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AUTHORITY: 42 U.S.C. 1302.

SOURCE: 43 FR 45201, Sept. 29, 1978, unless otherwise noted.

§ 433.1 Purpose.

This part specifies the rates of FFP for services and administration, and prescribes requirements, prohibitions, and FFP conditions relating to State fiscal activities.

Subpart A—Federal Matching and General Administration Provisions

§ 433.8 [Reserved]

§ 433.10 Rates of FFP for program services.

(a) *Basis.* Sections 1903(a)(1), 1903(g), 1905(b), 1905(y), and 1905(z) provide for payments to States, on the basis of a Federal medical assistance percentage, for part of their expenditures for services under an approved State plan.

(b) *Federal medical assistance percentage (FMAP)—Computations.* The FMAP is determined by the formula described in section 1905(b) of the Act. Under the formula, if a State's per capita income is equal to the national average per capita income, the Federal share is 55 percent. If a State's per capita income exceeds the national average, the Federal share is lower, with a statutory minimum of 50 percent. If a State's per capita income is lower than the national average, the Federal share is increased, with a statutory maximum of 83 percent. The formula used in determining the State and Federal share is as follows:

State Share = [(State per capita income)^{2}/(National per capita income)^{2}] × 45 percent

Federal share = 100 percent minus the State share (with a minimum of 50 percent and a maximum of 83 percent)

The formula provides for squaring both the State and national average per capita incomes; this procedure magnifies any difference between the State's income and the national average. Consequently, Federal matching to lower income States is increased, and Federal matching to higher income States is decreased, within the statutory 50–83 percent limits. The FMAP for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa is set by statute at 50 percent and is subject to dollar limitations specified in section 1108 of the Act.

(c) *Special provisions.* (1) Under section 1903(a)(5) of the Act, the Federal share of State expenditures for family planning services is 90 percent.

(2) Under section 1905(b), the Federal share of State expenditures for services provided through Indian Health Service facilities is 100 percent.

(3) Under section 1903(g), the FMAP is reduced if the State does not have an effective program to control use of institutional services.

(4) Under section 1905(b) of the Social Security Act, the Federal share of State expenditures described in § 433.11(a) for services provided to children, is the enhanced FMAP rate determined in accordance with § 457.622(b) of this chapter, subject to the conditions explained in § 433.11(b).

(5)(i) Under section 1933(d) of the Act, the Federal share of State expenditures for Medicare Part B premiums described in section 1905(p)(3)(A)(ii) of the Act on behalf of Qualifying Individuals described in section 1902(a)(10)(E)(iv) of the Act, is 100 percent, to the extent that the assistance does not exceed the State's allocation under paragraph (c)(5)(ii) of this section. To the extent that the assistance exceeds that allocation, the Federal share is 0 percent.

(ii) Under section 1933(c)(2) of the Act and subject to paragraph (c)(5)(iii) of this section, the allocation to each State is equal to the total allocation specified in section 1933(g) of the Act multiplied by the Secretary's estimate of the ratio of the total number of individuals described in section 1902(a)(10)(E)(iv) of the Act in the State to the total number of individuals described in section 1902(a)(10)(E)(iv) of

the Act for all eligible States. In estimating that ratio, the Secretary will use data from the U.S. Census Bureau.

(iii) If, based on projected expenditures for a fiscal year, or for a shorter period for which funding is available under section 1933 of the Act, the Secretary determines that the expenditures described in paragraph (c)(5)(i) of this section for one or more States are projected to exceed the allocation made to the State, the Secretary may adjust each State's fiscal year allocation, as follows:

(A) The Secretary will compare each State's projected total expenditures for the expenses described in paragraph (c)(5)(i) of this section to the State's initial allocation determined under paragraph (c)(5)(ii) of this section, to determine the extent of each State's projected surplus or deficit.

(B) The surplus of each State with a projected surplus, as determined in accordance with paragraph (c)(5)(iii)(A) of this section will be added together to arrive at the Total Projected Surplus.

(C) The deficit of each State with a projected deficit, as determined in accordance with paragraph (c)(5)(iii)(A) of this section will be added together to arrive at the Total Projected Deficit.

(D) Each State with a projected deficit will receive an additional allocation equal to the amount of its projected deficit, or a prorated amount of such deficit, if the Total Projected Deficit is greater than the Total Projected Surplus. Except as described in paragraph (c)(5)(iii)(E) of this section, the amount to be reallocated from each State with a projected surplus will be equal to A × B, where A equals the Total Projected Deficit and B equals the amount of the State's projected surplus as a percentage of the Total Projected Surplus.

(E) If the Total Projected Deficit determined under paragraph (c)(5)(iii)(C) of this section is greater than the Total Projected Surplus determined under paragraph (c)(5)(iii)(B) of this section, each State with a projected deficit will receive an additional allocation amount equal to the amount of the Total Projected Surplus multiplied by the amount of the projected deficit for such State as a percentage of the Total Projected Deficit. The amount to be reallocated from each State with a projected surplus will be equal to the amount of the projected surplus.

(iv) CMS will notify States of any changes in allotments resulting from any reallocations.

(v) The provisions in paragraph (c)(5) of this section will be in effect through the end of the period for which funding authority is available under section 1933 of the Act.

(6)(i) *Newly eligible FMAP.* Beginning January 1, 2014, under section 1905(y) of the Act, the FMAP for a State that is one of the 50 States or the District of Columbia, including a State that meets the definition of expansion State in § 433.204(b), for amounts expended by such State for medical assistance for newly eligible individuals, as defined in § 433.204(a)(1), will be an increased FMAP equal to:

(A) 100 percent, for calendar quarters in calendar years (CYs) 2014 through 2016;

(B) 95 percent, for calendar quarters in CY 2017;

(C) 94 percent, for calendar quarters in CY 2018;

(D) 93 percent, for calendar quarters in CY 2019;

(E) 90 percent, for calendar quarters in CY 2020 and all subsequent calendar years.

(ii) The FMAP specified in paragraph (c)(6)(i) of this section will apply to amounts expended by a State for medical assistance for newly eligible individuals in accordance with the requirements of the methodology applied by the State under § 433.206.

(7)(i) *Temporary FMAP increase.* During the period January 1, 2014, through December 31, 2015, under section 1905(z)(1) of the Act for a State described in paragraph (c)(7)(ii) of this section, the FMAP determined under paragraph (b) of this section will be increased by 2.2 percentage points.

(ii) A State qualifies for the targeted increase in the FMAP under paragraph (c)(7)(i) of this section, if the State:

(A) Is an expansion State, as described in § 433.204(b) of this section;

(B) Does not qualify for any payments on the basis of the increased FMAP under paragraph (c)(6) of this

section, as determined by the Secretary; and

(C) Has not been approved by the Secretary to divert a portion of the disproportionate share hospital allotment for the State under section 1923(f) of the Act to the costs of providing medical assistance or other health benefits coverage under a demonstration that is in effect on July 1, 2009.

(iii) The increased FMAP under paragraph (c)(7)(i) of this section is available for amounts expended by the State for medical assistance for individuals that are not newly eligible as defined in § 433.204(a)(1).

(8) *Expansion State FMAP.* Beginning January 1, 2014, under section 1905(z)(2) of the Act, the FMAP for an expansion State defined in § 433.204(b), for amounts expended by such State for medical assistance for individuals described in § 435.119 of this chapter who are not newly eligible as defined in § 433.204(a)(1), and who are nonpregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1937 of the Act, will be determined in accordance with the expansion State FMAP formula in paragraph (c)(8)(i).

$$F + (T \times (N - F))$$

F = The base FMAP for the State determined under paragraph (b) of this section, subject to paragraph (c)(7) of this section.

T = The transition percentage specified in paragraph (c)(8)(ii) of this section.

N = The Newly Eligible FMAP determined under paragraph (c)(6) of this section.

(i) *Expansion State FMAP.*

(ii) *Transition percentage.* For purposes of paragraph (c)(8)(i) of this section, the transition percentage is equal to:

(A) 50 percent, for calendar quarters in CY 2014;

(B) 60 percent, for calendar quarters in CY 2015;

(C) 70 percent, for calendar quarters in CY 2016;

(D) 80 percent, for calendar quarters in CY 2017;

(E) 90 percent, for calendar quarters in CY 2018; and

(F) 100 percent, for calendar quarters in CY 2019 and all subsequent calendar years.

(Sections 1902(a)(10), 1933 of the Social Security Act (42 U.S.C. 1396a), and Pub. L. 105–33)

[43 FR 45201, Sept. 29, 1978, as amended at 46 FR 48559, Oct. 1, 1981; 51 FR 41350, Nov. 14, 1986; 54 FR 21066, May 16, 1989; 66 FR 2666, Jan. 11, 2001; 70 FR 50220, Aug. 26, 2005; 71 FR 25092, Apr. 28, 2006; 73 FR 70893, Nov. 24, 2008; 78 FR 19942, Apr. 2, 2013]

§ 433.11 Enhanced FMAP rate for children.

(a) Subject to the conditions in paragraph (b) of this section, the enhanced FMAP determined in accordance with § 457.622 of this chapter will be used to determine the Federal share of State expenditures, except any expenditures pursuant to section 1923 of the Act for payments to disproportionate share hospitals for—

(1) Services provided to optional targeted low-income children described in § 435.4 or § 436.3 of this chapter; and

(2) Services provided to children born before October 1, 1983, with or without group health coverage or other health insurance coverage, who would be described in section 1902(l)(1)(D) of the Act (poverty-level-related children's groups) if—

(i) They had been born on or after that date; and

(ii) They would not qualify for medical assistance under the State plan in effect on March 31, 1997.

(b) Enhanced FMAP is not available if—

(1) A State adopts income and resource standards and methodologies for purposes of determining a child's eligibility under the Medicaid State plan that are more restrictive than those applied under policies of the State plan (as described in the definition of optional targeted low-income children at § 435.4 of this chapter) in effect on June 1, 1997; or

(2) No funds are available in the State's title XXI allotment, as determined under part 457, subpart F of this chapter for the quarter enhanced FMAP is claimed; or

(3) The State fails to maintain a valid method of identifying services provided on behalf of children listed in paragraph (a) of this section.

[66 FR 2666, Jan. 11, 2001]

§ 433.15 Rates of FFP for administration.

(a) *Basis.* Section 1903(a) (2) through (5) and (7) of the Act provide for payments to States, on the basis of specified percentages, for part of their expenditures for administration of an approved State plan.

(b) *Activities and rates.* (1) [Reserved]

(2) Administration of family planning services: 90 percent. (Section 1903 (a)(5); 42 CFR 432.50(b)(5).)

(3) Design, development, or installation of mechanized claims processing and information retrieval systems: 90 percent. (Section 1903(a)(3)(A)(i); 42 CFR part 433, subpart C, and § 432.50 (b)(3).)

(4) Operation of mechanized claims processing and information retrieval systems: 75 percent. (Section 1903(a)(3)(B); 42 CFR part 433, subpart C and § 432.50(b)(2).)

(5) Compensation and training of skilled professional medical personnel and staff directly supporting those personnel if the criteria specified in § 432.50 (c) and (d) are met: 75 percent. (Section 1903(a)(2); 42 CFR 432.50(b)(1).)

(6)(i) Funds expended for the performance of medical and utilization review by a QIO under a contract entered into under section 1902(d) of the Act: 75 percent (section 1903(a)(3)(C) of the Act).

(ii) If a State contracts for medical and utilization review with any individual or organization not designated under Part B of Title XI of the Act, funds expended for such review will be reimbursed as provided in paragraph (b)(7) of this section.

(7) All other activities the Secretary finds necessary for proper and efficient administration of the State plan: 50 percent. (Section 1903(a)(7).) (See also § 455.300 of this subchapter for FFP at 90 percent for State Medicaid fraud control units under section 1903(a)(6).)

(8) Nurse aide training and competency evaluation programs and competency evaluation programs described in 1919(e)(1) of the Act: for calendar quarters beginning on or after July 1, 1988 and before July 1, 1990: The lesser of 90% or the Federal medical assistance percentage plus 25 percentage points; for calendar quarters beginning on or after October 1, 1990: 50%. (Section 1903(a)(2)(B) of the Act.)

(9) Preadmission screening and annual resident review (PASARR) activities conducted by the State: 75 percent. (Sections 1903(a)(2)(C) and 1919(e)(7); 42 CFR part 483, subparts C and E.)

(10) Funds expended for the performance of external quality review or the related activities described in § 438.358 of this chapter consistent with § 438.370(a) of this chapter: 75 percent; consistent with § 438.370(b): 50 percent.

[43 FR 45201, Sept. 29, 1978, as amended at 46 FR 48566, Oct. 1, 1981; 46 FR 54744, Nov. 4, 1981; 50 FR 15327, Apr. 17, 1985; 50 FR 46664, Nov. 12, 1985; 56 FR 48918, Sept. 26, 1991; 57 FR 56506, Nov. 30, 1992; 68 FR 3635, Jan. 24, 2003; 81 FR 27853, May 6, 2016]

§ 433.32 Fiscal policies and accountability.

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

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

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

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

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

[44 FR 17935, Mar. 23, 1979]

§ 433.34 Cost allocation.

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

[47 FR 17490, Apr. 23, 1982]

§ 433.35 Equipment—Federal financial participation.

Claims for Federal financial participation in the cost of equipment under the Medicaid Program are determined in accordance with subpart G of 45 CFR part 95. Requirements concerning the management and disposition of equipment under the Medicaid Program are also prescribed in subpart G of 45 CFR part 95.

[47 FR 41564, Sept. 21, 1982]

§ 433.36 Liens and recoveries.

(a) *Basis and purpose.* This section implements sections 1902(a)(18) and 1917(a) and (b) of the Act, which describe the conditions under which an agency may impose a lien against a beneficiary's property, and when an agency may make an adjustment or recover funds in satisfaction of the claim against the individual's estate or real property.

(b) *Definition of property.* For purposes of this section, ''property'' includes the homestead and all other personal and real property in which the beneficiary has a legal interest.

(c) *State plan requirement.* If a State chooses to impose a lien against an individual's real property (or as provided in paragraph (g)(1) of this section, personal property), the State plan must provide that the provisions of paragraphs (d) through (i) of this section are met.

(d) *Procedures.* The State plan must specify the process by which the State will determine that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home as provided in paragraph (g)(2)(ii) of this section. The description of the process must include the type of notice to be given the individual, the process by which the individual will be given the opportunity for a hearing, the hearing procedures, and by whom and on what basis the determination that the individual cannot reasonably be expected to be discharged from the institution will be made. The notice to the individual must explain what is meant by the term lien, and that imposing a lien does not mean that the individual will lose ownership of the home.

