves waiver requests if the State's proposed program or activity meets the requirements of the Act and the regulations at § 431.55 or subpart G of part 441 of this chapter.

(2) *Waivers under section 1916.* The Administrator approves a waiver under section 1916 of the Act if the State shows, to CMS's satisfaction, that the Medicaid beneficiaries have available and accessible to them sources, other than a hospital emergency room, where they can obtain necessary nonemergency outpatient services.

(h) *Effective date and duration of waivers*—(1) *Effective date.* Waivers receive a prospective effective date determined, with State input, by the Administrator. The effective date is specified in the letter of approval to the State.

(2) *Duration of waivers*—(i) *Home and community-based services under section 1915(c) of the Act.* (A) The initial waiver is for a period of 3 years and may be renewed thereafter for periods of 5 years.

(B) For waivers that include individuals who are dually eligible for Medicare and Medicaid, 5-year initial approval periods may be granted at the discretion of the Secretary for waivers meeting all necessary programmatic, financial and quality requirements, and in a manner consistent with the interests of beneficiaries and the objectives of the Medicaid program.

(ii) *Waivers under section 1915(b) of the Act.* (A) The initial waiver is for a period of 2 years and may be renewed for additional periods of up to 2 years as determined by the Administrator.

(B) For waivers that include individuals who are dually eligible for Medicare and Medicaid, 5-year initial and renewal approval periods may be granted at the discretion of the Secretary for waivers meeting all necessary programmatic, financial and quality requirements, and in a manner consistent with the interests of beneficiaries and the objectives of the Medicaid program.

(iii) *Waivers under section 1916 of the Act.* The initial waiver is for a period of 2 years and may be renewed for additional periods of up to 2 years as determined by the Administrator.

(3) *Renewal of waivers.* (i) A renewal request must be submitted at least 90 days (but not more than 120 days) before a currently approved waiver expires, to provide adequate time for CMS review.

(ii) If a renewal request for a section 1915(c) waiver proposes a change in services provided, eligible population, service area, or statutory sections waived, the Administrator may consider it a new waiver, and approve it for a period of three years.

[56 FR 8846, Mar. 1, 1991, as amended at 79 FR 3028, Jan. 16, 2014]

Subpart C—Grants; Reviews and Audits; Withholding for Failure To Comply; Deferral and Disallowance of Claims; Reduction of Federal Medicaid Payments

§ 430.30 Grants procedures.

(a) *General provisions.* (1) Once CMS has approved a State plan, it makes quarterly grant awards to the State to cover the Federal share of expenditures for services, training, and administration.

(2) The amount of the quarterly grant is determined on the basis of information submitted by the State agency (in quarterly estimate and quarterly expenditure reports) and other pertinent documents.

(b) *Quarterly estimates.* The Medicaid agency must submit Form CMS–37 (Medicaid Program Budget Report; Quarterly Distribution of Funding Requirements) to the central office (with a copy to the regional office) 45 days before the beginning of each quarter.

(c) *Expenditure reports.* (1) The State must submit Form CMS–64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) to the central office (with a copy to the regional office) not later than 30 days after the end of each quarter.

(2) This report is the State's accounting of actual recorded expenditures. The disposition of Federal funds may not be reported on the basis of estimates.

(d) *Grant award*—(1) *Computation by CMS.* Regional office staff analyzes the State's estimates and sends a recommendation to the central office. Central office staff considers the State's estimates, the regional office recommendations and any other relevant information, including any adjustments to be made under paragraph (d)(2) of this section, and computes the grant.

(2) *Content of award.* The grant award computation form shows the estimate of expenditures for the ensuring quarter, and the amounts by which that estimate is increased or decreased because of an underestimate or overestimate for prior quarters, or for any of the following reasons:

(i) Penalty reductions imposed by law.

(ii) Accounting adjustments.

(iii) Deferrals or disallowances.

(iv) Interest assessments.

(v) Mandated adjustments such as those required by section 1914 of the Act.

(3) *Effect of award.* The grant award authorizes the State to draw Federal funds as needed to pay the Federal share of disbursements.

(4) *Drawing procedure.* The draw is through a commercial bank and the Federal Reserve system against a continuing letter of credit certified to the Secretary of the Treasury in favor of the State payee. (The letter of credit payment system was established in accordance with Treasury Department regulations—Circular No. 1075.)

(e) *General administrative requirements.* With the following exceptions, the provisions of 45 CFR 75, which establish uniform administrative requirements and cost principles, apply to all grants made to States under this subpart:

(1) Cost sharing or matching, 45 CFR 75.306; and

(2) Financial reporting, 45 CFR 75.341.

[53 FR 36571, Sept. 21, 1988, as amended at 77 FR 31507, May 29, 2012; 81 FR 3011, Jan. 20, 2016]

§ 430.32 Program reviews.

(a) *Review of State and local administration.* In order to determine whether the State is complying with the Federal requirements and the provisions of its plan, CMS reviews State and local administration through analysis of the State's policies and procedures, on-site review of selected aspects of agency operation, and examination of samples of individual case records.

(b) *Quality control program.* The State itself is required to carry out a continuing quality control program as set forth in part 431, subpart P, of this chapter.

(c) *Action on review findings.* If Federal or State reviews reveal serious problems with respect to compliance with any Federal requirement, the State must correct its practice accordingly.

§ 430.33 Audits.

(a) *Purpose.* The Department's Office of Inspector General (OIG) periodically audits State operations in order to determine whether—

(1) The program is being operated in a cost-efficient manner; and

(2) Funds are being properly expended for the purposes for which they were appropriated under Federal and State law and regulations.

(b) *Reports.* (1) The OIG releases audit reports simultaneously to State officials and the Department's program officials.

(2) The reports set forth OIG opinion and recommendations regarding the practices it reviewed, and the allowability of the costs it audited.

(3) Cognizant officials of the Department make final determinations on all audit findings.

(c) *Action on audit exceptions*—(1) *Concurrence or clearance.* The State agency has the opportunity of concurring in the exceptions or submitting additional facts that support clearance of the exceptions.

(2) *Appeal.* Any exceptions that are not disposed of under paragraph (c)(1) of this section are included in a disallowance letter that constitutes the Department's final decision unless the State requests reconsideration by the Administrator or the Departmental Appeals Board. (Specific rules are set forth in § 430.42.)

(3) *Adjustment.* If the decision by the Board requires an adjustment of FFP,

either upward or downward, a subsequent grant award promptly reflects the amount of increase or decrease.

[53 FR 36571, Sept. 21, 1988, as amended at 56 FR 8846, Mar. 1, 1991; 77 FR 31507, May 29, 2012]

§ 430.35 Withholding of payment for failure to comply with Federal requirements.

(a) *Basis for withholding.* CMS withholds payments to the State, in whole or in part, only if, after giving the agency reasonable notice and opportunity for a hearing in accordance with subpart D of this part, the Administrator finds—

(1) That the plan no longer complies with the provisions of section 1902 of the Act; or

(2) That in the administration of the plan there is failure to comply substantially with any of those provisions.

(Hearings under subpart D are generally not called until a reasonable effort has been made to resolve the issues through conferences and discussions. These may be continued even if a date and place have been set for the hearing.)