(e) *Definitions.* The State plan must define the following terms used in this section:

(1) Individual's home.

(2) Equity interest in home.

(3) Residing in the home for at least 1 (or 2) year(s).

(4) On a continuing basis.

(5) Discharge from the medical institution and return home.

(6) Lawfully residing.

(f) *Exception.* The State plan must specify the criteria by which a son or daughter can establish to the agency's satisfaction that he or she has been providing care which permitted the individual to reside at home rather than in an institution, as provided in paragraph (h)(2)(iii)(B) of this section.

(g) *Lien provisions*—(1) *Incorrect payments.* The agency may place a lien against an individual's property, both

personal and real, before his or her death because of Medicaid claims paid or to be paid on behalf of that individual following a court judgement which determined that benefits were incorrectly paid for that individual.

(2) *Correct payments.* Except as provided in paragraph (g)(3) of this section, the agency may place a lien against the real property of an individual at any age before his or her death because of Medicaid claims paid or to be paid for that individual when—

(i) An individual is an inpatient of a medical institution and must, as a condition of receiving services in the institution under the State plan, apply his or her income to the cost of care as provided in §§ 435.725, 435.832 and 436.832; and

(ii) The agency determines that he or she cannot reasonably be expected to be discharged and return home. The agency must notify the individual of its intention to make that determination and provide an opportunity for a hearing in accordance with State established procedures before the determination is made. The notice to an individual must include an explanation of liens and the effect on an individual's ownership of property.

(3) *Restrictions on placing liens.* The agency may not place a lien on an individual's home under paragraph (g)(2) of this section if any of the following individuals is lawfully residing in the home:

(i) The spouse;

(ii) The individual's child who is under age 21 or blind or disabled as defined in the State plan; or

(iii) The individual's sibling (who has an equity interest in the home, and who was residing in the individual's home for at least one year immediately before the date the individual was admitted to the medical institution).

(4) *Termination of lien.* Any lien imposed on an individual's real property under paragraph (g)(2) of this section will dissolve when that individual is discharged from the medical institution and returns home.

(h) *Adjustments and recoveries.* (1) The agency may make an adjustment or recover funds for Medicaid claims correctly paid for an individual as follows:

(i) From the estate of any individual who was 65 years of age or older when he or she received Medicaid; and

(ii) From the estate or upon sale of the property subject to a lien when the individual is institutionalized as described in paragraph (g)(2) of this section.

(2) The agency may make an adjustment or recovery under paragraph (h)(1) of this section only:

(i) After the death of the individual's surviving spouse; and

(ii) When the individual has no surviving child under age 21 or blind or disabled as defined in the State plan; and

(iii) In the case of liens placed on an individual's home under paragraph (g)(2) of this section, when there is no—

(A) Sibling of the individual residing in the home, who has resided there for at least one year immediately before the date of the individual's admission to the institution, and has resided there on a continuous basis since that time; or

(B) Son or daughter of the individual residing in the home, who has resided there for at least two years immediately before the date of the individual's admission to the institution, has resided there on a continuous basis since that time, and can establish to the agency's satisfaction that he or she has been providing care which permitted the individual to reside at home rather than in an institution.

(i) *Prohibition of reduction of money payments.* No money payment under another program may be reduced as a means of recovering Medicaid claims incorrectly paid.

[43 FR 45201, Sept. 29, 1978, as amended at 47 FR 43647, Oct. 1, 1982; 47 FR 49847, Nov. 3, 1982]

§ 433.37 Reporting provider payments to Internal Revenue Service.

(a) *Basis and purpose.* This section, based on section 1902(a)(4) of the Act, prescribes requirements concerning—

(1) Identification of providers; and

(2) Compliance with the information reporting requirements of the Internal Revenue Code.

(b) *Identification of providers.* A State plan must provide for the identification of providers by—

(1) Social security number if—

(i) The provider is in solo practice; or

(ii) The provider is not in solo practice but billing is by the individual practitioner; or

(2) Employer identification number for all other providers.

(c) *Compliance with section 6041 of the Internal Revenue Code.* The plan must provide that the Medicaid agency complies with the information reporting requirements of section 6041 of the Internal Revenue Code (26 U.S.C. 6041). Section 6041 requires the filing of annual information returns showing amounts paid to providers, who are identified by name, address, and social security number or employer identification number.

§ 433.38 Interest charge on disallowed claims for FFP.

(a) *Basis and scope.* This section is based on section 1903(d)(5) of the Act, which requires that the Secretary charge a State interest on the Federal share of claims that have been disallowed but have been retained by the State during the administrative appeals process under section 1116(e) of the Act and the Secretary later recovers after the administrative appeals process has been completed. This section does not apply to—

(1) Claims that have been deferred by the Secretary and disallowed within the time limits of § 430.40 of this chapter. Deferral of claims for FFP; or

(2) Claims for expenditures that have never been paid on a grant award; or

(3) Disallowances of any claims for services furnished before October 1, 1980, regardless of the date of the claim submitted to CMS.

(b) *General principles.* (1) CMS will charge the State interest on FFP when—

(i) CMS has notified the Medicaid agency under § 430.42 of this subpart that a State's claim for FFP is not allowable;

(ii) The agency has requested a reconsideration of the disallowance to the Administrator under § 430.42 of this chapter and has chosen to retain the FFP during the administrative reconsideration process in accordance with paragraph (c)(2) of this section;

(iii)(A) CMS has made a final determination upholding part or all of the disallowance;

(B) The agency has withdrawn its request for administrative reconsideration on all or part of the disallowance; or

(C) The agency has reversed its decision to retain the funds without withdrawing its request for administrative reconsideration and CMS upholds all or part of the disallowance.

(iv) The agency has appealed the disallowance to the Departmental Appeals Board under 45 CFR part 16 and has chosen to retain the FFP during the administrative appeals process in accordance with paragraph (c)(2) of this section.

(v)(A)The Board has made a final determination upholding part or all of the disallowance;

(B) The agency has withdrawn its appeal on all or part of the disallowance; or

(C) The agency has reversed its decision to retain the funds without withdrawing its appeal and the Board upholds all or part of the disallowance.

(2) If the courts overturn, in whole or in part, a Board decision that has sustained a disallowance, CMS will return the principal and the interest collected on the funds that were disallowed, upon the completion of all judicial appeals.

(3) Unless an agency decides to withdraw its request for administrative reconsideration or appeal on part of the disallowance and therefore returns only that part of the funds on which it has withdrawn its request for administrative reconsideration or appeal, any decision to retain or return disallowed funds must apply to the entire amount in dispute.

(4) If the agency elects to have CMS recover the disputed amount, it may not reverse that election.

(c) *State procedures.* (1) If the Medicaid agency has requested administrative reconsideration to CMS or appeal of a disallowance to the Board and wishes to retain the disallowed funds until CMS or the Board issues a final determination, the agency must notify the CMS Regional Office in writing of its decision to do so.

(2) The agency must mail its notice to the CMS Regional Office within 60 days of the date of receipt of the notice of the disallowance, as established by the certified mail receipt accompanying the notice.

(3) If the agency withdraws its decision to retain the FFP or its request for administrative reconsideration or appeal on all or part of the FFP, the agency must notify CMS in writing.

(d) *Amount of interest charged.* (1) If the agency retains funds that later become subject to an interest charge under paragraph (b) of this section, CMS will offset from the next Medicaid grant award to the State the amount of the funds subject to the interest charge, plus interest on that amount.

(2) The interest charge is at the rate CMS determines to be the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during the period for which interest will be charged.

(e) *Duration of interest.* (1) The interest charge on the amount of disallowed FFP retained by the agency will begin on the date of the disallowance notice and end—

(i) On the date of the final determination by CMS of the administrative reconsideration if the State elects not to appeal to the Board, or final determination by the Board;

(ii) On the date CMS receives written notice from the State that it is withdrawing its request for administrative reconsideration and elects not to appeal to the Board, or withdraws its appeal to the Board on all of the disallowed funds; or

(iii) If the agency withdraws its request for administrative reconsideration on part of the funds on—

(A) The date CMS receives written notice from the agency that it is withdrawing its request for administrative reconsideration on a specified part of the disallowed funds for the part on which the agency withdraws its request for administrative reconsideration; and

(B) The date of the final determination by CMS on the part for which the agency pursues its administrative reconsideration; or

(iv) If the agency withdraws its appeal on part of the funds, on—

(A) The date CMS receives written notice from the agency that it is withdrawing its appeal on a specified part of the disallowed funds for the part on which the agency withdraws its appeal; and

(B) The date of the final determination by the Board on the part for which the agency pursues its appeal; or

(v) If the agency has given CMS written notice of its intent to repay by installment, in the quarter in which the final installment is paid. Interest during the repayment of Federal funds by installments will be at the Current Value of Funds Rate (CVFR); or

(vi) The date CMS receives written notice from the agency that it no longer chooses to retain the funds.

(2) CMS will not charge interest on FFP retained by an agency for more than 12 months for disallowances of FFP made between October 1, 1980 and August 13, 1981.

[48 FR 29485, June 27, 1983, as amended at 77 FR 31510, May 29, 2012]

§ 433.40 Treatment of uncashed or cancelled (voided) Medicaid checks.

(a) *Purpose.* This section provides the rules to ensure that States refund the Federal portion of uncashed or cancelled (voided) checks under title XIX.

(b) *Definitions.* As used in this section—

Cancelled (voided) check means a Medicaid check issued by a State or fiscal agent which prior to its being cashed is cancelled (voided) by the State or fiscal agent, thus preventing disbursement of funds.

Check means a check or warrant that a State or local agency uses to make a payment.

Fiscal agent means an entity that processes or pays vendor claims for the Medicaid State agency.

Uncashed check means a Medicaid check issued by a State or fiscal agent which has not been cashed by the payee.

Warrant means an order by which the State agency or local agency without the authority to issue checks recognizes a claim. Presentation of a warrant by the payee to a State officer with authority to issue checks will result in release of funds due.

(c) *Refund of Federal financial participation (FFP) for uncashed checks*—(1) *General provisions.* If a check remains uncashed beyond a period of 180 days from the date it was issued; *i.e.*, the date of the check, it will no longer be regarded as an allowable program expenditure. If the State has claimed and received FFP for the amount of the uncashed check, it must refund the amount of FFP received.

(2) *Report of refund.* At the end of each calendar quarter, the State must identify those checks which remain uncashed beyond a period of 180 days after issuance. The State agency must refund all FFP that it received for uncashed checks by adjusting the Quarterly Statement of Expenditures for that quarter. If an uncashed check is cashed after the refund is made, the State may file a claim. The claim will be considered to be an adjustment to the costs for the quarter in which the check was originally claimed. This claim will be paid if otherwise allowed by the Act and the regulations issued pursuant to the Act.

(3) If the State does not refund the appropriate amount as specified in paragraph (c)(2) of this section, the amount will be disallowed.

(d) *Refund of FFP for cancelled (voided) checks*—(1) *General provision.* If the State has claimed and received FFP for the amount of a cancelled (voided) check, it must refund the amount of FFP received.

(2) *Report of refund.* At the end of each calendar quarter, the State agency must identify those checks which were cancelled (voided). The State must refund all FFP that it received for cancelled (voided) checks by adjusting the Quarterly Statement of Expenditures for that quarter.

(3) If the State does not refund the appropriate amount as specified in paragraph (d)(2) of this section, the amount will be disallowed.

[51 FR 36227, Oct. 9, 1986]

Subpart B—General Administrative Requirements State Financial Participation

SOURCE: 57 FR 55138, Nov. 24, 1992, unless otherwise noted.

§ 433.50 Basis, scope, and applicability.

(a) *Basis.* This subpart interprets and implements—(1) Section 1902(a)(2) of the Act which requires States to share in the cost of medical assistance expenditures and permit both State and local governments to participate in the financing of the non-Federal portion of medical assistance expenditures.

(2) Section 1903(a) of the Act, which requires the Secretary to pay each State an amount equal to the Federal medical assistance percentage of the total amount expended as medical assistance under the State's plan.

(3) Section 1903(w) of the Act, which specifies the treatment of revenues from provider-related donations and health care-related taxes in determining a State's medical assistance expenditures for which Federal financial participation (FFP) is available under the Medicaid program.

(b) *Scope.* This subpart—

(1) Specifies State plan requirements for State financial participation in expenditures for medical assistance.

(2) Defines provider-related donations and health care-related taxes that may be received without a reduction in FFP.

(3) Specifies rules for revenues received from provider-related donations and health care-related taxes during a transition period.

(4) Establishes limitations on FFP when States receive funds from provider-related donations and revenues generated by health care-related taxes.

(c) *Applicability.* The provisions of this subpart apply to the 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act.

[57 FR 55138, Nov. 24, 1992; 58 FR 6095, Jan. 26, 1993; 72 FR 29832, May 29, 2007; 72 FR 29832, May 29, 2007; 75 FR 73975, Nov. 30, 2010]

§ 433.51 Public Funds as the State share of financial participation.

(a) Public Funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.

(b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian

tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.

(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

[75 FR 73975, Nov. 30, 2010]

§ 433.52 General definitions.

As used in this subpart—

Entity related to a health care provider means—

(1) An organization, association, corporation, or partnership formed by or on behalf of a health care provider;

(2) An individual with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Act;

(3) An employee, spouse, parent, child, or sibling of the provider, or of a person with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Act; or

(4) A supplier of health care items or services or a supplier to providers of health care items or services.

Health care provider means the individual or entity that receives any payment or payments for health care items or services provided.

Provider-related donation means a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a State or unit of local government by or on behalf of a health care provider, an entity related to such a health care provider, or an entity providing goods or services to the State for administration of the State's Medicaid plan.

(1) Donations made by a health care provider to an organization, which in turn donates money to the State, may be considered to be a donation made indirectly to the State by a health care provider.

(2) When an organization receives less than 25 percent of its revenues from providers and/or provider-related entities, its donations will not generally be presumed to be provider-related donations. Under these circumstances, a provider-related donation to an organization will not be considered a donation made indirectly to the State. However, if the donations from providers to an organization are subsequently determined to be indirect donations to the State or unit of local government for administration of the State's Medicaid program, then such donations will be considered to be health care related.

(3) When the organization receives more than 25 percent of its revenue from donations from providers or provider-related entities, the organization always will be considered as acting on behalf of health care providers if it makes a donation to the State. The amount of the organization's donation to the State, in a State fiscal year, that will be considered health care related, will be based on the percentage of donations the organization received from the providers during that period.