(b) *Noncompliance of the plan.* A question of noncompliance of a State plan may arise from an unapprovable change in the approved State plan or the failure of the State to change its approved plan to conform to a new Federal requirement for approval of State plans.

(c) *Noncompliance in practice.* A question of noncompliance in practice may arise from the State's failure to actually comply with a Federal requirement, regardless of whether the plan itself complies with that requirement.

(d) *Notice and implementation of withholding.* If the Administrator makes a finding of noncompliance under paragraph (a) of this section, the following rules apply:

(1) The Administrator notifies the State:

(i) That no further payments will be made to the State (or that payments will be made only for those portions or aspects of the program that are not affected by the noncompliance); and

(ii) That the total or partial withholding will continue until the Administrator is satisfied that the State's plan and practice are, and will continue to be, in compliance with Federal requirements.

(2) CMS withholds payments, in whole or in part, until the Administrator is satisfied regarding the State's compliance.

§ 430.38 Judicial review.

(a) *Right to judicial review.* Any State dissatisfied with the Administrator's final determination on approvability of plan material (§ 430.18) or compliance with Federal requirements (§ 430.35) has a right to judicial review.

(b) *Petition for review.* (1) The State must file a petition for review with the U.S. Court of Appeals for the circuit in which the State is located, within 60 days after it is notified of the determination.

(2) The clerk of the court will file a copy of the petition with the Administrator and the Administrator will file in the court the record of the proceedings on which the determination was based.

(c) *Court action.* (1) The court is bound by the Administrator's findings of fact if they are supported by substantial evidence.

(2) The court has jurisdiction to affirm the Administrator's decision, to set it aside in whole or in part, or, for good cause, to remand the case for additional evidence.

(d) *Response to remand.* (1) If the court remands the case, the Administrator may make new or modified findings of fact and may modify his or her previous determination.

(2) The Administrator will certify to the court the transcript and record of the further proceedings.

(e) *Review by the Supreme Court.* The judgment of the appeals court is subject to review by the U.S. Supreme Court upon certiorari or certification, as provided in 28 U.S.C. 1254.

§ 430.40 Deferral of claims for FFP.

(a) *Requirements for deferral.* Payment of a claim or any portion of a claim for FFP is deferred only if—

(1) The Administrator or current Designee questions its allowability and needs additional information to resolve the question; and

(2) CMS takes action to defer the claim (by excluding the claimed amount from the grant award) within 60 days after the receipt of a Quarterly Statement of Expenditures (prepared in accordance with CMS instructions) that includes that claim.

(b) *Notice of deferral and State's responsibility.* (1) Within 15 days of the action described in paragraph (a)(2) of this section, the current Designee sends the State a written notice of deferral that—

(i) Identifies the type and amount of the deferred claim and specifies the reason for deferral; and

(ii) Requests the State to make available all the documents and materials the regional office then believes are necessary to determine the allowability of the claim.

(2) It is the responsibility of the State to establish the allowability of a deferred claim.

(c) *Handling of documents and materials.* (1) Within 60 days (or within 120 days if the State requests an extension) after receipt of the notice of deferral, the State must make available to the regional office, in readily reviewable form, all requested documents and materials except any that it identifies as not being available.

(2) Regional office staff usually initiates review within 30 days after receipt of the documents and materials.

(3) If the current Designee finds that the materials are not in readily reviewable form or that additional information is needed, he or she promptly notifies the State that it has 15 days to submit the readily reviewable or additional materials.

(4) If the State does not provide the necessary materials within 15 days, the current Designee disallows the claim.

(5) The current Designee has 90 days, after all documentation is available in readily reviewable form, to determine the allowability of the claim.

(6) If the current Designee cannot complete review of the material within 90 days, CMS pays the claim, subject to a later determination of allowability.

(d) *Effect of decision to pay a deferred claim.* Payment of a deferred claim under paragraph (c)(6) of this section does not preclude a subsequent disallowance based on the results of an audit or financial review. (If there is a subsequent disallowance, the State may request reconsideration as provided in paragraph (e)(2) of this section.)

(e) *Notice and effect of decision on allowability.* (1) The Administrator or current Designee gives the State written notice of his or her decision to pay or disallow a deferred claim.

(2) If the decision is to disallow, the notice informs the State of its right to reconsideration in accordance with 45 CFR part 16.

[53 FR 36571, Sept. 21, 1988, as amended at 77 FR 31507, May 29, 2012]

§ 430.42 Disallowance of claims for FFP.

(a) *Notice of disallowance and of right to reconsideration.* When the Administrator or current Designee determines that a claim or portion of claim is not allowable, he or she promptly sends the State a disallowance letter that includes the following, as appropriate:

(1) The date or dates on which the State's claim for FFP was made.

(2) The time period during which the expenditures in question were made or claimed to have been made.

(3) The date and amount of any payment or notice of deferral.

(4) A statement of the amount of FFP claimed, allowed, and disallowed and the manner in which these amounts were computed.

(5) Findings of fact on which the disallowance determination is based or a reference to other documents previously furnished to the State or included with the notice (such as a report of a financial review or audit) which contain the findings of fact on which the disallowance determination is based.

(6) Pertinent citations to the law, regulations, guides and instructions supporting the action taken.

(7) A request that the State make appropriate adjustment in a subsequent expenditure report.

(8) Notice of the State's right to request reconsideration of the disallowance and the time allowed to make the request.

(9) A statement indicating that the disallowance letter is the Department's final decision unless the State requests

reconsideration under paragraph (b)(2) or (f)(2) of this section.

(b) *Reconsideration of a disallowance.* (1) The Administrator will reconsider Medicaid disallowance determinations.

(2) To request reconsideration of a disallowance, a State must complete the following:

(i) Submit the following within 60 days after receipt of the disallowance letter:

(A) A written request to the Administrator that includes the following:

(*1*) A copy of the disallowance letter.

(*2*) A statement of the amount in dispute.

(*3*) A brief statement of why the disallowance should be reversed or revised, including any information to support the State's position with respect to each issue.

(*4*) Additional information regarding factual matters or policy considerations.

(B) A copy of the written request to the Regional Office.

(C) Send all requests for reconsideration via registered or certified mail to establish the date the reconsideration was received by CMS.

(ii) In all cases, the State has the burden of documenting the allowability of its claims for FFP.

(iii) Additional information regarding the legal authority for the disallowance will not be reviewed in the reconsideration but may be presented in any appeal to the Departmental Appeals Board under paragraph (f)(2) of this section.

(3) A State may request to retain the FFP during the reconsideration of the disallowance under section 1116(e) of the Act, in accordance with § 433.38 of this subchapter.

(4) The State is not required to request reconsideration before seeking review from the Departmental Appeals Board.

(5) The State may also seek reconsideration, and following the reconsideration decision, request a review from the Board.

(6) If the State elects reconsideration, the reconsideration process must be completed or withdrawn before requesting review by the Board.

(c) *Procedures for reconsideration of a disallowance.* (1) Within 60 days after receipt of the disallowance letter, the State shall, in accordance with (b)(2) of this section, submit in writing to the Administrator any relevant evidence, documentation, or explanation and shall simultaneously submit a copy thereof to the Regional Office.

(2) After consideration of the policies and factual matters pertinent to the issues in question, the Administrator shall, within 60 days from the date of receipt of the request for reconsideration, issue a written decision or a request for additional information as described in paragraph (c)(3) of this section.

(3) At the Administrator's option, CMS may request from the State any additional information or documents necessary to make a decision. The request for additional information must be sent via registered or certified mail to establish the date the request was sent by CMS and received by the State.

(4) Within 30 days after receipt of the request for additional information, the State must submit to the Administrator, with a copy to the Regional Office in readily reviewable form, all requested documents and materials.

(i) If the Administrator finds that the materials are not in readily reviewable form or that additional information is needed, he or she shall notify the State via registered or certified mail that it has 15 business days from the date of receipt of the notice to submit the readily reviewable or additional materials.

(ii) If the State does not provide the necessary materials within 15 business days from the date of receipt of such notice, the Administrator shall affirm the disallowance in a final reconsideration decision issued within 15 days from the due date of additional information from the State.

(5) If additional documentation is provided in readily reviewable form under the paragraph (c)(4) of this section, the Administrator shall issue a written decision, within 60 days from the due date of such information.

(6) The final written decision shall constitute final CMS administrative action on the reconsideration and shall be (within 15 business days of the decision) mailed to the State agency via registered or certified mail to establish

the date the reconsideration decision was received by the State.

(7) If the Administrator does not issue a decision within 60 days from the date of receipt of the request for reconsideration or the date of receipt of the requested additional information, the disallowance shall be deemed to be affirmed upon reconsideration.

(8) No section of this regulation shall be interpreted as waiving the Department's right to assert any provision or exemption under the Freedom of Information Act.

(d) *Withdrawal of a request for reconsideration of a disallowance.* (1) A State may withdraw the request for reconsideration at any time before the notice of the reconsideration decision is received by the State without affecting its right to submit a notice of appeal to the Board. The request for withdrawal must be in writing and sent to the Administrator, with a copy to the Regional Office, via registered or certified mail.

(2) Within 60 days after CMS' receipt of a State's withdrawal request, a State may, in accordance with (f)(2) of this section, submit a notice of appeal to the Board.

(e) *Implementation of decisions for reconsideration of a disallowance.* (1) After undertaking a reconsideration, the Administrator may affirm, reverse, or revise the disallowance and shall issue a final written reconsideration decision to the State in accordance with paragraph (c)(4) of this section.

(2) If the reconsideration decision requires an adjustment of FFP, either upward or downward, a subsequent grant award will be issued in the amount of such increase or decrease.

(3) Within 60 days after the receipt of a reconsideration decision from CMS a State may, in accordance with paragraph (f)(2) of this section, submit a notice of appeal to the Board.

(f) *Appeal of Disallowance.* (1) The Departmental Appeals Board reviews disallowances of FFP under title XIX.

(2) A State that wishes to appeal a disallowance to the Board must:

(i) Submit a notice of appeal to the Board at the address given on the Departmental Appeals Board's web site within 60 days after receipt of the disallowance letter.

(A) If a reconsideration of a disallowance was requested, within 60 days after receipt of the reconsideration decision; or

(B) If reconsideration of a disallowance was requested and no written decision was issued, within 60 days from the date the decision on reconsideration of the disallowance was due to be issued by CMS.

(ii) Include all of the following:

(A) A copy of the disallowance letter.

(B) A statement of the amount in dispute.

(C) A brief statement of why the disallowance is wrong.

(3) The Board's decision of an appeal under paragraph (f)(2) of this section shall be the final decision of the Secretary and shall be subject to reconsideration by the Board only upon a motion by either party that alleges a clear error of fact or law and is filed during the 60-day period that begins on the date of the Board's decision or to judicial review in accordance with paragraph (f)(2)(i) of this section.

(g) *Appeals procedures.* The appeals procedures are those set forth in 45 CFR part 16 for Medicaid and for many other programs administered by the Department.

(1) In all cases, the State has the burden of documenting the allowability of its claims for FFP.

(2) The Board shall conduct a thorough review of the issues, taking into account all relevant evidence, including such documentation as the State may submit and the Board may require.

(h) *Implementation of decisions.* (1) The Board may affirm the disallowance, reverse the disallowance, modify the disallowance, or remand the disallowance to CMS for further consideration.

(2) The Board will issue a final written decision to the State consistent with 45 CFR part 16.

(3) If the appeal decision requires an adjustment of FFP, either upward or downward, a subsequent grant award will be issued in the amount of increase or decrease.

[53 FR 36571, Sept. 21, 1988, as amended at 56 FR 8846, Mar. 1, 1991; 77 FR 31507, May 29, 2012]

§ 430.45 Reduction of Federal Medicaid payments.

(a) *Methods of reduction.* CMS may reduce Medicaid payments to a State as required under the Act by reducing—

(1) The Federal Medical Assistance Percentage;

(2) The amount of State expenditures subject to FFP;

(3) The rates of FFP; or

(4) The amount otherwise payable to the State.

(b) *Right to reconsideration.* A state that receives written final notice of a reduction under paragraph (a) of this section has a right to reconsideration. The provisions of § 430.42 (b) and (c) apply.

(c) *Other applicable rules.* Other rules regarding reduction of Medicaid payments are set forth in parts 433 and 447 of this chapter.

§ 430.48 Repayment of Federal funds by installments.

(a) *Basic conditions.* When Federal payments have been made for claims that are later found to be unallowable, the State may repay the Federal funds by installments if all of the following conditions are met:

(1) The amount to be repaid exceeds 0.25 percent of the estimated or actual annual State share for the Medicaid program.

(2) The State has given the Regional Office written notice, before total repayment was due, of its intent to repay by installments.

(b) *Annual State share determination.* CMS determines whether the amount to be repaid exceeds 0.25 percent of the annual State share as follows:

(1) If the Medicaid program is ongoing, CMS uses the annual estimated State share of Medicaid expenditures for the current year, as shown on the State's latest Medicaid Program Budget Report (CMS–37). The current year is the year in which the State requests the repayment by installments.

(2) If the Medicaid program has been terminated by Federal law or by the State, CMS uses the actual State share that is shown on the State's CMS–64 Quarterly Expense Report for the last four quarters filed.

(c) *Standard Repayment amounts, schedules, and procedures*—(1) *Repayment amount.* The repayment amount may not include any amount previously approved for installment repayment.

(2) *Repayment schedule.* The maximum number of quarters allowed for the standard repayment schedule is 12 quarters (3 years), except as provided in paragraphs (c)(4) and (e) of this section.

(3) *Quarterly repayment amounts.* (i) The quarterly repayment amounts for each of the quarters in the repayment schedule will be the larger of the repayment amount divided by 12 quarters or the minimum repayment amount;

(ii) The minimum quarterly repayment amounts for each of the quarters in the repayment schedule is 0.25 percent of the estimated State share of the current annual expenditures for Medicaid;

(iii) The repayment period may be less than 12 quarters when the minimum repayment amount is required.

(4) *Extended schedule.* (i) The repayment schedule may be extended beyond 12 quarterly installments if the total repayment amount exceeds 100 percent of the estimated State share of the current annual expenditures;

(ii) The quarterly repayment amount will be 8⅓ percent of the estimated State share of the current annual expenditures until fully repaid.

(5) *Repayment process.* (i) Repayment is accomplished through deposits into the State's Payment Management System (PMS) account;

(ii) A State may choose to make payment by Automated Clearing House (ACH) direct deposit, by check, or by Fedwire transfer.