§ 433.53 State plan requirements.

A State plan must provide that—

(a) State (as distinguished from local) funds will be used both for medical assistance and administration;

(b) State funds will be used to pay at least 40 percent of the non-Federal share of total expenditures under the plan; and

(c) State and Federal funds will be apportioned among the political subdivisions of the State on a basis that assures that—

(1) Individuals in similar circumstances will be treated similarly throughout the State; and

(2) If there is local financial participation, lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan in any part of the State.

[57 FR 55138, Nov. 24, 1992; 58 FR 6095, Jan. 26, 1993]

§ 433.54 Bona fide donations.

(a) A bona fide donation means a provider-related donation, as defined in § 433.52, made to the State or unit of local government, that has no direct or indirect relationship, as described in paragraph (b) of this section, to Medicaid payments made to—

(1) The health care provider;

(2) Any related entity providing health care items and services; or

(3) Other providers furnishing the same class of items or services as the provider or entity.

(b) Provider-related donations will be determined to have no direct or indirect relationship to Medicaid payments if those donations are not returned to the individual provider, the provider class, or related entity under a hold harmless provision or practice, as described in paragraph (c) of this section.

(c) A hold harmless practice exists if any of the following applies:

(1) The State (or other unit of government) provides for a direct or indirect non-Medicaid payment to those providers or others making, or responsible for, the donation, and the payment amount is positively correlated to the donation. A positive correlation includes any positive relationship between these variables, even if not consistent over time.

(2) All or any portion of the Medicaid payment to the donor, provider class, or related entity, varies based only on the amount of the donation, including where Medicaid payment is conditional on receipt of the donation.

(3) The State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to return any portion of the donation to the provider (or other parties responsible for the donation).

(d) CMS will presume provider-related donations to be bona fide if the voluntary payments, including, but not limited to, gifts, contributions, presentations or awards, made by or on behalf of individual health care providers to the State, county, or any other unit of local government does not exceed—

(1) $5,000 per year in the case of an individual provider donation; or

(2) $50,000 per year in the case of a donation from any health care organizational entity.

(e) To the extent that a donation presumed to be bona fide contains a hold harmless provision, as described in paragraph (c) of this section, it will not be considered a bona fide donation. When provider-related donations are not bona fide, CMS will deduct this amount from the State's medical assistance expenditures before calculating FFP. This offset will apply to all years the State received such donations and any subsequent fiscal year in which a similar donation is received.

[57 FR 55138, Nov. 24, 1992, as amended at 73 FR 9698, Feb. 22, 2008]

§ 433.55 Health care-related taxes defined.

(a) A health care-related tax is a licensing fee, assessment, or other mandatory payment that is related to—

(1) Health care items or services;

(2) The provision of, or the authority to provide, the health care items or services; or

(3) The payment for the health care items or services.

(b) A tax will be considered to be related to health care items or services under paragraph (a)(1) of this section if at least 85 percent of the burden of the tax revenue falls on health care providers.

(c) A tax is considered to be health care related if the tax is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to other individuals or entities.

(d) A health care-related tax does not include payment of a criminal or civil fine or penalty, unless the fine or penalty was imposed instead of a tax.

(e) Health care insurance premiums and health maintenance organization premiums paid by an individual or group to ensure coverage or enrollment are not considered to be payments for health care items and services for purposes of determining whether a health care-related tax exists.

§ 433.56 Classes of health care services and providers defined.

(a) For purposes of this subpart, each of the following will be considered as a separate class of health care items or services:

(1) Inpatient hospital services;

(2) Outpatient hospital services;

(3) Nursing facility services (other than services of intermediate care facilities for individuals with intellectual disabilities);

(4) Intermediate care facility services for individuals with intellectual disabilities, and similar services furnished by community-based residences for individuals with intellectual disabilities, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/IIDs prior to the grant of the waiver;

(5) Physician services;

(6) Home health care services;

(7) Outpatient prescription drugs;

(8) Services of managed care organizations (including health maintenance organizations, preferred provider organizations);

(9) Ambulatory surgical center services, as described for purposes of the Medicare program in section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures;

(10) Dental services;

(11) Podiatric services;

(12) Chiropractic services;

(13) Optometric/optician services;

(14) Psychological services;

(15) Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services;

(16) Nursing services, defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses;

(17) Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department;

(18) Emergency ambulance services; and

(19) Other health care items or services not listed above on which the State has enacted a licensing or certification fee, subject to the following:

(i) The fee must be broad based and uniform or the State must receive a waiver of these requirements;

(ii) The payer of the fee cannot be held harmless; and

(iii) The aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program.

(b) Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43180, Aug. 13, 1993; 73 FR 9698, Feb. 22, 2008]

§ 433.57 General rules regarding revenues from provider-related donations and health care-related taxes.

Effective January 1, 1992, CMS will deduct from a State's expenditures for medical assistance, before calculating FFP, funds from provider-related donations and revenues generated by health care-related taxes received by a State or unit of local government, in accordance with the requirements, conditions, and limitations of this subpart, if the donations and taxes are not—

(a) Permissible provider-related donations, as specified in § 433.66(b); or

(b) Health care-related taxes, as specified in § 433.68(b).

[57 FR 55138, Nov. 24, 1992, as amended at 73 FR 9698, Feb. 22, 2008]

§§ 433.58–433.60 [Reserved]

§ 433.66 Permissible provider-related donations.

(a) *General rule.* (1) Except as specified in paragraph (a)(2) of this section, a State may receive revenues from provider-related donations without a reduction in FFP, only in accordance with the requirements of this section.

(2) The provisions of this section relating to provider-related donations for outstationed eligibility workers are effective on October 1, 1992.

(b) *Permissible donations.* Subject to the limitations specified in § 433.67, a State may receive, without a reduction in FFP, provider-related donations that meet at least one of the following requirements:

(1) The donations must be bona fide donations, as defined in § 433.54; or

(2) The donations are made by a hospital, clinic, or similar entity (such as a Federally-qualified health center) for the direct costs of State or local agency personnel who are stationed at the

facility to determine the eligibility (including eligibility redeterminations) of individuals for Medicaid or to provide outreach services to eligible (or potentially eligible) Medicaid individuals. Direct costs of outstationed eligibility workers refers to the costs of training, salaries and fringe benefits associated with each outstationed worker and similar allocated costs of State or local agency support staff, and a prorated cost of outreach activities applicable to the outstationed workers at these sites. The prorated costs of outreach activities will be calculated taking the percent of State outstationed eligibility workers at a facility to total outstationed eligibility workers in the State, and multiplying the percent by the total cost of outreach activities in the State. Costs for such items as State agency overhead and provider office space are not allowable for this purpose.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43180, Aug. 13, 1993; 73 FR 9698, Feb. 22, 2008]

§ 433.67 Limitations on level of FFP for permissible provider-related donations.

(a)(1) *Limitations on bona fide donations.* There are no limitations on the amount of bona fide provider-related donations that a State may receive without a reduction in FFP, as long as the bona fide donations meet the requirements of § 433.66(b)(1).

(2) *Limitations on donations for outstationed eligibility workers.* Effective October 1, 1992, the maximum amount of provider-related donations for outstationed eligibility workers, as described in § 433.66(b)(2), that a State may receive without a reduction in FFP may not exceed 10 percent of a State's medical assistance administrative costs (both the Federal and State share), excluding the costs of family planning activities. The 10 percent limit for provider-related donations for outstationed eligibility workers is not included in the limit in effect through September 30, 1995, for health care-related taxes as described in § 433.70.

(b) *Calculation of FFP.* CMS will deduct from a State's quarterly medical assistance expenditures, before calculating FFP, any provider-related donations received in that quarter that do not meet the requirements of § 433.66(b)(1) and provider donations for outstationed eligibility workers in excess of the limits specified under paragraph (a)(2) of this section.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43180, Aug. 13, 1993; 73 FR 9698, Feb. 22, 2008]

§ 433.68 Permissible health care-related taxes.

(a) *General rule.* A State may receive health care-related taxes, without a reduction in FFP, only in accordance with the requirements of this section.

(b) *Permissible health care-related taxes.* Subject to the limitations specified in § 433.70, a State may receive, without a reduction in FFP, health care-related taxes if all of the following are met:

(1) The taxes are broad based, as specified in paragraph (c) of this section;

(2) The taxes are uniformly imposed throughout a jurisdiction, as specified in paragraph (d) of this section; and

(3) The tax program does not violate the hold harmless provisions specified in paragraph (f) of this section.

(c) *Broad based health care-related taxes.* (1) A health care-related tax will be considered to be broad based if the tax is imposed on at least all health care items or services in the class or providers of such items or services furnished by all non-Federal, non-public providers in the State, and is imposed uniformly, as specified in paragraph (d) of this section.

(2) If a health care-related tax is imposed by a unit of local government, the tax must extend to all items or services or providers (or to all providers in a class) in the area over which the unit of government has jurisdiction.

(3) A State may request a waiver from CMS of the requirement that a tax program be broad based, in accordance with the procedures specified in § 433.72. Waivers from the uniform and broad-based requirements will automatically be granted in cases of variations in licensing and certification fees for providers if the amount of such fees is not more than $1,000 annually per provider and the total amount

raised by the State from the fees is used in the administration of the licensing or certification program.

(d) *Uniformly imposed health care-related taxes.* A health care-related tax will be considered to be imposed uniformly even if it excludes Medicaid or Medicare payments (in whole or in part), or both; or, in the case of a health care-related tax based on revenues or receipts with respect to a class of items or services (or providers of items or services), if it excludes either Medicaid or Medicare revenues with respect to a class of items or services, or both. The exclusion of Medicaid revenues must be applied uniformly to all providers being taxed.

(1) A health care-related tax will be considered to be imposed uniformly if it meets any one of the following criteria:

(i) If the tax is a licensing fee or similar tax imposed on a class of health care services (or providers of those health care items or services), the tax is the same amount for every provider furnishing those items or services within the class.

(ii) If the tax is a licensing fee or similar tax imposed on a class of health care items or services (or providers of those items or services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of those items or services in the class.

(iii) If the tax is imposed on provider revenue or receipts with respect to a class of items or services (or providers of those health care items or services), the tax is imposed at a uniform rate for all services (or providers of those items or services) in the class on all the gross revenues or receipts, or on net operating revenues relating to the provision of all items or services in the State, unit, or jurisdiction. Net operating revenue means gross charges of facilities less any deducted amounts for bad debts, charity care, and payer discounts.

(iv) The tax is imposed on items or services on a basis other than those specified in paragraphs (d)(1) (i) through (iii) of this section, e.g., an admission tax, and the State establishes to the satisfaction of the Secretary that the amount of the tax is the same for each provider of such items or services in the class.

(2) A tax imposed with respect to a class of health care items or services will not be considered to be imposed uniformly if it meets either one of the following two criteria:

(i) The tax provides for credits, exclusions, or deductions which have as its purpose, or results in, the return to providers of all, or a portion, of the tax paid, and it results, directly or indirectly, in a tax program in which—

(A) The net impact of the tax and payments is not generally redistributive, as specified in paragraph (e) of this section; and

(B) The amount of the tax is directly correlated to payments under the Medicaid program.

(ii) The tax holds taxpayers harmless for the cost of the tax, as described in paragraph (f) of this section.

(3) If a tax does not meet the criteria specified in paragraphs (d)(1)(i) through (iv) of this section, but the State establishes that the tax is imposed uniformly in accordance with the procedures for a waiver specified in § 433.72, the tax will be treated as a uniform tax.

(e) *Generally redistributive.* A tax will be considered to be generally redistributive if it meets the requirements of this paragraph. If the State desires waiver of only the broad-based tax requirement, it must demonstrate compliance with paragraph (e)(1) of this section. If the State desires waiver of the uniform tax requirement, whether or not the tax is broad-based, it must demonstrate compliance with paragraph (e)(2) of this section.

(1) *Waiver of broad-based requirement only.* This test is applied on a per class basis to a tax that is imposed on all revenues but excludes certain providers. For example, a tax that is imposed on all revenues (including Medicare and Medicaid) but excludes teaching hospitals would have to meet this test. This test cannot be used when a State excludes any or all Medicaid revenue from its tax in addition to the exclusion of providers, since the test compares the proportion of Medicaid revenue being taxed under the proposed tax with the proportion of Medicaid

revenue being taxed under a broad-based tax.

(i) A State seeking waiver of the broad-based tax requirement only must demonstrate that its proposed tax plan meets the requirement that its plan is generally redistributive by:

(A) Calculating the proportion of the tax revenue applicable to Medicaid if the tax were broad based and applied to all providers or activities within the class (called P1);

(B) Calculating the proportion of the tax revenue applicable to Medicaid under the tax program for which the State seeks a waiver (called P2); and

(C) Calculating the value of P1/P2.

(ii) If the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 1, CMS will automatically approve the waiver request.

(iii) If a tax is enacted and in effect prior to August 13, 1993, and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.90, CMS will review the waiver request. Such a waiver will be approved only if the following two criteria are met:

(A) The value of P1/P2 is at least 0.90; and

(B) The tax excludes or provides credits or deductions only to one or more of the following providers of items and services within the class to be taxed:

(*1*) Providers that furnish no services within the class in the State;

(*2*) Providers that do not charge for services within the class;

(*3*) Rural hospitals (defined as any hospital located outside of an urban area as defined in § 412.62(f)(1)(ii) of this chapter);

(*4*) Sole community hospitals as defined in § 412.92(a) of this chapter;

(*5*) Physicians practicing primarily in medically underserved areas as defined in section 1302(7) of the Public Health Service Act;

(*6*) Financially distressed hospitals if:

(*i*) A financially distressed hospital is defined by the State law;

(*ii*) The State law specifies reasonable standards for determining financially distressed hospitals, and these standards are applied uniformly to all hospitals in the State; and

(*iii*) No more than 10 percent of non-public hospitals in the State are exempt from the tax;

(*7*) Psychiatric hospitals; or

(*8*) Hospitals owned and operated by HMOs.

(iv) If a tax is enacted and in effect after August 13, 1993, and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.95, CMS will review the waiver request. Such a waiver request will be approved only if the following two criteria are met:

(A) The value of P1/P2 is at least 0.95; and

(B) The tax complies with the provisions of § 433.68(e)(1)(iii)(B).

(2) *Waiver of uniform tax requirement.* This test is applied on a per class basis to all taxes that are not uniform. This includes those taxes that are neither broad based (as specified in § 433.68(c)) nor uniform (as specified in § 433.68(d)).