(6) *Reductions.* If the State chooses to repay amounts representing higher percentages during the early quarters, any corresponding reduction in required minimum percentages is applied first to the last scheduled payment, then to the next to the last payment, and so forth as necessary.

(d) *Alternate repayment amounts, schedules, and procedures for States experiencing economic distress immediately prior to the repayment period*—(1) *Repayment amount.* The repayment amount may not include amounts previously approved for installment repayment if

a State initially qualifies for the alternate repayment schedule at the onset of an installment repayment period.

(2) *Qualifying period of economic distress.* (i) A State will qualify to avail itself of the alternate repayment schedule if it demonstrates the State is experiencing a period of economic distress;

(ii) A period of economic distress is one in which the State demonstrates distress for at least each of the previous 6 months, ending the month prior to the date of the State's written request for an alternate repayment schedule, as determined by a negative percent change in the monthly Philadelphia Federal Reserve Bank State coincident index.

(3) *Repayment schedule.* The maximum number of quarters allowed for the alternate repayment schedule is 12 quarters (3 years), except as provided in paragraph (d)(5) of this section.

(4) *Quarterly repayment amounts.* (i) The quarterly repayment amounts for each of the first 8 quarters in the repayment schedule will be the smaller of the repayment amount divided by 12 quarters or the maximum quarterly repayment amount;

(ii) The maximum quarterly repayment amounts for each of the first 8 quarters in the repayment schedule is 0.25 percent of the annual State share determination as defined in paragraph (b) of this section;

(iii) For the remaining 4 quarters, the quarterly repayment amount equals the remaining balance of the overpayment amount divided by the remaining 4 quarters.

(5) *Extended schedule.* (i) For a State that initiated its repayment under an alternate payment schedule for economic distress, the repayment schedule may be extended beyond 12 quarterly installments if the total repayment amount exceeds 100 percent of the estimated State share of current annual expenditures;

(A) In these circumstances, paragraph (d)(3) of this section is followed for repayment of the amount equal to 100 percent of the estimated State share of current annual expenditures.

(B) The remaining amount of the repayment is in quarterly amounts equal to 8⅓ percent of the estimated State share of current annual expenditures until fully repaid.

(ii) Upon request by the State, the repayment schedule may be extended beyond 12 quarterly installments if the State has qualifying periods of economic distress in accordance with paragraph (d)(2) of this section during the first 8 quarters of the alternate repayment schedule.

(A) To qualify for additional quarters, the States must demonstrate a period of economic distress in accordance with paragraph (d)(2) of this section for at least 1 month of a quarter during the first 8 quarters of the alternate repayment schedule.

(B) For each quarter (of the first 8 quarters of the alternate payment schedule) identified as qualified period of economic distress, one quarter will be added to the remaining 4 quarters of the original 12 quarter repayment period.

(C) The total number of quarters in the alternate repayment schedule shall not exceed 20 quarters.

(6) *Repayment process.* (i) Repayment is accomplished through deposits into the State's Payment Management System (PMS) account;

(ii) A State may choose to make payment by Automated Clearing House (ACH) direct deposit, by check, or by Fedwire transfer.

(7) If the State chooses to repay amounts representing higher percentages during the early quarters, any corresponding reduction in required minimum percentages is applied first to the last scheduled payment, then to the next to the last payment, and so forth as necessary.

(e) *Alternate repayment amounts, schedules, and procedures for States entering into distress during a standard repayment schedule*—(1) *Repayment amount.* The repayment amount may include amounts previously approved for installment repayment if a State enters into a qualifying period of economic distress during an installment repayment period.

(2) *Qualifying period of economic distress.* (i) A State will qualify to avail itself of the alternate repayment schedule if it demonstrates the State is experiencing economic distress;

(ii) A period of economic distress is one in which the State demonstrates distress for each of the previous 6 months, that begins on the date of the State's request for an alternate repayment schedule, as determined by a negative percent change in the monthly Philadelphia Federal Reserve Bank State coincident index.

(3) *Repayment schedule.* The maximum number of quarters allowed for the alternate repayment schedule is 12 quarters (3 years), except as provided in paragraph (e)(5) of this section.

(4) *Quarterly repayment amounts.* (i) The quarterly repayment amounts for each of the first 8 quarters in the repayment schedule will be the smaller of the repayment amount divided by 12 quarters or the maximum repayment amount;

(ii) The maximum quarterly repayment amounts for each of the first 8 quarters in the repayment schedule is 0.25 percent of the annual State share determination as defined in paragraph (b) of this section;

(iii) For the remaining 4 quarters, the quarterly repayment amount equals the remaining balance of the overpayment amount divided by the remaining 4 quarters.

(5) *Extended schedule.* (i) For a State that initiated its repayment under the standard payment schedule and later experienced periods of economic distress and elected an alternate repayment schedule, the repayment schedule may be extended beyond 12 quarterly installments if the total repayment amount of the remaining balance of the standard schedule, exceeds 100 percent of the estimated State share of the current annual expenditures;

(ii) In these circumstances, paragraph (d)(3) of this section is followed for repayment of the amount equal to 100 percent of the estimated State share of current annual expenditures;

(iii) The remaining amount of the repayment is in quarterly amounts equal to 8⅓ percent of the estimated State share of the current annual expenditures until fully repaid.

(6) *Repayment process.* (i) Repayment is accomplished through deposits into the State's Payment Management System (PMS) account;

(ii) A State may choose to make payment by Automated Clearing House (ACH) direct deposit, by check, or by Fedwire transfer.

(7) If the State chooses to repay amounts representing higher percentages during the early quarters, any corresponding reduction in required minimum percentages is applied first to the last scheduled payment, then to the next to the last payment, and so forth as necessary.

[77 FR 31509, May 29, 2012]

§ 430.49 Corrective action plans, suspensions of procedural disenrollments, and civil money penalties.

(a) *Statutory basis.* This section interprets and implements section 1902(tt)(2)(B) of the Social Security Act.

(b) *Corrective action plans*—(1) *Basis for corrective action.* After consideration of any mitigating circumstances in accordance with paragraph (d) of this section and notwithstanding whether an FMAP reduction has been imposed under § 435.928 of this subchapter, CMS will determine whether to require the State to submit a corrective action plan if CMS finds that the State is not in compliance during the period beginning on April 1, 2023, through June 30, 2024, with either of the following requirements:

(i) The requirement to submit data required under section 1902(tt)(1) of the Act in accordance with § 435.927 of this subchapter; or

(ii) Federal redetermination requirements described at § 430.5.

(2) *Notice of need for corrective action plan.* If, after considering mitigating circumstances as described in paragraph (d) of this section, the Administrator decides to require the State to submit and implement a corrective action plan for noncompliance described in paragraph (b)(1) of this section or to revise or resubmit such a plan, the Administrator will provide the State with a written notice directing the State to submit a corrective action plan to correct the identified areas of noncompliance. Such notice will—

(i) Explain the violation of Federal redetermination or reporting requirements that CMS has identified and the basis for CMS' finding;

(ii) Inform the State of the requirement to submit and implement a corrective action plan:

(iii) Include instructions on the method and deadline by which the State must submit a corrective action plan to CMS; and

(iv) Explain the enforcement actions that CMS may pursue if the State fails to submit or implement an approved corrective action plan, including if CMS disapproves the State's submitted CAP or if the State fails to meet the requirements set forth in the approved CAP, in accordance with this section.

(3) *Content of corrective action plan.* A corrective action plan must describe in detail—

(i) The actions the State will take immediately, if needed to prevent further harm or risk of harm to beneficiaries while it implements the corrective action plan, including to prevent increased burden for beneficiaries in completing the renewal process, loss of coverage at renewal for individuals who continue to meet the substantive eligibility criteria and whose eligibility should otherwise be retained but for failure to meet a procedural requirement, and delays in access to coverage or care;

(ii) The steps the State will take to ensure compliance with Federal requirements, including but not limited to new policies, procedures, operational processes or systems changes it will implement;

(iii) Key milestones and a detailed timeline for achieving compliance; and

(iv) A plan for communicating the steps the State will take to prevent actual harm or risk of harm to beneficiaries and to ensure compliance with Federal requirements per paragraphs (b)(3)(i) and (ii) of this section to State staff, including staff of non-Medicaid agencies or entities to which the agency has delegated authority to conduct redeterminations of eligibility in accordance with § 431.10(c)(1)(i) of this subchapter; CMS; and beneficiaries, as applicable.

(4) *Timeframes for submission, approval, and implementation of corrective action plan*—(i) *Submission.* A State that receives a notice described in paragraph (b)(2) of this section must submit a corrective action plan, including the elements in paragraph (b)(3) of this section, not later than 14 calendar days from the date of the notice of noncompliance.

(ii) *Approval.* CMS must approve or disapprove a corrective action plan submitted by the State within 21 calendar days of the date it is submitted. If CMS does not approve or disapprove the corrective action plan within 21 calendar days of submission, the corrective action plan will be deemed approved.

(iii) *Implementation.* A State must begin implementation of the corrective action plan not later than 14 calendar days after the date that either the State receives CMS approval, or the corrective action plan is deemed approved.

(5) *Approval or disapproval of corrective action plan.* A corrective action plan will be approved if CMS determines that the plan–

(i) Meets the requirements at paragraph (b)(3) of this section;

(ii) Promptly eliminates or minimizes any harm or risk of harm to beneficiaries, including increased burden for beneficiaries in completing the renewal process, loss of coverage at renewal for individuals who continue to meet the substantive eligibility criteria and whose eligibility should otherwise be retained but for failure to meet a procedural requirement, and delays in access to coverage or care due to the noncompliance to be addressed by the plan; and

(iii) Results in the State achieving compliance in a reasonable time, taking into account systems challenges and circumstances faced by the agencies involved.

(c) *Suspensions of procedural disenrollments and civil money penalties.* (1) After considering any applicable mitigating circumstances in accordance with paragraph (d) of this section and notwithstanding whether the State is subject to an FMAP reduction under § 435.928 of this subchapter, CMS may take one or both of the following actions if the State fails to submit or implement an approved corrective action

plan, including if CMS disapproves the State's submitted corrective action plan due to the State's failure to include required elements in accordance with the requirements described in paragraph (b) of this section, or if the State fails to meet the requirements set forth in the approved corrective action plan:

(i) Require the State to suspend some or all procedural disenrollments, in accordance with paragraph (c)(3)(i) of this section; and

(ii) Impose civil money penalties in accordance with paragraph (c)(3)(ii) of this section.

(2) *Notice.* (i) Prior to requiring the State to suspend procedural disenrollments of Medicaid eligibility or imposing civil money penalties, CMS will issue a notice to the State. Such notice will include—

(A) A description of the enforcement action(s) CMS is taking and the basis for such action(s);

(B) Whether CMS is requiring the State to suspend some or all procedural disenrollments and, in the case of a partial suspension, the affected populations;

(C) The date on which the State must begin suspending procedural disenrollments, if applicable;

(D) The daily amount owed for any civil money penalties imposed, the date the penalties will begin to be charged, the timeline for payment (including information on how the timeline for payment would be affected by an appeal), and instructions on how to submit payment;

(E) The steps the State must take to cure its noncompliance and for CMS to lift the enforcement action(s); and

(F) Information on the State's appeal rights as described in paragraph (f) of this section, including the deadline to submit an appeal request, and the effect of requesting an appeal on the applicability of any enforcement actions pending the decision in such appeal. The notice must also provide that the decision outlined in the notice is final unless it is timely appealed as described in paragraph (f) of this section.

(ii) CMS may issue additional notices requiring a State to take additional actions (including paying increased civil money penalties or implementing or broadening the scope of a required suspension of procedural disenrollments) if CMS identifies additional violations of corrective action plan provisions. Such notices will meet the requirements outlined in paragraph (c)(2)(i) of this section.

(3) *Scope of actions*—(i) *Suspensions of procedural disenrollments.* (A) If the noncompliance determined by CMS under paragraph (b)(1) of this section impacts a substantial number of (meaning all or nearly all) individuals who are or should have been found eligible for Medicaid, CMS will require the State to suspend all procedural disenrollments.

(B) If the impact of the noncompliance is limited (for example, to a specific population or geographic area), CMS may limit the suspension of procedural disenrollments to the impacted population(s). After requiring a limited suspension of procedural disenrollments, CMS may later opt to require the State to suspend all procedural disenrollments if CMS subsequently determines that the impact of the noncompliance is greater than was initially determined, or if the State fails to comply with the initial requirement to suspend some procedural disenrollments in accordance with the notice issued under paragraph (c)(2) of this section. In these circumstances, CMS will issue a subsequent notice under paragraph (c)(2).

(ii) *Civil money penalties.* CMS may require the State to pay a civil money penalty of not more than $100,000, as adjusted annually under 45 CFR part 102, for each day that the State has not submitted or implemented an approved corrective action plan in accordance with the requirements described in paragraph (b) of this section or has failed to meet the requirements of the approved plan, until the penalty is lifted due to the State meeting the conditions described in paragraph (e) of this section.

(A) Civil money penalties will start accruing five (5) calendar days after the date of the initial notice described in paragraph (c)(2) of this section and become payable 60 calendar days after the date of the notice, if not timely appealed, or 60 calendar days after issuance of a final determination at the

conclusion of any appeal pursuant to paragraph (f) of this section.

(B) The amount of any applicable civil money penalties for failure to submit or implement a corrective action plan, including if CMS disapproves the State's submitted corrective action plan or if the State fails to meet the requirements set forth in the approved corrective action plan, will be determined according to the following formula, after the date specified in paragraph (c)(3)(ii)(A) of this section: Days 1–30 of noncompliance: $25,000/day; Days 31–60 of noncompliance: $50,000/day; and Days 61 or more of noncompliance until lifted in accordance with paragraph (e) of this section: $100,000/day. Each of these amounts is adjusted annually under 45 CFR part 102.

(C) Consistent with paragraph (c)(2)(ii) of this section, if CMS identifies additional violations of corrective action plan provisions, CMS may issue additional notices to increase civil money penalties more quickly than provided for by the formula in paragraph (c)(3)(ii)(B) of this section.