(i) A State seeking waiver of the uniform tax requirement (whether or not the tax is broad based) must demonstrate that its proposed tax plan meets the requirement that its plan is generally redistributive by:

(A) Calculating, using ordinary least squares, the slope (designated as (*B*) (that is. the value of the x coefficient) of two linear regressions, in which the dependent variable is each provider's percentage share of the total tax paid by all taxpayers during a 12-month period, and the independent variable is the taxpayer's ''Medicaid Statistic''. The term ''Medicaid Statistic'' means the number of the provider's taxable units applicable to the Medicaid program during a 12-month period. If, for example, the State imposed a tax based on provider charges, the amount of a provider's Medicaid charges paid during a 12-month period would be its ''Medicaid Statistic''. If the tax were based on provider inpatient days, the number of the provider's Medicaid days during a 12-month period would be its ''Medicaid Statistic''. For the purpose of this test, it is not relevant that a tax program exempts Medicaid from the tax.

(B) Calculating the slope (designated as B1) of the linear regression, as described in paragraph (e)(2)(i) of this

section, for the State's tax program, if it were broad based and uniform.

(C) Calculating the slope (designated as B2) of the linear regression, as described in paragraph (e)(2)(i) of this section, for the State's tax program, as proposed.

(ii) If the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least 1, CMS will automatically approve the waiver request.

(iii) If the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least 0.95, CMS will review the waiver request. Such a waiver will be approved only if the following two criteria are met:

(A) The value of B1/B2 is at least 0.95; and

(B) The tax excludes or provides credits or deductions only to one or more of the following providers of items and services within the class to be taxes:

(*1*) Providers that furnish no services within the class in the State;

(*2*) Providers that do not charge for services within the class;

(*3*) Rural hospitals (defined as any hospital located outside of an urban area as defined in § 412.62(f)(1)(ii) of this chapter;

(*4*) Sole community hospitals as defined in § 412.92(a) of this chapter;

(*5*) Physicians practicing primarily in medically underserved areas as defined in section 1302(7) of the Public Health Service Act;

(*6*) Financially distressed hospitals if:

(*i*) A financially distressed hospital is defined by the State law;

(*ii*) The State law specifies reasonable standards for determining financially distressed hospitals, and these standards are applied uniformly to all hospitals in the State; and

(*iii*) No more than 10 percent of nonpublic hospitals in the State are exempt from the tax;

(*7*) Psychiatric hospitals; or

(*8*) Providers or payers with tax rates that vary based exclusively on regions, but only if the regional variations are coterminous with preexisting political (and not special purpose) boundaries. Taxes within each regional boundary must meet the broad-based and uniformity requirements as specified in paragraphs (c) and (d) of this section.

(iv) A B1/B2 value of 0.70 will be applied to taxes that vary based exclusively on regional variations, and enacted and in effect prior to November 24, 1992, to permit such variations.

(f) *Hold harmless.* A taxpayer will be considered to be held harmless under a tax program if any of the following conditions applies:

(1) The State (or other unit of government) imposing the tax provides for a direct or indirect non-Medicaid payment to those providers or others paying the tax and the payment amount is positively correlated to either the tax amount or to the difference between the Medicaid payment and the tax amount. A positive correlation includes any positive relationship between these variables, even if not consistent over time.

(2) All or any portion of the Medicaid payment to the taxpayer varies based only on the tax amount, including where Medicaid payment is conditional on receipt of the tax amount.

(3) The State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount.

(i)(A) An indirect guarantee will be determined to exist under a two prong ''guarantee'' test. If the health care-related tax or taxes on each health care class are applied at a rate that produces revenues less than or equal to 6 percent of the revenues received by the taxpayer, the tax or taxes are permissible under this test. The phrase ''revenues received by the taxpayer'' refers to the net patient revenue attributable to the assessed permissible class of health care items or services. However, for the period of January 1, 2008 through September 30, 2011, the applicable percentage of net patient service revenue is 5.5 percent. Compliance in State fiscal year 2008 will be evaluated from January 1, 2008 through the last day of State fiscal year 2008. Beginning with State fiscal year 2009 the 5.5 percent tax collection will be measured on an annual State fiscal year basis.

(B) When the tax or taxes produce revenues in excess of the applicable

percentage of the revenue received by the taxpayer, CMS will consider an indirect hold harmless provision to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments. The second prong of the indirect hold harmless test is applied in the aggregate to all health care taxes applied to each class. If this standard is violated, the amount of tax revenue to be offset from medical assistance expenditures is the total amount of the taxpayers' revenues received by the State.

(ii) [Reserved]

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43181, Aug. 13, 1993; 62 FR 53572, Oct. 15, 1997; 73 FR 9698, Feb. 22, 2008]

§ 433.70 Limitation on level of FFP for revenues from health care-related taxes.

(a) *Limitations.* Beginning October 1, 1995, there is no limitation on the amount of health care-related taxes that a State may receive without a reduction in FFP, as long as the health care-related taxes meet the requirements specified in § 433.68.

(b) *Calculation of FFP.* CMS will deduct from a State's medical assistance expenditures, before calculating FFP, revenues from health care-related taxes that do not meet the requirements of § 433.68 and any health care-related taxes in excess of the limits specified in paragraph (a)(1) of this section.

[57 FR 55138, Nov. 24, 1992, as amended at 73 FR 9699, Feb. 22, 2008]

§ 433.72 Waiver provisions applicable to health care-related taxes.

(a) *Bases for requesting waiver.* (1) A State may submit to CMS a request for a waiver if a health care-related tax does not meet any or all of the following:

(i) The tax does not meet the broad based criteria specified in § 433.68c); and/or

(ii) The tax is not imposed uniformly but meets the criteria specified in § 433.68(d)(2) or (d)(3).

(2) When a tax that meets the criteria specified in paragraph (a)(1) of this section is imposed on more than one class of health care items or services, a separate waiver must be obtained for each class of health care items and services subject to the tax.

(b) *Waiver conditions.* In order for CMS to approve a waiver request that would permit a State to receive tax revenue (within specified limitations) without a reduction in FFP, the State must demonstrate, to CMS's satisfaction, that its tax program meets all of the following requirements:

(1) The net impact of the tax and any payments made to the provider by the State under the Medicaid program is generally redistributive, as described in § 433.68(e);

(2) The amount of the tax is not directly correlated to Medicaid payments; and

(3) The tax program does not fall within the hold harmless provisions specified in § 433.68(f).

(c) *Effective date.* A waiver will be effective:

(1) The date of enactment of the tax for programs in existence prior to August 13, 1993 or;

(2) For tax programs commencing on or after August 13, 1993, on the first day in the quarter in which the waiver is received by CMS.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43182, Aug. 13, 1993]

§ 433.74 Reporting requirements.

(a) Beginning with the first quarter of Federal fiscal year 1993, each State must submit to CMS quarterly summary information on the source and use of all provider-related donations (including all bona fide and presumed-to-be bona fide donations) received by the State or unit of local government, and health care-related taxes collected. Each State must also provide any additional information requested by the Secretary related to any other donations made by, or any taxes imposed on, health care providers. States' reports must present a complete, accurate, and full disclosure of all of their donation and tax programs and expenditures.

(b) Each State must provide the summary information specified in paragraph (a) of this section on a quarterly basis in accordance with procedures established by CMS.

(c) Each State must maintain, in readily reviewable form, supporting documentation that provides a detailed description and legal basis for each donation and tax program being reported, as well as the source and use of all donations received and taxes collected. This information must be made available to Federal reviewers upon request.

(d) If a State fails to comply with the reporting requirements contained in this section, future grant awards will be reduced by the amount of FFP CMS estimates is attributable to the sums raised by tax and donation programs as to which the State has not reported properly, until such time as the State complies with the reporting requirements. Deferrals and/or disallowances of equivalent amounts may also be imposed with respect to quarters for which the State has failed to report properly. Unless otherwise prohibited by law, FFP for those expenditures will be released when the State complies with all reporting requirements.

Subpart C—Mechanized Claims Processing and Information Retrieval Systems

§ 433.110 Basis, purpose, and applicability.

(a) This subpart implements the following sections of the Act:

(1) Section 1903(a)(3) of the Act, which provides for FFP in State expenditures for the design, development, or installation of mechanized claims processing and information retrieval systems and for the operation of certain systems. Additional HHS regulations and CMS procedures for implementing these regulations are in 45 CFR part 75, 45 CFR part 95, subpart F, and part 11, State Medicaid Manual; and

(2) Section 1903(r) of the Act, which imposes certain standards and conditions on mechanized claims processing and information retrieval systems (including eligibility determination systems) in order for these systems to be eligible for Federal funding under section 1903(a) of the Act.

(b) [Reserved]

[50 FR 30846, July 30, 1985, as amended at 54 FR 41973, Oct. 13, 1989; 76 FR 21973, Apr. 19, 2011; 80 FR 75841, Dec. 4, 2015]

§ 433.111 Definitions.

For purposes of this section:

(a) The following terms are defined at 45 CFR part 95, subpart F § 95.605:

''Advance Planning Document''; ''Design'' or ''System Design''; ''Development''; ''Enhancement''; ''Hardware''; ''Installation''; ''Operation''; and, ''Software''.

(b) ''Mechanized claims processing and information retrieval system'' means:

(1) ''Mechanized claims processing and information retrieval system'' means the system of software and/or hardware used to process claims for medical assistance and to retrieve and produce service utilization and management information required by the Medicaid single state agency and Federal government for program administration and audit purposes. It may include modules of hardware, software, and other technical capabilities that are used by the Medicaid Single State Agency to manage, monitor, and administer the Medicaid enterprise, including transaction processing, information management, and reporting and data analytics.

(2) ''Mechanized claims processing and information retrieval system'' includes a ''System of Systems.'' Under this definition all modules or systems developed to support a Medicaid Management Information System (MMIS) and Eligibility and Enrollment (E&E) may be implemented as discrete, independent, interoperable elements. Use of a System of Systems requires interoperability between the systems.

(i) The system consists of—

(A) Required modules specified by the Secretary.

(B) Required changes to the system or required module that are specified by the Secretary.

(C) Approved enhancements to the system or module.

(ii) A ''Mechanized claims processing and information retrieval system'' include—s—

(A) An Eligibility and Enrollment (E&E) System which is used to process applications from Medicaid or CHIP applicants and beneficiaries to determine eligibility for enrollment in the Medicaid or CHIP programs, as well as

change in circumstance updates and renewals; and

(B) A Medicaid Management Information System (MMIS) which is used to process claims for Medicaid payment from providers of medical care and services furnished to beneficiaries under the medical assistance program and to perform other functions necessary for economic and efficient operations, management, monitoring, and administration of the Medicaid program. The pertinent business areas are those included in the MMIS Certification Toolkit, and they may be applicable to Fee-For-Service, Managed Care, or an Administrative Services Organization (ASO) model.

(c) ''Medicaid Information Technology Architecture (MITA)'' is defined at § 495.302 of this chapter.

(d) ''Open source'' means software that can be used freely, changed, and shared (in modified or unmodified form) by anyone. Open source software is distributed under Open Source Initiative-approved licenses that comply with an open source framework that allows for free redistribution, provision of the source code, allowance for modifications and derived works, free and open distribution of licenses without restrictions and licenses that are technology-neutral.

(e) ''Proprietary'' means a closed source product licensed under exclusive legal right of the copyright holder with the intent that the licensee is given the right to use the software only under certain conditions, and restricted from other uses, such as modification, sharing, studying, redistribution, or reverse engineering.

(f) ''Service'' means a self-contained unit of functionality that is a discretely invokable operation. Services can be combined to provide the functionality of a large software application.

(g) ''Shared Service'' means the use of a service, including SaaS, by one part of an organization or group, including states, where that service is also made available to other entities of the organization, group or states. Thus the funding and resourcing of the service is shared and the providing department effectively becomes an internal service provider.

(h) ''Module'' means a packaged, functional business process or set of processes implemented through software, data, and interoperable interfaces that are enabled through design principles in which functions of a complex system are partitioned into discrete, scalable, reusable components.

(i) ''Commercial Off the Shelf'' (COTS) software means specialized software (which could be a system, subsystem or module) designed for specific applications that is available for sale or lease to other users in the commercial marketplace, and that can be used with little or no modification.

(j) ''Software-as-a-Service'' (SaaS) means a software delivery model in which software is managed and licensed by its vendor-owner on a pay-for-use or subscription basis, centrally hosted, on-demand, and common to all users.

[51 FR 45330, Dec. 18, 1986, as amended at 54 FR 41973, Oct. 13, 1989; 76 FR 21973, Apr. 19, 2011; 80 FR 75841, Dec. 4, 2015]

§ 433.112 FFP for design, development, installation or enhancement of mechanized processing and information retrieval systems.

(a) Subject to paragraph (c) of this section, FFP is available at the 90 percent rate in State expenditures for the design, development, installation, or enhancement of a mechanized claims processing and information retrieval system only if the APD is approved by CMS prior to the State's expenditure of funds for these purposes.

(b) CMS will approve the E&E or claims system described in an APD if certain conditions are met. The conditions that a system must meet are:

(1) CMS determines the system is likely to provide more efficient, economical, and effective administration of the State plan.

(2) The system meets the system requirements, standards and conditions, and performance standards in Part 11 of the State Medicaid Manual, as periodically amended.

(3) The system is compatible with the claims processing and information retrieval systems used in the administration of Medicare for prompt eligibility verification and for processing claims for persons eligible for both programs.

(4) The system supports the data requirements of quality improvement organizations established under Part B of title XI of the Act.

(5) The State owns any software that is designed, developed, installed or improved with 90 percent FFP.

(6) The Department has a royalty free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use and authorize others to use, for Federal Government purposes, software, modifications to software, and documentation that is designed, developed, installed or enhanced with 90 percent FFP.

(7) The costs of the system are determined in accordance with 2 CFR parts 200 and 300, subpart E.

(8) The Medicaid agency agrees in writing to use the system for the period of time specified in the advance planning document approved by CMS or for any shorter period of time that CMS determines justifies the Federal funds invested.

(9) The agency agrees in writing that the information in the system will be safeguarded in accordance with subpart F, part 431 of this subchapter.

(10) Use a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces; the separation of business rules from core programming, available in both human and machine readable formats.

(11) Align to, and advance increasingly, in MITA maturity for business, architecture, and data.