(4) *Noncompliance with requirements to suspend procedural disenrollments or pay civil money penalties.* If the State fails to suspend procedural disenrollments as required pursuant to a notice described in paragraph (c)(2) of this section, or to pay civil money penalties as specified in that notice, or both, CMS may issue an additional notice pursuant to paragraph (c)(2) of this section to increase the civil money penalties to the maximum allowable daily amount, if not already reached, or may pursue additional enforcement action under section 1904 of the Act and § 430.35 of this subpart, including withholding some or all Federal financial participation.

(d) *Mitigating circumstances.* CMS will consider the following mitigating circumstances when deciding whether to take the following enforcement actions:

(1) *Requirement to submit corrective action plan for violation of redetermination requirements.* In the case of noncompliance relating to a violation of Federal redetermination requirements, CMS may delay requiring, or determine not to require, a State to submit a corrective action plan under paragraph (b) of this section if—

(i) The noncompliance caused neither actual harm nor a substantial risk of harm to beneficiaries, including increased burden for beneficiaries in completing the renewal process, loss of coverage at renewal for individuals who continue to meet the substantive eligibility criteria and whose eligibility should otherwise be retained but for failure to meet a procedural requirement, and delays in access to coverage or care to beneficiaries; or

(ii) CMS determines that there is an emergency or other extraordinary circumstances preventing the State's compliance.

(2) *Requirement to submit corrective action plan for violation of reporting requirements.* In the case of noncompliance relating to a violation of the reporting requirements under § 435.927 of this subchapter, CMS may delay requiring, or determine not to require, a State to submit a corrective action plan under paragraph (b) of this section if—

(i) CMS has determined that the State implementing a corrective action plan is not necessary to ensure that the noncompliance is remedied; or

(ii) CMS determines that there is an emergency or other extraordinary circumstances preventing the State's compliance.

(3) *Suspensions of procedural disenrollments and imposition of civil money penalties.* (i) In the case of a State that has failed to submit or implement an approved corrective action plan relating to a violation of either the reporting requirements under § 435.927 of this subchapter or Federal redetermination requirements, CMS may delay or forgo imposing civil money penalties if CMS determines that the State faces an emergency or other extraordinary circumstances that—

(A) Occurred after the violation resulting in CMS' requirement of a CAP for noncompliance with Federal redetermination requirements or reporting requirements under § 435.927; and

(B) Has significantly impeded the State's ability to submit or implement a corrective action plan.

(ii) In the case of a State's failure to submit or implement a corrective action plan relating to a violation of the reporting requirements under § 435.927 of this subchapter in which the underlying reporting violation does not impede CMS' oversight of the State's procedural disenrollments, CMS will:

(A) Delay suspension of procedural disenrollments for 1 month; and

(B) Impose civil money penalties, except in cases where there are also extraordinary circumstances as described in paragraph (d)(3)(i) of this section.

(e) *Lifting of enforcement actions.* (1) In cases where CMS had sent a State a notice under paragraph (c)(2) of this section for failure to submit or implement an approved corrective action plan—

(i) The State will be required to continue any suspension of procedural disenrollments required pursuant to such notice, and any civil money penalties imposed in accordance with the terms of such notice will continue to be charged, until—

(A) For a State that failed to submit a corrective action plan, the State submits a corrective action plan that CMS determines is approvable consistent with paragraph (b)(5) of this section.

(B) For a State that failed to implement an approved corrective action plan, the State has implemented or resumed implementation of such plan.

(ii) CMS will continue the accrual of civil money penalties from the date specified in the original notice provided to the State under paragraph (c)(2) of this section until CMS determines whether the plan is approvable. If CMS determines that the plan is approvable, CMS will retroactively end the accrual of the civil money penalties on the day the CAP was submitted and cease charging civil money penalties prospectively. If CMS determines that the plan is not approvable, CMS will continue charging civil money penalties imposed under the terms of the enforcement notice without interruption until the State submits an approvable plan.

(2) Where a State has met the conditions under paragraph (e)(1)(i) of this section, CMS will notify the State that the enforcement actions are being lifted. For States that were required to suspend procedural disenrollments, such notice will include the date on which the State may resume such disenrollments. For States that were subject to civil money penalties, such notice will include the date on which such civil money penalties stopped accruing, the total number of days for which civil money penalties accrued and the amount(s) of such civil money penalties, and the total amount of civil money penalties owed.

(f) *Administrative review*—(1) *Appeal to the Departmental Appeals Board.* A State that is dissatisfied with CMS's determination under paragraph (c) of this section that the State must suspend procedural disenrollments or pay civil money penalties because the State has failed to submit or implement an approvable corrective action plan may appeal, pursuant to 45 CFR part 16, the imposition of such suspensions of procedural disenrollments or civil money penalties to the Departmental Appeals Board (the Board) within 30 days after receipt of a notice described in paragraph (c)(2) of this section. The appeal request must comply with 45 CFR 16.7, and the process for counting days to submit an appeal will follow the provisions under 45 CFR 16.19. The appeals process is governed by 45 CFR part 16. If the State does not submit an appeal request within the 30-day timeframe provided for an appeal to the Board, then the decision described in the notice received by the State under paragraph (c)(2) of this section is the final decision of the Secretary and is final agency action within the meaning of 5 U.S.C. 704.

(2) *Reconsiderations by* the *Administrator.* (i) If any party to the appeal is dissatisfied with the Board's decision under paragraph (f)(1) of this section, it may seek the Administrator's reconsideration of that decision within 15 calendar days of receiving notice of the decision pursuant to 45 CFR 16.21.

(A) The request for reconsideration must be filed with the Administrator and must include a copy of the Board's decision, a brief statement of why the party believes the decision was wrong, and a statement of the amount of any civil money penalties in dispute.

(B) The party requesting reconsideration must send a copy of the request described in paragraph (f)(2)(i)(A) of

this section to all other parties to the appeal and other participants in the appeal (as described in 45 CFR 16.16) at the same time that the request is filed with the Administrator.

(C) Any other party to the appeal, or other participant in the appeal, may respond to the request for reconsideration in writing and file their response with the Administrator within 15 calendar days of the date the request for reconsideration is filed with the Administrator.

(D) The Administrator will review the Board's decision and any additional information submitted by the parties and other participants under paragraphs (f)(2)(i)(A) or (C) of this section and, within 60 calendar days after the Board issues notice of its decision under 45 CFR 16.21, will either affirm the Board's decision or issue a new decision.

(ii) Within the 60-day period that is described in paragraph (f)(2)(i)(D) of this section, the Administrator may also modify or reverse the Board's decision even if no party to the appeal has requested reconsideration of that decision.

(iii) If no request for reconsideration is filed under paragraph (f)(2)(i) of this section and the Administrator does not modify or reverse the Board's decision within the 60-day period described in paragraph (f)(2)(ii) of this section, then the decision of the Board is the final determination of the Secretary and is final agency action, as described in paragraph (f)(2)(v) of this section, and the Administrator will provide notice to all parties and other participants of such decision as described in paragraph (f)(2)(iv) of this section.

(iv) The Administrator will provide a notice to all parties and other participants of the final decision together with a notice indicating that this is the final determination of the *Secretary* and is final agency action, as described in paragraph (f)(2)(v) of this section.

(v) The determination of the Administrator pursuant to paragraph (f)(2)(i)(D) or (f)(2)(ii) of this section is the final determination of the *Secretary* and is final agency action within the meaning of 5 U.S.C. 704.