(12) The agency ensures alignment with, and incorporation of, standards and implementation specifications for health information technology adopted by the Office of the National Coordinator for Health IT in 45 CFR part 170, subpart B. The agency also ensures alignment with: the HIPAA privacy, security, breach notification and enforcement regulations in 45 CFR parts 160 and 164; and the transaction standards and operating rules adopted by the Secretary under HIPAA and/or section 1104 of the Affordable Care Act. The agency meets accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with Federal civil rights laws; standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act; standards and protocols for reporting on the Child and Adult Core Sets as adopted by the Secretary under sections 1139A, 1139B, and 1902(a)(6) of the Act, and 42 CFR part 437 subpart A; and standards and protocols for reporting on the Health Home Core Sets as adopted by the Secretary under sections 1902(a)(6), 1945(c)(4)(B) and (g), and 1945A(g) of the Act and 42 CFR part 437 subpart A.

(13) Promote sharing, leverage, and reuse of Medicaid technologies and systems within and among States.

(14) Support accurate and timely processing and adjudications/eligibility determinations and effective communications with providers, beneficiaries, and the public.

(15) Produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.

(16) The system supports seamless coordination and integration with the Marketplace, the Federal Data Services Hub, and allows interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services as applicable.

(17) For E&E systems, the State must have delivered acceptable MAGI-based system functionality, demonstrated by performance testing and results based on critical success factors, with limited mitigations and workarounds.

(18) The State must submit plans that contain strategies for reducing the operational consequences of failure to meet applicable requirements for all major milestones and functionality.

(19) The agency, in writing through the APD, must identify key state personnel by name, type and time commitment assigned to each project.

(20) Systems and modules developed, installed or improved with 90 percent match must include documentation of components and procedures such that the systems could be operated by a variety of contractors or other users.

(21) For software systems and modules developed, installed or improved with 90 percent match, the State must consider strategies to minimize the costs and difficulty of operating the software on alternate hardware or operating systems.

(22) Other conditions for compliance with existing statutory and regulatory requirements, issued through formal guidance procedures, determined by the Secretary to be necessary to update and ensure proper implementation of those existing requirements.

(c)(1) FFP is available at 90 percent of a State's expenditures for the design, development, installation or enhancement of an E&E system that meets the requirements of this subpart and only for costs incurred for goods and services provided on or after April 19, 2011.

(2) Design, development, installation, or enhancement costs include costs for initial licensing of commercial off the shelf (COTS) software, and the minimum necessary costs to analyze the suitability of COTS software, install, configure and integrate the COTS software, and modify non-COTS software to ensure coordination of operations. The nature and extent of such costs must be expressly described in the approved APD.

[43 FR 45201, Sept. 29, 1978, as amended at 44 FR 17937, Mar. 23, 1979; 45 FR 14213, Mar. 5, 1980; 50 FR 30846, July 30, 1985; 51 FR 45330, Dec. 18, 1986; 54 FR 41973, Oct. 13, 1989; 55 FR 1820, Jan. 19, 1990; 55 FR 4375, Feb. 7, 1990; 76 FR 21973, Apr. 19, 2011; 80 FR 75842, Dec. 4, 2015; 81 FR 3011, Jan. 20, 2016; 88 FR 60312, Aug. 31, 2023; 89 FR 80069, Oct. 2, 2024]

§ 433.114 Procedures for obtaining initial approval; notice of decision.

(a) To obtain initial approval, the Medicaid agency must inform CMS in writing that the system meets the conditions specified in § 433.116(c) through (i).

(b) If CMS disapproves the system, the notice will include all of the following information:

(1) The findings of fact upon which the determination was made.

(2) The procedures for appeal of the determination in the context of a reconsideration of the resulting disallowance to the Departmental Appeals Board.

[50 FR 30847, July 30, 1985, as amended at 54 FR 41973, Oct. 13, 1989; 76 FR 21974, Apr. 19, 2011]

§ 433.116 FFP for operation of mechanized claims processing and information retrieval systems.

(a) Subject to paragraph (j) of this section, FFP is available at 75 percent of expenditures for operation of a mechanized claims processing and information retrieval system approved by CMS, from the first day of the calendar quarter after the date the system met the conditions of initial approval, as established by CMS (including a retroactive adjustment of FFP if necessary to provide the 75 percent rate beginning on the first day of that calendar quarter). Subject to 45 CFR 95.611(a), the State shall obtain prior written approval from CMS when it plans to acquire ADP equipment or services, when it anticipates the total acquisition costs will exceed thresholds, and meets other conditions of the subpart.

(b) CMS will approve enhanced FFP for system operations if the conditions specified in paragraphs (c) through (i) of this section are met.

(c) The conditions of § 433.112(b)(1) through (22) must be met at the time of approval.

(d) The system must have been operating continuously during the period for which FFP is claimed.

(e) The system must provide individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan.

(f) The notice required by paragraph (e) of this section—

(1) Must specify—

(i) The service furnished;

(ii) The name of the provider furnishing the service;

(iii) The date on which the service was furnished; and

(iv) The amount of the payment made under the plan for the service; and

(2) Must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential.

(g) The system must provide both patient and provider profiles for program management and utilization review purposes.

(h) If the State has a Medicaid fraud control unit certified under section 1903(q) of the Act and §455.300 of this chapter, the Medicaid agency must have procedures to assure that information on probable fraud or abuse that is obtained from, or developed by, the system is made available to that unit. (See §455.21 of this chapter for State plan requirements.)

(i) The standards and conditions of §433.112(b)(10) through (b)(16) of this subpart must be met.

(j) Beginning, and no earlier than, April 19, 2011, FFP is available at 75 percent of a State's expenditures for the operation of an E&E system that meets the requirements of this subpart. FFP is not available for E&E systems that do not meet the standards and conditions.

[45 FR 14213, Mar. 5, 1980. Redesignated and amended at 50 FR 30847, July 30, 1985; 55 FR 4375, Feb. 7, 1990; 76 FR 21974, Apr. 19, 2011; 80 FR 75842, Dec. 4, 2015]

§433.117 Initial approval of replacement systems.

(a) A replacement system must meet all standards and conditions of initial approval of a mechanized claims processing and information retrieval system.

(b) The agency must submit a APD that includes—

(1) The date the replacement system will be in operation; and

(2) A plan for orderly transition from the system being replaced to the replacement system.

(c) FFP is available at—

(1) 90 percent in expenditures for design, development, and installation in accordance with the provisions of §433.112; and

(2) 75 percent in expenditures for operation of an approved replacement system in accordance with the provisions of §433.116(b) through (j), from the date that the system met the conditions of initial approval, as established by CMS.

(d) FFP is available at 75 percent in expenditures for the operation of an approved system that is being replaced (or at a reduced rate determined under §433.120 of this subpart for a system that has been disapproved) until the replacement system is in operation and approved.

[50 FR 30847, July 30, 1985, as amended at 76 FR 21974, Apr. 19, 2011]

§433.119 Conditions for reapproval; notice of decision.

(a) CMS periodically reviews each system operation initially approved under §433.114 of this subpart and reapproves it for FFP at 75 percent of expenditures if the following standards and conditions are met:

(1) The system meets the requirements of §433.112(b)(1), (3), (4), and (7) through (22).

(2) The system meets the conditions of §433.116 (d) through (j).

(3) The system meets the standards, conditions, and performance standards for reapproval and the system requirements in part 11 of the State Medicaid Manual as periodically amended.

(4) A State system must meet all of the requirements of this subpart within the appropriate period CMS determines should apply as required by §433.123(b) of this subpart.

(b) CMS may review an entire system operation or focus its review on parts of the operation. However, at a minimum, CMS will review standards, system requirements and other conditions of reapproval that have demonstrated weakness in a previous review or reviews.

(c) After performing the review under paragraph (a) of this section, CMS will issue to the Medicaid agency a written notice informing the agency whether the system is reapproved or disapproved. If the system is disapproved, the notice will include the following information:

(1) CMS's decision to reduce FFP for system operations from 75 percent to 50 percent of expenditures, beginning with the first day of the first calendar quarter after CMS issues the written notice to the State.

(2) The findings of fact upon which the determination was made.

(3) A statement that State claims in excess of the reduced FFP rate will be

disallowed and that any such disallowance will be appealable to the Departmental Appeals Board.

[54 FR 41973, Oct. 13, 1989; 55 FR 1820, Jan. 19, 1990; 76 FR 21974, Apr. 19, 2011; 80 FR 75843, Dec. 4, 2015]

§ 433.120 Procedures for reduction of FFP after reapproval review.

(a) If CMS determines after the reapproval review that the system no longer meets the conditions for reapproval in § 433.119, CMS may reduce FFP for certain expenditures for system operations.

(b) CMS may reduce FFP from 75 percent to 50 percent for expenditures related to the operations of non-compliant functionality or system components.

[80 FR 75843, Dec. 4, 2015]

§ 433.121 Reconsideration of the decision to reduce FFP after reapproval review.

(a) The State Medicaid agency may appeal (to the Departmental Appeals Board under 45 CFR part 16) a disallowance concerning a reduction in FFP claimed for system operations caused by a disapproval of the State's system.

(b) The decisions concerning whether to restore any FFP retroactively and the actual number of quarters for which FFP will be restored under § 433.122 of this subpart are not subject to administrative appeal to the Departmental Appeals Board under 45 CFR part 16.

(c) An agency's request for a reconsideration before the Board under paragraph (a) of this section does not delay implementation of the reduction in FFP. However, any reduction is subject to retroactive adjustment if required by the Board's determination on reconsideration.

[50 FR 30848, July 30, 1985, as amended at 54 FR 41974, Oct. 13, 1989; 55 FR 1820, Jan. 19, 1990; 76 FR 21974, Apr. 19, 2011]

§ 433.122 Reapproval of a disapproved system.

When FFP has been reduced under § 433.120(a), and CMS determines upon subsequent review that the system meets all current performance standards, system requirements and other conditions of reapproval, the following provisions apply:

(a) CMS will resume FFP in expenditures for system operations at the 75 percent level beginning with the quarter following the review determination that the system again meets conditions of reapproval.

(b) CMS may retroactively waive a reduction of FFP in expenditures for system operations if CMS determines that the waiver could improve the administration of the State Medicaid plan. However, CMS cannot waive this reduction for any quarter before the fourth quarter immediately preceding the quarter in which CMS issues the determination (as part of the review process) stating that the system is reapproved.

[54 FR 41974, Oct. 13, 1989]

§ 433.123 Notification of changes in system requirements, performance standards or other conditions for approval or reapproval.

(a) Whenever CMS modifies system requirements or other conditions for approval under § 433.112 or § 433.116, CMS will—

(1) Publish a notice in the FEDERAL REGISTER making available the proposed changes for public comment;

(2) Respond in a subsequent FEDERAL REGISTER notice to comments received; and

(3) Issue the new or modified requirements or conditions in the State Medicaid Manual.

(b) For changes in system requirements or other conditions for approval, CMS will allow an appropriate period for Medicaid agencies to meet the requirement determining this period on the basis of the requirement's complexity and other relevant factors.

(c) Whenever CMS modifies performance standards and other conditions for reapproval under § 433.119, CMS will notify Medicaid agencies at least one calendar quarter before the review period to which the new or modified standards or conditions apply.

[57 FR 38782, Aug. 27, 1992]

§ 433.127 Termination of FFP for failure to provide access to claims processing and information retrieval systems.

CMS will terminate FFP at any time if the Medicaid agency fails to provide State and Federal representatives with full access to the system, including on-site inspection. CMS may request such access at any time to determine whether the conditions in this subpart are being met.

[43 FR 45201, Sept. 29, 1978. Redesignated and amended at 50 FR 30847 and 30848, July 30, 1985]

§ 433.131 Waiver for noncompliance with conditions of approval and reapproval.

If a State is unable to comply with the conditions of approval or of reapproval and the noncompliance will cause a percentum reduction in FFP, CMS will waive the FFP reduction in the following circumstances:

(a) *Good cause.* If CMS determines that good cause existed, CMS will waive the FFP reduction attributable to those items for which the good cause existed. A waiver of FFP consequences of the failure to meet the conditions of approval or reapproval based upon good cause will not extend beyond two consecutive quarters.

(b) *Circumstances beyond the control of a State.* The State must satisfactorily explain the circumstances that are beyond its control. When CMS grants the waiver, CMS will also defer all other system deadlines for the same length of time that the waiver applies.

(c) *Waiver of deadline.* In no case will CMS waive the December 31, 2015 deadlines referenced in § 433.112(c) and § 433.116(j).

[50 FR 30848, July 30, 1985, as amended at 54 FR 41974, Oct. 13, 1989; 76 FR 21975, Apr. 19, 2011]

Subpart D—Third Party Liability

SOURCE: 45 FR 8984, Feb. 11, 1980, unless otherwise noted.

§ 433.135 Basis and purpose.

This subpart implements sections 1902(a)(25), 1902(a)(45), 1903(d)(2), 1903(o), 1903(p), and 1912 of the Act by setting forth State plan requirements concerning—

(a) The legal liability of third parties to pay for services provided under the plan;

(b) Assignment to the State of an individual's rights to third party payments; and

(c) Cooperative agreements between the Medicaid agency and other entities for obtaining third party payments.

[50 FR 46664, Nov. 12, 1985]

§ 433.136 Definitions.

For purposes of this subpart—

Private insurer means:

(1) Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated insurance contracts and indemnity contracts);

(2) Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for services included in the State plan; and

(3) Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.

Third party means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.

Title IV-D agency means the organizational unit in the State that has the responsibility for administering or supervising the administration of a State plan for child support enforcement under title IV-D of the Act.

[49 FR 8984, Feb. 11, 1980, as amended at 50 FR 46664, Nov. 12, 1985; 50 FR 49389, Dec. 2, 1985]

§ 433.137 State plan requirements.

(a) A State plan must provide that the requirements of §§ 433.138 and 433.139 are met for identifying third parties liable for payment of services under the plan and for payment of claims involving third parties.

(b) A State plan must provide that—

(1) The requirements of §§ 433.145 through 433.148 are met for assignment

of rights to benefits, cooperation with the agency in obtaining medical support or payments, and cooperation in identifying and providing information to assist the State in pursuing any liable third parties; and

(2) The requirements of §§ 433.151 through 433.154 are met for cooperative agreements and incentive payments for third party collections.

(c) The requirements of paragraph (b)(1) of this section relating to assignment of rights to benefits and cooperation in obtaining medical support or payments and paragraph (b)(2) of this section are effective for medical assistance furnished on or after October 1, 1984. The requirements of paragraph (b)(1) of this section relating to cooperation in identifying and providing information to assist the State in pursuing liable third parties are effective for medical assistance furnished on or after July 1, 1986.