(g) *Severability*. Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further State action, shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

[88 FR 84733, Dec. 6, 2023]

Subpart D—Hearings on Conformity of State Medicaid Plans and Practice to Federal Requirements

§ 430.60 Scope.

(a) This subpart sets forth the rules for hearings to States that appeal a decision to disapprove State plan material (under § 430.18) or to withhold Federal funds (under § 430.35), because the State plan or State practice in the Medicaid program is not in compliance with Federal requirements.

(b) Nothing in this subpart is intended to preclude or limit negotiations between CMS and the State, whether before, during, or after the hearing to resolve the issues that are, or otherwise would be, considered at the hearing. Such negotiations and resolution of issues are not part of the hearing, and are not governed by the rules in this subpart except as expressly provided.

§ 430.62 Records to be public.

All pleadings, correspondence, exhibits, transcripts of testimony, exceptions, briefs, decisions, and other documents filed in the docket in any proceeding may be inspected and copied in the office of the CMS Docket Clerk. Inquiries may be made to the Docket Clerk, Hearing Staff, Bureau of Eligibility, Reimbursment and Coverage, 300 East High Rise, 6325 Security Boulevard, Baltimore, Maryland, 21207. Telephone: (301) 594–8261.

§ 430.63 Filing and service of papers.

(a) *Filing*. All papers in the proceedings are filed with the CMS Docket Clerk, in an original and two copies. Originals only of exhibits and transcripts of testimony need be filed.

(b) *Service*. All papers in the proceedings are served on all parties by

personal delivery or by mail. Service on the party's designated attorney is considered service upon the party.

§ 430.64 Suspension of rules.

Upon notice to all parties, the Administrator or the presiding officer may modify or waive any rule in this subpart upon determination that no party will be unduly prejudiced and the ends of justice will thereby be served.

§ 430.66 Designation of presiding officer for hearing.

(a) The presiding officer at a hearing is the Administrator or his designee.

(b) The designation of the presiding officer is in writing. A copy of the designation is served on all parties.

§ 430.70 Notice of hearing or opportunity for hearing.

The Administrator mails the State a notice of hearing or opportunity for hearing that—

(a) Specifies the time and place for the hearing;

(b) Specifies the issues that will be considered;

(c) Identifies the presiding officer; and

(d) Is published in the FEDERAL REGISTER.

§ 430.72 Time and place of hearing.

(a) *Time.* The hearing is scheduled not less than 30 nor more than 60 days after the date of notice to the State. The scheduled date may be changed by written agreement between CMS and the State.

(b) *Place.* The hearing is conducted in the city in which the CMS regional office is located or in another place fixed by the presiding officer in light of the circumstances of the case, with due regard for the convenience and necessity of the parties or their representatives.

§ 430.74 Issues at hearing.

The list of issues specified in the notice of hearing may be augmented or reduced as provided in this section.

(a) *Additional issues.* (1) Before a hearing under § 430.35, the Administrator may send written notice to the State listing additional issues to be considered at the hearing. That notice is published in the FEDERAL REGISTER.

(2) If the notice of additional issues is furnished to the State less than 20 days before the scheduled hearing date, postponement is granted if requested by the State or any other party. The new date may be 20 days after the date of the notice, or a later date agreed to by the presiding officer.

(b) *New or modified issues.* If, as a result of negotiations between CMS and the State, the submittal of plan amendment, a change in the State program, or other actions by the State, any issue is resolved in whole or in part, but new or modified issues are presented, as specified by the presiding officer, the hearing proceeds on the new or modified issues.

(c) *Issues removed from consideration—*

(1) *Basis for removal.* If at any time before, during, or after the hearing, the presiding officer finds that the State has come into compliance with Federal requirements on any issue or part of an issue, he or she removes the appropriate issue or part of an issue from consideration. If all issues are removed, the hearing is terminated.

(2) *Notice to parties.* Before removing any issue or part of an issue from consideration, the presiding officer provides all parties other than CMS and the State with—

(i) A statement of the intent to remove and the reasons for removal; and

(ii) A copy of the proposed State plan provision on which CMS and the State have agreed.

(3) *Opportunity for written comment.* The notified parties have 15 days to submit, for consideration by the presiding officer, and for the record, their views as to, or any information bearing upon, the merits of the proposed plan provision and the merits of the reasons for removing the issue from consideration.

(d) *Remaining issues.* The issues considered at the hearing are limited to those issues of which the State is notified as provided in § 430.70 and paragraph (a) of this section, and new or modified issues described in paragraph (b) of this section. They do not include issues or parts of issues removed in accordance with paragraph (c) of this section.

§ 430.76 Parties to the hearing.

(a) *CMS and the State.* CMS and the State are parties to the hearing.

(b) *Other individuals*—(1) *Basis for participation.* Other individuals or groups may be recognized as parties if the issues to be considered at the hearing have caused them injury and their interest is within the zone of interests to be protected by the governing Federal statute.

(2) *Petition for participation.* Any individual or group wishing to participate as a party must, within 15 days after notice of hearing is published in the FEDERAL REGISTER, file with the CMS Docket Clerk, a petition that concisely states—

(i) Petitioner's interest in the proceeding;

(ii) Who will appear for petitioner;

(iii) The issues on which petitioner wishes to participate; and

(iv) Whether petitioner intends to present witnesses.

The petitioner must also serve a copy of the petition on each party of record at that time.

(3) *Comments on petition.* Any party may, within 5 days of receipt of the copy of the petition, file comments on it.

(4) *Action on petition.* (i) The presiding officer promptly determines whether each petitioner has the requisite interest in the proceedings and approves or denies participation accordingly.

(ii) If petitions are made by more than one individual or group with common interests, the presiding officer may—

(A) Request all those petitioners to designate a single representative; or

(B) Recognize one or more of those petitioners to represent all of them.

(iii) The presiding officer gives each petitioner written notice of the decision and, if the decision is to deny, briefly states the grounds for denial.

(c) *Amicus curiae (friend of the court)*—(1) *Petition for participation.* Any person or organization that wishes to participate as amicus curiae must, before the hearing begins, file with the CMS Docket Clerk, a petition that concisely states—

(i) The petitioners' interest in the hearing;

(ii) Who will represent the petitioner; and

(iii) The issues on which the petitioner intends to present argument.

(2) *Action on amicus curiae petition.* The presiding officer may grant the petition if he or she finds that the petitioner has a legitimate interest in the proceedings, that such participation will not unduly delay the outcome and may contribute materially to the proper disposition of the issues.

(3) *Nature of amicus participation.* An amicus curiae is not a party to the hearing but may participate by—

(i) Submitting a written statement of position to the presiding officer before the beginning of the hearing;

(ii) Presenting a brief oral statement at the hearing, at the point in the proceedings specified by the presiding officer; and

(iii) Submitting a brief or written statement when the parties submit briefs.

The amicus curiae must serve copies of any briefs or written statements on all parties.

§ 430.80 Authority of the presiding officer.

(a) The presiding officer has the duty to conduct a fair hearing, to avoid delay, maintain order, and make a record of the proceedings. He or she has the authority necessary to accomplish those ends, including but not limited to authority to take the following actions:

(1) Change the date, time, and place of the hearing after due notice to the parties. This includes authority to postpone or adjourn the hearing in whole or in part. In a hearing on disapproval of a State plan, or State plan amendments, changes in the date of the hearing are subject to the time limits imposed by section 1116(a)(2) of the Act.