[50 FR 46665, Nov. 12, 1985, as amended at 55 FR 48606, Nov. 21, 1990; 55 FR 52130, Dec. 19, 1990; 60 FR 35502, July 10, 1995]

§ 433.138 Identifying liable third parties.

(a) *Basic provisions.* The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (k) of this section, unless waived under paragraph (l) of this section.

(b) *Obtaining health insurance information: Initial application and redetermination processes for Medicaid eligibility.* (1) If the Medicaid agency determines eligibility for Medicaid, it must, during the initial application and each redetermination process, obtain from the applicant or beneficiary such health insurance information as would be useful in identifying legally liable third party resources so that the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f). Health insurance information may include, but is not limited to, the name of the policy holder, his or her relationship to the applicant or beneficiary, the social security number (SSN) of the policy holder, and the name and address of insurance company and policy number.

(2) If Medicaid eligibility is determined by the Federal agency administering the supplemental security income program under title XVI in accordance with a written agreement under section 1634 of the Act, the Medicaid agency must take the following action. It must enter into an agreement with CMS or must have, prior to February 1, 1985, executed a modified section 1634 agreement that is still in effect to provide for—

(i) Collection, from the applicant or beneficiary during the initial application and each redetermination process, of health insurance information in the form and manner specified by the Secretary; and

(ii) Transmittal of the information to the Medicaid agency.

(3) If Medicaid eligibility is determined by any other agency in accordance with a written agreement, the Medicaid agency must modify the agreement to provide for—

(i) Collection, from the applicant or beneficiary during the initial application and each redetermination process, of such health insurance information as would be useful in identifying legally liable third party resources so that the Medicaid agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f). Health insurance information may include, but is not limited to, those elements described in paragraph (b)(1) of this section; and

(ii) Transmittal of the information to the Medicaid agency.

(c) *Obtaining other information.* Except as provided in paragraph (l) of this section, the agency must, for the purpose of implementing the requirements in paragraphs (d)(1)(ii) and (d)(4)(i) of this section, incorporate into the eligibility case file the names and SSNs of absent or custodial parents of Medicaid beneficiaries to the extent such information is available.

(d) *Exchange of data.* Except as provided in paragraph (l) of this section, to obtain and use information for the purpose of determining the legal liability of the third parties so that the agency may process claims under the

third party liability payment procedures specified in §433.139(b) through (f), the agency must take the following actions:

(1) Except as specified in paragraph (d)(2) of this section, as part of the data exchange requirements under §435.945 of this chapter, from the State wage information collection agency (SWICA) defined in §435.4 of this chapter and from the SSA wage and earnings files data as specified in §435.948(a)(1) of this chapter, the agency must—

(i) Use the information that identifies Medicaid beneficiaries that are employed and their employer(s); and

(ii) Obtain and use, if their names and SSNs are available to the agency under paragraph (c) of this section, information that identifies employed absent or custodial parents of beneficiaries and their employer(s).

(2) If the agency can demonstrate to CMS that it has an alternate source of information that furnishes information as timely, complete and useful as the SWICA and SSA wage and earnings files in determining the legal liability of third parties, the requirements of paragraph (d)(1) of this section are deemed to be met.

(3) The agency must request, as required under §435.948(a)(2) of this chapter, from the State title IV–A agency, information not previously reported that identifies those Medicaid beneficiaries who are employed and their employer(s).

(4) Except as specified in paragraph (d)(5) of this section, the agency must attempt to secure agreements (to the extent permitted by State law) to provide for obtaining—

(i) From State Workers' Compensation or Industrial Accident Commission files, information that identifies Medicaid beneficiaries and, (if their names and SSNs were available to the agency under paragraph (c) of this section) absent or custodial parents of Medicaid beneficiaries with employment-related injuries or illnesses; and

(ii) From State Motor Vehicle accident report files, information that identifies those Medicaid beneficiaries injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists.

(5) If unable to secure agreements as specified in paragraph (d)(4) of this section, the agency must submit documentation to the regional office that demonstrates the agency made a reasonable attempt to secure these agreements. If CMS determines that a reasonable attempt was made, the requirements of paragraph (d)(4) of this section are deemed to be met.

(e) *Diagnosis and trauma code edits.* Except as specified under paragraph (l) of this section, the agency must take action to identify those paid claims for Medicaid beneficiaries that contain diagnosis codes that are indicative of trauma, or injury, poisoning, and other consequences of external causes, for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in §433.139(b) through (f).

(f) *Data exchanges and trauma code edits: Frequency.* Except as provided in paragraph (l) of this section, the agency must conduct the data exchanges required in paragraphs (d)(1) and (3) of this section, and diagnosis and trauma edits required in paragraphs (d)(4) and (e) of this section on a routine and timely basis. The State plan must specify the frequency of these activities.

(g) *Followup procedures for identifying legally liable third party resources.* Except as provided in paragraph (l) of this section, the State must meet the requirements of this paragraph.

(1) *SWICA, SSA wage and earnings files, and title IV-A data exchanges.* With respect to information obtained under paragraphs (d)(1) through (d)(3) of this section—

(i) Within 45 days, the agency must follow up (if appropriate) on such information to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in §433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting

the requirements of paragraph (g)(1)(i) of this section.

(2) *Health insurance information and workers' compensation data exchanges.* With respect to information obtained under paragraphs (b) and (d)(4)(i) of this section—

(i) Within 60 days, the agency must followup on such information (if appropriate) in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(2)(i) of this section.

(3) *State motor vehicle accident report file data exchanges.* With respect to information obtained under paragraph (d)(4)(ii) of this section—

(i) The State plan must describe the methods the agency uses for following up on such information in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify timeframes for incorporation of the information.

(4) *Diagnosis and trauma code edits.* With respect to the paid claims identified under paragraph (e) of this section—

(i) The State plan must describe the methods the agency uses to follow up on such claims in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f) (Methods must include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes.);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify the timeframes for incorporation of the information.

(h) *Obtaining other information and data exchanges: Safeguarding information.* (1) The agency must safeguard information obtained from and exchanged under this section with other agencies in accordance with the requirements set forth in part 431, subpart F of this chapter.

(2) Before requesting information from, or releasing information to other agencies to identify legally liable third party resources under paragraph (d) of this section the agency must execute data exchange agreements with those agencies. The agreements, at a minimum, must specify—

(i) The information to be exchanged;

(ii) The titles of all agency officials with the authority to request third party information;

(iii) The methods, including the formats to be used, and the timing for requesting and providing the information;

(iv) The safeguards limiting the use and disclosure of the information as required by Federal or State law or regulations; and

(v) The method the agency will use to reimburse reasonable costs of furnishing the information if payment is requested.

(i) *Reimbursement.* The agency must, upon request, reimburse an agency for the reasonable costs incurred in furnishing information under this section to the Medicaid agency.

(j) *Reports.* The agency must provide such reports with respect to the data exchanges and trauma code edits set forth in paragraphs (d)(1) through (d)(4) and paragraph (e) of this section, respectively, as the Secretary prescribes for the purpose of determining compliance under § 433.138 and evaluating the effectiveness of the third party liability identification system. However, if the State is not meeting the provisions of paragraph (e) of this section because it has been granted a waiver of those

provisions under paragraph (l) of this section, it is not required to provide the reports required in this paragraph.

(k) *Integration with the State mechanized claims processing and information retrieval system. Basic requirement—Development of an action plan.* (1) If a State has a mechanized claims processing and information retrieval system approved by CMS under subpart C of this part, the agency must have an action plan for pursuing third party liability claims and the action plan must be integrated with the mechanized claims processing and information retrieval system.

(2) The action plan must describe the actions and methodologies the State will follow to—

(i) Identify third parties;

(ii) Determine the liability of third parties;

(iii) Avoid payment of third party claims as required in § 433.139;

(iv) Recover reimbursement from third parties after Medicaid claims payment as required in § 433.139; and,

(v) Record information and actions relating to the action plan.

(3) The action plan must be consistent with the conditions for reapproval set forth in § 433.119. The portion of the plan which is integrated with MMIS is monitored in accordance with those conditions and if the conditions are not met; it is subject to FFP reduction in accordance with procedures set forth in § 433.120. The State is not subject to any other penalty as a result of other monitoring, quality control, or auditing requirements for those items in the action plan.

(4) The agency must submit its action plan to the CMS Regional Office within 120 days from the date CMS issues implementing instructions for the State Medicaid Manual. If a State does not have an approved MMIS on the date of issuance of the State Medicaid Manual but subsequently implements an MMIS, the State must submit its action plan within 90 days from the date the system is operational. The CMS Regional Office approves or disapproves the action plan.

(l) *Waiver of requirements.* (1) The agency may request initial and continuing waiver of the requirements to determine third party liability found in paragraphs (c), (d)(4), (d)(5), (e), (f), (g)(1), (g)(2), (g)(3), and (g)(4) of this section if the State determines the activity to be not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the CMS regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are claims recovery data and a State analysis documenting a cost-effective alternative that accomplished the same task.

(iii) The agency must agree, if a waiver is granted, to notify CMS of any event that occurs that changes the conditions upon which the waiver was approved.

(2) CMS will review a State's request to have a requirement specified under paragraph (l)(1) of this section waived and will request additional information from the State, if necessary. CMS will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) CMS may rescind a waiver at any time that it determines that the agency no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

[52 FR 5975, Feb. 27, 1987, as amended at 54 FR 8741, Mar. 2, 1989; 55 FR 1432, Jan. 16, 1990; 55 FR 5118, Feb. 13, 1990; 60 FR 35502, July 10, 1995; 81 FR 27853, May 6, 2016; 81 FR 86449, Nov. 30, 2016]

§ 433.139 Payment of claims.

(a) *Basic provisions.* (1) For claims involving third party liability that are processed on or after May 12, 1986, the agency must use the procedures specified in paragraphs (b) through (f) of this section.

(2) The agency must submit documentation of the methods (e.g., cost

avoidance, pay and recover later) it uses for payment of claims involving third party liability to the CMS Regional Office.

(b) *Probable liability is established at the time claim is filed.* Except as provided in paragraph (e) of this section—

(1) If the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

(2) [Reserved]

(3) The agency must pay the full amount allowed under the agency's payment schedule for the claim and seek reimbursement from any liable third party to the limit of legal liability (and for purposes of paragraph (b)(3)(ii) of this section, from a third party, if the third party liability is derived from an absent parent whose obligation to pay support is being enforced by the State title IV-D agency), consistent with paragraph (f) of this section if—

(i) The claim is for preventive pediatric services, including early and periodic screening, diagnosis and treatment services provided for under part 441, subpart B, of this chapter, that are covered under the State plan that requires a State to make payments without regard to third party liability for pediatric preventive services except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services; or

(ii) The claim is for a service covered under the State plan that is provided to an individual on whose behalf child support enforcement is being carried out by the State title IV-D agency. The agency prior to making any payment under this section must assure that the following requirements are met:

(A) The State plan specifies whether or not providers are required to bill the third party.

(B) For child support enforcement services beginning February 9, 2018, the provider certifies that before billing Medicaid, if the provider has billed a third party, the provider has waited up to 100 days after the date of the service and provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care.

(C) The State plan specifies the method used in determining the provider's compliance with the billing requirements.

(c) *Probable liability is not established or benefits are not available at the time claim is filed.* If the probable existence of third party liability cannot be established or third party benefits are not available to pay the beneficiary's medical expenses at the time the claim is filed, the agency must pay the full amount allowed under the agency's payment schedule.

(d) *Recovery of reimbursement.* (1) If the agency has an approved waiver under paragraph (e) of this section to pay a claim in which the probable existence of third party liability has been established and then seek reimbursement, the agency must seek recovery of reimbursement from the third party to the limit of legal liability within 60 days after the end of the month in which payment is made unless the agency has a waiver of the 60-day requirement under paragraph (e) of this section.

(2) Except as provided in paragraph (e) of this section, if the agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid, the agency must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable

third party or benefits become available.

(3) Reimbursement must be sought unless the agency determines that recovery would not be cost effective in accordance with paragraph (f) of this section.

(e) *Waiver of requirements.* (1) The agency may request initial and continuing waiver of the requirements in paragraphs (b)(1), (d)(1), and (d)(2) of this section, if it determines that the requirement is not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the CMS regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are costs associated with billing, claims recovery data, and a State analysis documenting a cost-effective alternative that accomplishes the same task.

(iii) The agency must agree, if a waiver is granted, to notify CMS of any event that occurs that changes the conditions upon which the waiver was approved.

(2) CMS will review a State's request to have a requirement specified under paragraph (e)(1) of this section waived and will request additional information from the State, if necessary. CMS will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) CMS may rescind the waiver at any time that it determines that the State no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

(4) An agency requesting a waiver of the requirements specifically concerning either the 60-day limit in paragraph (d)(1) or (d)(2) of this section must submit documentation of written agreement between the agency and the third party, including Medicare fiscal intermediaries and carriers, that extension of the billing requirement is agreeable to all parties.

(f) *Suspension or termination of recovery of reimbursement.* (1) An agency must seek reimbursement from a liable third party on all claims for which it determines that the amount it reasonably expects to recover will be greater than the cost of recovery. Recovery efforts may be suspended or terminated only if they are not cost effective.

(2) The State plan must specify the threshold amount or other guideline that the agency uses in determining whether to seek recovery of reimbursement from a liable third party, or describe the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

(3) The State plan must also specify the dollar amount or period of time for which it will accumulate billings with respect to a particular liable third party in making the decision whether to seek recovery of reimbursement.

[50 FR 46665, Nov. 12, 1985, as amended at 51 FR 16319, May 2, 1986; 60 FR 35503, July 10, 1995; 62 FR 23140, Apr. 29, 1997; 85 FR 87100, Dec. 31, 2020; 89 FR 79081, Sept. 26, 2024]

§ 433.140 FFP and repayment of Federal share.

(a) FFP is not available in Medicaid payments if—

(1) The agency failed to fulfill the requirements of §§ 433.138 and 433.139 with regard to establishing liability and seeking reimbursement from a third party;

(2) The agency received reimbursement from a liable third party; or

(3) A private insurer would have been obligated to pay for the service except that its insurance contract limits or excludes payments if the individual is eligible for Medicaid.

(b) FFP is available at the 50 percent rate for the agency's expenditures in carrying out the requirements of this subpart.

(c) If the State receives FFP in Medicaid payments for which it receives third party reimbursement, the State must pay the Federal government a

portion of the reimbursement determined in accordance with the FMAP for the State. This payment may be reduced by the total amount needed to meet the incentive payment in § 433.153.

ASSIGNMENT OF RIGHTS TO BENEFITS

§ 433.145 Assignment of rights to benefits—State plan requirements.

(a) A State plan must provide that, as a condition of eligibility, each legally able applicant or beneficiary is required to:

(1) Assign to the Medicaid agency his or her rights, or the rights of any other individual eligible under the plan for whom he or she can legally make an assignment, to medical support and to payment for medical care from any third party;

(2) Cooperate with the agency in establishing the identity of a child's parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in § 435.116 of this chapter (pregnant women), who are exempt from cooperating in establishing the identity of a child's parents and obtaining medical support and payments from, or derived from, the non-custodial parent of a child; and

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(b) A State plan must provide that the requirements for assignments, cooperation in establishing paternity and obtaining support, and cooperation in identifying and providing information to assist the State in pursuing any liable third party under §§ 433.146 through 433.148 are met.

(c) A State plan must provide that the assignment of rights to benefits obtained from an applicant or beneficiary is effective only for services that are reimbursed by Medicaid.

[55 FR 48606, Nov. 21, 1990, as amended at 58 FR 4907, Jan. 19, 1993; 81 FR 86450, Nov. 30, 2016]

§ 433.146 Rights assigned; assignment method.

(a) Except as specified in paragraph (b) of this section, the agency must require the individual to assign to the State—

(1) His own rights to any medical care support available under an order of a court or an administrative agency, and any third party payments for medical care; and

(2) The rights of any other individual eligible under the plan, for whom he can legally make an assignment.

(b) Assignment of rights to benefits may not include assignment of rights to Medicare benefits.

(c) If assignment of rights to benefits is automatic because of State law, the agency may substitute such an assignment for an individual executed assignment, as long as the agency informs the individual of the terms and consequences of the State law.

§ 433.147 Cooperation in establishing the identity of a child's parents and in obtaining medical support and payments and in identifying and providing information to assist in pursuing third parties who may be liable to pay.

(a) *Scope of requirement.* The agency must require the individual who assigns his or her rights to cooperate in—

(1) Except as exempt under § 433.145(a)(2), establishing the identity of a child's parents and obtaining medical support and payments for himself or herself and any other person for whom the individual can legally assign rights; and

(2) Identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan.

(b) *Essentials of cooperation.* As part of a cooperation, the agency may require an individual to—

(1) Appear at a State or local office designated by the agency to provide information or evidence relevant to the case;

(2) Appear as a witness at a court or other proceeding;

(3) Provide information, or attest to lack of information, under penalty of perjury;

(4) Pay to the agency any support or medical care funds received that are covered by the assignment of rights; and

(5) Take any other reasonable steps to assist in establishing paternity and securing medical support and payments, and in identifying and providing information to assist the State in pursuing any liable third party.

(c) *Waiver of cooperation for good cause.* The agency must waive the requirements in paragraphs (a) and (b) of this section if it determines that the individual has good cause for refusing to cooperate.

(1) For establishing the identity of a child's parents or obtaining medical care support and payments, or identifying or providing information to assist the State in pursuing any liable third party for a child for whom the individual can legally assign rights, the agency must find that cooperation is against the best interests of the child.

(2) With respect to obtaining medical care support and payments for an individual and identifying and providing information to assist in pursuing liable third parties in any case not covered by paragraph (c)(1) of this section, the agency must find that cooperation is against the best interests of the individual or the person to whom Medicaid is being furnished because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person.

[45 FR 8984, Feb. 11, 1980, as amended at 55 FR 48606, Nov. 21, 1990; 58 FR 4907, Jan. 19, 1993; 81 FR 86450, Nov. 30, 2016]

§ 433.148 Denial or termination of eligibility.

In administering the assignment of rights provision, the agency must:

(a) Deny or terminate eligibility for any applicant or beneficiary who—

(1) Refuses to assign his own rights or those of any other individual for whom he can legally make an assignment; or

(2) In the case of an applicant, does not attest to willingness to cooperate, and in the case of a beneficiary, refuses to cooperate in establishing the identity of a child's parents, obtaining medical child support and pursuing liable third parties, as required under § 433.147(a) unless cooperation has been waived;

(b) Provide Medicaid to any individual who—

(1) Cannot legally assign his own rights; and

(2) Would otherwise be eligible for Medicaid but for the refusal, by a person legally able to assign his rights, to assign his rights or to cooperate as required by this subpart; and

(c) In denying or terminating eligibility, comply with the notice and hearing requirements of part 431, subpart E of this subchapter.

[45 FR 8984, Feb. 11, 1980, as amended at 81 FR 86450, Nov. 30, 2016]

Cooperative Agreements and Incentive Payments

§ 433.151 Cooperative agreements and incentive payments—State plan requirements.

For medical assistance furnished on or after October 1, 1984—

(a) A State plan must provide for entering into written cooperative agreements for enforcement of rights to and collection of third party benefits with at least one of the following entities: The State title IV-D agency, any appropriate agency of any State, and appropriate courts and law enforcement officials. The agreements must be in accordance with the provisions of § 433.152.

(b) A State plan must provide that the requirements for making incentive payments and for distributing third party collections specified in §§ 433.153 and 433.154 are met.

[50 FR 46665, Nov. 12, 1985; 50 FR 49389, Dec. 2, 1985]

§ 433.152 Requirements for cooperative agreements for third party collections.

(a) Except as specified in paragraph (b) of this section, the State agency may develop the specific terms of cooperative agreements with other agencies as it determines appropriate for individual circumstances.

(b) Agreements with title IV–D agencies must specify that:

(1) The Medicaid agency may not refer a case for medical support enforcement when the following criteria have been met:

(i) The Medicaid referral is based solely upon health care services provided through an Indian Health Program (as defined at 25 U.S.C. 1603(12)), including through the Purchased/Referred Care program, to a child who is eligible for health care services from the Indian Health Service (IHS).

(ii) [Reserved]

(2) The Medicaid agency will provide reimbursement to the IV–D agency only for those child support services performed that are not reimbursable by the Office of Child Support Enforcement under title IV–D of the Act and that are necessary for the collection of amounts for the Medicaid program.

[50 FR 46666, Nov. 12, 1985, as amended at 81 FR 93560, Dec. 20, 2016]

§ 433.153 Incentive payments to States and political subdivisions.

(a) *When payments are required.* The agency must make an incentive payment to a political subdivision, a legal entity of the subdivision such as a prosecuting or district attorney or a friend of the court, or another State that enforces and collects medical support and payments for the agency.

(b) *Amount and source of payment.* The incentive payment must equal 15 percent of the amount collected, and must be made from the Federal share of that amount.

(c) *Payment to two or more jurisdictions.* If more than one State or political subdivision is involved in enforcing and collecting support and payments:

(1) The agency must pay all of the incentive payment to the political subdivision, legal entity of the subdivision, or another State that collected medical support and payments at the request of the agency.

(2) The political subdivision, legal entity or other State that receives the incentive payment must then divide the incentive payment equally with any other political subdivisions, legal entities, or other States that assisted in the collection, unless an alternative allocation is agreed upon by all jurisdictions involved.

§ 433.154 Distribution of collections.

The agency must distribute collections as follows—

(a) To itself, an amount equal to State Medicaid expenditures for the individual on whose right the collection was based.

(b) To the Federal Government, the Federal share of the State Medicaid expenditures, minus any incentive payment made in accordance with § 433.153.

(c) To the beneficiary, any remaining amount. This amount must be treated as income or resources under part 435 or part 436 of this subchapter, as appropriate.

Subpart E—Methodologies for Determining Federal Share of Medicaid Expenditures for Adult Eligibility Group

SOURCE: 78 FR 19942, Apr. 2, 2013, unless otherwise noted.

§ 433.202 Scope.

This subpart sets forth the requirements and procedures that are applicable to support State claims for the increased FMAP specified at § 433.10(c)(6) for the medical assistance expenditures for individuals determined eligible as specified in § 435.119 of this chapter who meet the definition of newly eligible individual specified in § 433.204(a)(1). These procedures will also identify individuals determined eligible as specified in § 435.119 of this chapter for whom the State may claim the regular FMAP rate specified at § 433.10(b) or the increased FMAP rate specified at § 433.10(c)(7) or (8), as applicable.

§ 433.204 Definitions.

(a)(1) *Newly eligible individual* means an individual determined eligible for Medicaid in accordance with the requirements of the adult group described in § 435.119 of this chapter, and who, as determined by the State in accordance with the requirements of § 433.206, would not have been eligible for Medicaid under the State's eligibility standards and methodologies for the Medicaid State plan, waiver or demonstration programs in effect in the State as of December 1, 2009, for full benefits or for benchmark coverage

described in § 440.330(a), (b), or (c) of this chapter or benchmark equivalent coverage described in § 440.335 of this chapter that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in § 440.330(a), (b), or (c) of this chapter, or would have been eligible but not enrolled (or placed on a waiting list) for such benefits or coverage through a waiver under the plan that had a capped or limited enrollment that was full.

(2) *Full benefits* means, for purposes of paragraph (a)(1) of this section, with respect to an adult individual, medical assistance for all services covered under the State plan under Title XIX of the Act that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i) of the Act.

(3) For purposes of establishing under paragraphs (a)(1) and (2) of this section whether an individual would not have been eligible for full benefits, benchmark coverage, or benchmark equivalent coverage under a waiver or demonstration program in effect on December 1, 2009, the State must provide CMS with its analysis, in accordance with guidance issued by CMS, about whether the benefits available under such waiver or demonstration constituted full benefits, benchmark coverage, or benchmark equivalent coverage. CMS will review such analysis and confirm the applicable FMAP. Individuals for whom such benefits or coverage would have been available under such waiver or demonstration are not newly eligible individuals.

(b)(1) *Expansion State* means a State that, as of March 23, 2010, offered health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the Federal Poverty Level. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence will not be considered to be an expansion State. Such health benefits coverage must:

(i) Have included inpatient hospital services;

(ii) Not have been dependent on access to employer coverage, employer contribution, or employment; and

(iii) Not have been limited to premium assistance, hospital-only benefits, a high deductible health plan, or benefits under a demonstration program authorized under section 1938 of the Act.

(2) For purposes of paragraph (b)(1) of this section and for § 433.10(c)(8), a nonpregnant childless adult means an individual who is not eligible based on pregnancy and does not meet the definition of a caretaker relative in § 435.4 of this chapter.

§ 433.206 Threshold methodology.

(a) *Overview.* Effective January 1, 2014, States must apply the threshold methodology described in this paragraph for purposes of determining the appropriate claiming for the Federal share of expenditures at the applicable FMAP rates described in § 433.10(b) and (c) for medical assistance provided with respect to individuals who have been determined eligible for the Medicaid program under § 435.119 of this chapter. Subject to the provisions of this paragraph, States must apply the CMS-approved State specific threshold methodology to determine and distinguish such individuals as newly or not newly eligible individuals in accordance with the definition in § 433.204(a)(1), and in accordance with States' Medicaid eligibility criteria as in effect on December 1, 2009 and to attribute their associated medical expenditures with the appropriate FMAP. The threshold methodology must not be applied by States for the purpose of determining the applicable FMAP for individuals under any other eligibility category other than § 435.119 of this chapter.

(b) *General principles.* The threshold methodology should:

(1) Not impact the timing or approval of an individual's eligibility for Medicaid.

(2) Not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

(3) Provide a valid and accurate accounting of individuals who would have

been eligible in accordance with the December 1, 2009 eligibility standards and applicable eligibility categories for the benefits described in § 433.204(a)(1), and subject to paragraphs (d), (e), and (g) of this section, by incorporating simplified assessments of resources, enrollment cap requirements in place at that time, and other special circumstances as approved by CMS, respectively.

(4) Operate efficiently, without further review once an individual has been determined not to be newly eligible based on the December 1, 2009 standards for any eligibility category.

(c) *Components of the threshold methodology.* Subject to the submission of a threshold methodology State plan amendment as specified in paragraph (h) of this section, the provisions of the threshold methodology consist of two components, the individual income-based determination and population-based non-income adjustments to reflect resource criteria, enrollment caps in effect on December 1, 2009, and other factors in accordance with paragraph (g) of this section.

(1) *Scope.* The threshold methodology shall apply with respect to the population, and the associated expenditures for such population, which has been determined eligible for Medicaid under section 1902(a)(10)(A)(i)(VIII) of the Act and in accordance with § 435.119 of this chapter. This population and associated expenditures must not include individuals who have been determined eligible for Medicaid under any other mandatory or optional eligibility category.

(2) *Benefit criteria for newly eligible.* An individual eligible for and enrolled under § 435.119 of this chapter is considered newly eligible if, with respect to the applicable eligibility category in effect on December 1, 2009, the benefits did not meet the criteria described in the newly eligible definition at § 433.204(a)(1).

(3) *Individual income-based determination.* The individual income-based determination shall be a comparison of the individual's MAGI-based income to the income standard in effect on December 1, 2009, as converted to an equivalent MAGI-based income standard for each applicable eligibility category as in effect on that date, as follows.

(i) The amount of an individual's income under the threshold methodology is the MAGI-based income determined in accordance with § 435.603 of this chapter.

(ii) For each individual, the equivalent MAGI-based income eligibility standard is the applicable income eligibility standard for the applicable category of eligibility as in effect on December 1, 2009 that is converted to an equivalent MAGI-based income standard. For example, as applicable, a separate MAGI-based income standard will be applied for individuals determined to be disabled who would have been eligible under an optional eligibility category in effect on December 1, 2009 that was based on disability. For these purposes, the applicable equivalent MAGI-based standard is the standard as submitted by the State and approved by CMS in accordance with CMS guidance.

(iii) With respect to income eligibility criteria, if the individual's MAGI-based income is at or below the applicable converted MAGI-based income standard for the relevant eligibility category or group, then the individual is included in the population that is not newly eligible;

(iv) With respect to income eligibility criteria, if the individual's MAGI-based income is greater than the applicable converted MAGI-based income standard for the relevant eligibility category or group, then the individual is included in the population that is newly eligible;

(v) *Treatment of spend-down programs.* Treatment of medically needy or spend-down programs under the threshold methodology is described in paragraph (f) of this section.

(vi) For purposes of comparing the individual's MAGI-based income to the applicable converted MAGI-based income standard in effect on December 1, 2009, an individual will not be considered disabled absent an actual disability determination for the individual that is in accordance with the disability definition applicable for the State under Title XIX of the Act.