(2) Hold conferences to settle or simplify the issues, or to consider other matters that may aid in the expeditious disposition of the issues.

(3) Regulate participation of parties and amici curiae and require parties and amici curiae to state their position with respect to the various issues in the proceeding.

(4) Administer oaths and affirmations.

(5) Rule on motions and other procedural items, including issuance of protective orders or other relief to a party against whom discovery is sought.

(6) Regulate the course of the hearing and conduct of counsel.

(7) Examine witnesses.

(8) Receive, rule on, exclude or limit evidence or discovery.

(9) Fix the time for filing motions, petitions, briefs, or other items.

(10) If the presiding officer is the Administrator, make a final decision.

(11) If the presiding officer is a designee of the Administrator, certify the entire record including recommended findings and proposed decision to the Administrator.

(12) Take any action authorized by the rules in this subpart or in conformance with the provisions of 5 U.S.C. 551 through 559.

(b) The presiding officer does not have authority to compel by subpoena the production of witnesses, papers, or other evidence.

(c) If the presiding officer is a designee of the Administrator, his or her authority pertains to the issues of compliance by a State with Federal requirements, and does not extend to the question of whether, in case of any noncompliance, Federal payments will be denied in respect to the entire State plan or only for certain categories under, or parts of, the State plan affected by the noncompliance.

§ 430.83 Rights of parties.

All parties may:

(a) Appear by counsel or other authorized representative, in all hearing proceedings.

(b) Participate in any prehearing conference held by the presiding officer.

(c) Agree to stipulations as to facts which will be made a part of the record.

(d) Make opening statements at the hearing.

(e) Present relevant evidence on the issues at the hearing.

(f) Present witnesses who then must be available for cross-examination by all other parties.

(g) Present oral arguments at the hearing.

(h) Submit written briefs, proposed findings of fact, and proposed conclusions of law, after the hearing.

§ 430.86 Discovery.

CMS and any party named in the notice issued under § 430.70 has the right to conduct discovery (including depositions) against opposing parties. Rules 26–37 of the Federal Rules of Civil Procedures apply to such proceedings; there will be no fixed rule on priority of discovery. Upon written motion, the presiding officer promptly rules upon any objection to discovery action initiated under this section. The presiding officer also has the power to grant a protective order or relief to any party against whom discovery is sought and to restrict or control discovery so as to prevent undue delay in the conduct of the hearing. Upon the failure of any party to make discovery, the presiding officer may issue any order and impose any sanction (other than contempt orders) authorized by Rule 37 of the Federal Rules of Civil Procedure.

§ 430.88 Evidence.

(a) *Evidentiary purpose.* The hearing is directed to receiving factual evidence and expert opinion testimony related to the issues involved in the proceeding. Argument is not received in evidence. It must be presented in statements, memoranda, or briefs, as determined by the presiding officer. Brief opening statements, concerning the party's position and what he or she intends to prove, may be made at hearings.

(b) *Testimony.* Testimony is given orally under oath or affirmation by witnesses at the hearing. Witnesses are available at the hearing for cross-examination by all parties.

(c) *Stipulations and exhibits.* Two or more parties may agree to stipulations of fact. Those stipulations, and any exhibit proposed by any party, are exchanged before the hearing if the presiding officer so requires.

(d) *Rules of evidence.* (1) Technical rules of evidence do not apply to hearings conducted under this subpart. However, rules or principles designed

to ensure production of the most credible evidence available and to subject testimony to test by cross-examination are applied by the presiding officer when reasonably necessary.

(2) A witness may be cross-examined on any matter material to the proceeding without regard to the scope of his or her direct examination.

(3) The presiding officer may exclude irrelevant, immaterial, or unduly repetitious evidence.

(4) All documents and other evidence offered or taken for the record are open to examination by the parties and an opportunity is given to refute facts and arguments advanced on either side of the issues.

§ 430.90 Exclusion from hearing for misconduct.

The presiding officer may immediately exclude from the hearing any person who—

(a) Uses disrespectful, disorderly, or contumacious language or engages in contemptuous behavior;

(b) Refuses to comply with directions; or

(c) Uses dilatory tactics.

§ 430.92 Unsponsored written material.

Letters expressing views or urging action and other unsponsored written material regarding matters in issue in a hearing are placed in the correspondence section of the docket of the proceeding. These data are not considered part of the evidence or record in the hearing.

§ 430.94 Official transcript.

(a) *Filing.* The official transcripts of testimony, together with any stipulations, briefs, or memoranda of law, are filed with CMS.

(b) *Availability of transcripts.* CMS designates an official reporter for each hearing. Transcripts of testimony in hearings may be obtained from the official reporter by the parties and the public at rates not in excess of the maximum rates fixed by the contract between CMS and the reporter.

(c) *Correction of transcript.* Upon notice to all parties, the presiding officer may authorize corrections that affect substantive matters in the transcript.

§ 430.96 Record for decision.

The transcript of testimony, exhibits, and all papers and requests filed in the proceedings, except the correspondence section of the docket, including rulings and any recommended or initial decision constitute the exclusive record for decision.

§ 430.100 Posthearing briefs.

The presiding officer fixes the time for filing posthearing briefs, which may contain proposed findings of fact and conclusions of law. The presiding officer may also permit reply briefs.

§ 430.102 Decisions following hearing.

(a) *Administrator presides.* If the presiding officer is the Administrator, he or she issues the hearing decision within 60 days after expiration of the period for submission of posthearing briefs.

(b) *Administrator's designee presides.* If the presiding officer is other than the Administrator, the procedure is as follows:

(1) Upon expiration of the period allowed for submission of posthearing briefs, the presiding officer certifies the entire record, including his or her recommended findings and proposed decision, to the Administrator. The Administrator serves a copy of the recommended findings and proposed decision upon all parties and amici, if any.

(2) Any party may, within 20 days, file with the Administrator exceptions to the recommended findings and proposed decision and a supporting brief or statement.

(3) The Administrator reviews the recommended decision and, within 60 days of its issuance, issues his or her own decision.

(c) *Effect of Administrator's decision.* The decision of the Administrator under this section is the final decision of the Secretary and constitutes ''final agency action'' within the meaning of 5 U.S.C. 704 and a ''final determination'' within the meaning of section 1116(a)(3) of the Act and § 430.38. The Administrator's decision is promptly served on all parties and amici.

§ 430.104 Decisions that affect FFP.

(a) *Scope of decisions.* If the Administrator concludes that withholding of

FFP is necessary because a State is out of compliance with Federal requirements, in accordance with §430.35, the decision also specifies—

(1) Whether no further payments will be made to the State or whether payments will be limited to parts of the program not affected by the noncompliance; and

(2) The effective date of the decision to withhold.

(b) *Consultation.* The Administrator may ask the parties for recommendations or briefs or may hold conferences of the parties on the question of further payments to the State.

(c) *Effective date of decision.* The effective date of a decision to withhold Federal funds will not be earlier than the date of the Administrator's decision and will not be later than the first day of the next calendar quarter. The provisions of this section may not be waived under §430.64.

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

Sec.