(4) *Treatment of disability.* For purposes of applying the appropriate FMAP under § 433.10(b) or (c) for the

medical assistance expenditures of an individual in applying the definition of newly eligible under § 433.204(a)(1), for eligibility categories or groups as in effect on December 1, 2009 for which disability was an eligibility criteria:

(i) *During the period of a disability determination.* During the period for which a disability determination is pending, including during the period of any appeal process, and absent an actual disability determination for the individual that is in accordance with the disability definition applicable for the State under Title XIX of the Act, the individual is not considered to be disabled.

(ii) *Following a disability determination.* With respect to an individual for which a disability determination was pending, following the actual determination of disability, the individual will be considered disabled effective with the date of the disability determination, or, if later, the disability onset date, as determined.

(5) *Population-based adjustments to the populations of newly eligible and not newly eligible.* (i) The State may elect a resource criteria proxy adjustment described in paragraph (d) of this section.

(ii) States that had a waiver or demonstration program with an enrollment cap in effect as of December 1, 2009 must apply an adjustment based on enrollment caps, subject to the definition of newly eligible individual in § 433.204(a)(1) and paragraph (e) of this section.

(iii) States that have special circumstances may need to submit associated proxy methodologies to CMS for approval by CMS as described in paragraph (g) of this section.

(6) *Application of FMAP rates to adult group expenditures.* Subject to population adjustments under paragraphs (d), (e), or (g) of this section, federal funding for a State's expenditures for medical assistance provided to individuals determined eligible under § 435.119 of this chapter, including individuals determined eligible under that eligibility group during the evaluation for another eligibility category, must be claimed using the applicable FMAP as follows:

(i) The newly eligible FMAP under § 433.10(c)(6) is applicable for the medical assistance expenditures for individuals determined to be newly eligible, as defined in § 433.204(a)(1).

(ii) The applicable FMAP under § 433.10(b) or § 433.10(c)(7) or (8) is applicable for the medical assistance expenditures for individuals determined not to be newly eligible.

(7) *Status as newly or not newly eligible.* Under the threshold methodology States must provide that once individuals are determined under the threshold methodology to be either newly or not newly eligible individuals in accordance with the applicable December 1, 2009 eligibility criteria, the State would apply that determination until a new determination of MAGI-based income has been made in accordance with § 435.916 of this chapter, or the individual has been otherwise determined not to be covered under the adult group set forth at § 435.119 of this chapter.

(d) *Optional resource criteria proxy adjustment*—(1) *General.* Under an election under this paragraph (d), the State may use a resource proxy methodology for purposes of adjusting the claims for the expenditures of the population enrolled under § 435.119 of this chapter to account for individuals who would not have been eligible for Medicaid because of the application of resource criteria as in effect for such population as of December 1, 2009, and therefore would meet the newly eligible individual definition at § 433.204(a)(1). Under this paragraph (d), a State may elect to apply a resource proxy methodology with respect to the resource criteria as in effect on December 1, 2009 and applied to the expenditures for a specific eligibility category or categories of individuals as in effect on December 1, 2009, or applied to the expenditures of the entire population enrolled under § 435.119 of this chapter. As provided in paragraph (d)(4) of this section, the State must indicate any resource proxy election in the threshold methodology State plan amendment submitted under paragraph (h) of this section. The use of a resource proxy methodology must not delay or interfere with the eligibility determination for an individual.

(2) A State's resource proxy methodology must:

(i) Describe each eligibility group or groups for which an individual eligible under § 435.119 would have been eligible on December 1, 2009, subject to resource criteria, and a methodology to apply those resource criteria as an adjustment to the total expenditures to adjust determinations of the newly eligible population under paragraph (c) of this section.

(ii) Be auditable.

(iii) Be based on statistically valid data, which is either:

(A) Existing State data from and for periods before January 1, 2014 on the resources of individuals who had applied and received a determination with respect to Medicaid eligibility, including resource eligibility under the State's applicable December 1, 2009 eligibility criteria. The existing State data must be specifically related to resource eligibility determinations, indicate the number and types of individuals for whom resource determinations were made, and establish the denial rates specifically identified as due to excess resources; or

(B) Post-eligibility State data on the resources of individuals described in paragraph (d)(2)(iii)(B)(*1*) and (*2*) of this section, based on and obtained through a post-eligibility statistically valid sample of such individuals with respect to the applicable Medicaid eligibility categories and resource eligibility criteria under the State's applicable December 1, 2009 eligibility criteria:

(*1*) State data from and for periods before January 1, 2014 must be for individuals in eligibility categories relevant to § 435.119 of this chapter who apply and receive a determination with respect to Medicaid eligibility, including both approvals and denials, to establish denial rates specifically due to excess resources and identify numbers and types of individuals.

(*2*) State data from and for periods on or after January 1, 2014 must only be for individuals determined eligible and enrolled under § 435.119 of this chapter, must compare individuals' resources to the applicable December 1, 2009 resource criteria to establish denial rates specifically due to excess resources, and identify numbers and types of individuals.

(iv) Describe the State data on individuals' resources used and the application of such data. Whether such State data is based on data described in paragraph (d)(2)(iii)(A) or (B) of this section, such State data must represent sampling results for a period of sufficient length to be statistically valid.

(v) Provide that the resource proxy methodology will account for the treatment of resources in a statistically valid manner when there is a lack of sufficient information to make a resource determination for a particular individual in a sampled population.

(vi) Describe the application of the resource proxy methodology in establishing the amount and submission of claims for Federal funding by the State for the medical assistance expenditures of the applicable eligibility group(s). Such claims submitted under the resource proxy methodology must reflect the appropriate FMAP for the medical assistance expenditures of the affected eligibility group(s).

(vii) As appropriate, describe and demonstrate the statistical validity of the resource proxy methodology and the use of data under such methodology.

(3) *Effective date for application of resource proxy.* The resource proxy shall not be effective prior to the beginning of the quarter in which such resource proxy is submitted to CMS under the threshold methodology State plan in paragraph (h) of this section.

(4) *One time election for resource proxy.* The election, application, and description of a resource proxy methodology under this paragraph for individuals determined eligible under § 435.119 must be included in a one-time submission of a State plan amendment submitted under paragraph (h) of this section no later than one year from the first day of the quarter in which eligibility for individuals under § 435.119 of this chapter is initially effective for the State.

(e) *Enrollment caps adjustment*—(1) *Scope.* Certain States may have applied enrollment caps, limits, or waiting lists in their Medicaid programs as in effect on December 1, 2009. Under the definition of newly eligible individual

in § 433.204(a)(1), such States must consider as newly eligible those individuals eligible under § 435.119 of this chapter who would otherwise be eligible for full benefits, benchmark coverage, or benchmark equivalent coverage provided through a demonstration under the State plan effective December 1, 2009, but would not have been enrolled (or would have been on a waiting list) based on the application of an enrollment cap or limit determined in accordance with the approved demonstration as in effect on that date. Such States must only apply such enrollment cap, limit or waiting list provisions with respect to eligibility category or categories for which such provisions were applicable (for example, nonpregnant childless adults or parents/caretaker relatives) and in effect under the State's Medicaid program on December 1, 2009. For this purpose, individuals who would have been on a waiting list are considered as not enrolled under the demonstration.

(2) A State for which multiple enrollment caps or limits were in effect under its December 1, 2009 Medicaid program may elect to combine such enrollment caps or limits, unless such treatment would preclude claiming of Federal funding at the applicable FMAP rate required under § 433.10(b) or (c) (for example, to distinguish claims for childless adults and parents in an expansion State) for the medical assistance expenditures of individuals determined eligible and enrolled under § 435.119 of this chapter; a State with enrollment cap or limit provisions that would preclude combining enrollment caps or limit provisions must use separate caps; or, the State, at its option, may elect to use separate caps.

(3) For purposes of claiming Federal funding, with respect to each claiming period for which the State claims Federal funding for an eligibility category for which an enrollment cap or limit is applicable and in effect on December 1, 2009, the State must account for:

(i) The total unduplicated number of individuals eligible and enrolled under § 435.119 of this chapter for the applicable claiming period.

(ii) The total State medical assistance expenditures for individuals eligible and enrolled under § 435.119 of this chapter for the applicable claiming period.

(iii) The enrollment cap or limit in effect on December 1, 2009 for the eligibility category, determined in accordance with the approved demonstration as in effect on December 1, 2009.

(A) For States that elect under paragraph (e)(2) of this section to combine the enrollment caps, the enrollment cap is the sum of the enrollment caps for each eligibility group which is being combined.

(B) For States that elect to treat the enrollment caps separately under paragraph (e)(2) of this section, each enrollment cap will be accounted for separately.

(C) The level of the enrollment cap will be as authorized under the demonstration in effect on December 1, 2009; or, if the State had affirmatively set the cap at a lower level consistent with flexibility provided by the demonstration terms and conditions, the State may elect to apply the lower cap as in effect in the State on December 1, 2009. If a State elects to use such an alternate State-specified enrollment cap, the State will provide CMS with evidence, in its State plan amendment submitted to CMS under paragraph (h) of this section, that it had affirmatively implemented such a cap. Whether the State uses the authorized cap or a lower, verifiable cap as in effect in the State consistent with the demonstration special terms and conditions, the amount of expenditures up to the proportion of the 2009 enrollment cap to the total number of currently enrolled people in the group would not be claimed at the newly eligible FMAP.

(4) States for which an enrollment cap, limit, or waiting list was applicable under their Medicaid programs as in effect on December 1, 2009, must describe the treatment of such provision or provisions in the submission to CMS for approval by CMS in accordance with the State plan requirements outlined in § 433.206(h).

(f) *Application of spend-down income eligibility criteria*—(1) *General.* Certain States' Medicaid programs as in effect on December 1, 2009 may have included eligibility categories for which deduction of incurred medical expenses from income (referred to as spend-down)

under the provisions of sections 1902(a)(10)(C) or 1902(f) of the Act was applied in determining individuals' Medicaid eligibility. Paragraphs (f)(2) and (3) of this section apply, for purposes of determining whether an individual enrolled under §435.119 of this chapter meets the definition of newly eligible under §433.204(a)(1), and for purposes of applying the appropriate FMAP under §433.10(b) or (c) for the medical assistance expenditures of the individual for which a spend-down eligibility category of a State effective on December 1, 2009 is applicable.

(2) *Not newly eligible individual.* For purposes of a State's spend-down provision, an individual enrolled under §435.119 of this chapter whose income before the deduction of incurred medical expenses is less than or equal to the applicable December 1, 2009 State spend-down eligibility income level that would have resulted in full benefits is considered not newly eligible. The FMAP applicable for the medical assistance expenditures of such an individual is the appropriate FMAP under §433.10(b) and (c) as applicable for an individual who is not newly eligible.

(3) *Newly eligible individual.* For purposes of a State's spend-down provision, an individual enrolled under §435.119 of this chapter whose income before the deduction of incurred medical expenses is greater than the applicable State spend-down eligibility income level is considered newly eligible. The FMAP applicable for the medical assistance expenditures of such an individual is the appropriate FMAP under §433.10(b) and (c) as applicable for an individual who is newly eligible.

(g) *Special circumstances.* States may submit additional proxy methodologies to CMS for approval by CMS in accordance with the State plan requirements outlined in §433.206(h).

(h) *Threshold methodology State plan requirements.* To claim expenditures at the increased FMAPs described in §433.210(c)(6) or (c)(8), the State must amend its State plan under the provisions of subpart B of part 430 to reflect the threshold methodology the State implements in accordance with the provisions of this section. The threshold methodology will be included as an attachment to the State plan and, explicitly and by reference, must:

(1) Specify that the threshold methodology the State implements is in accordance with this section;

(2) Specify that the threshold methodology the State implements accounts for the individuals determined eligible under the adult group in §435.119 of this chapter as a newly eligible individual or not newly eligible individual; and, on that basis, the State implements appropriate tracking for purpose of claiming Federal Medicaid funding for the associated medical assistance expenditures.

(3) Reference the converted MAGI-based December 1, 2009 income eligibility standards and the associated eligibility groups, describe how the State will apply such standards and methodologies, and include other relevant criteria in the assignment of FMAP.

(4) Indicate any required provisions, or options and alternatives the State elects, with respect to:

(i) Treatment of resources, in accordance with paragraph (d) of this section;

(ii) Treatment of enrollment caps or waiting lists, in accordance with paragraph (e) of this section; and

(iii) Special circumstances as approved by CMS in accordance with paragraph (g) of this section.

[78 FR 19942, Apr. 2, 2013, as amended at 78 FR 32991, June 3, 2013]

Subpart F—Refunding of Federal Share of Medicaid Overpayments to Providers

SOURCE: 54 FR 5460, Feb. 3, 1989, unless otherwise noted.

§ 433.300 Basis.

This subpart implements—

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.

(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment

for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

(c) Section 1903(d)(3) of the Act, which provides that the Secretary will consider the pro rata Federal share of the net amount recovered by a State during any quarter to be an overpayment.

[54 FR 5460, Feb. 3, 1989, as amended at 77 FR 31511, May 29, 2012]

§ 433.302 Scope of subpart.

This subpart sets forth the requirements and procedures under which States have 1 year following discovery of overpayments made to providers for Medicaid services to recover or attempt to recover that amount before the States must refund the Federal share of these overpayments to CMS, with certain exceptions.

[77 FR 31511, May 29, 2012]

§ 433.304 Definitions.

As used in this subpart—

Discovery (or *discovered*) means identification by any State Medicaid agency official or other State official, the Federal Government, or the provider of an overpayment, and the communication of that overpayment finding or the initiation of a formal recoupment action without notice as described in § 433.316.

Final written notice means that written communication, immediately preceding the first level of formal administrative or judicial proceedings, from a Medicaid agency official or other State official that notifies the provider of the State's overpayment determination and allows the provider to contest that determination, or that notifies the State Medicaid agency of the filing of a civil or criminal action.

Fraud (in accordance with § 455.2) means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Overpayment means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.

Provider (in accordance with § 400.203) means any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid agency.

Recoupment means any formal action by the State or its fiscal agent to initiate recovery of an overpayment without advance official notice by reducing future payments to a provider.

Third party (in accordance with § 433.136) means an individual, entity, or program that is or may be liable to pay for all or part of the expenditures for medical assistance furnished under a State plan.

[54 FR 5460, Feb. 3, 1989; 54 FR 8435, Feb. 28, 1989, as amended at 77 FR 31511, May 29, 2012]

§ 433.310 Applicability of requirements.

(a) *General rule.* Except as provided in paragraphs (b) and (c) of this section, the provisions of this subpart apply to—

(1) Overpayments made to providers that are discovered by the State;

(2) Overpayments made to providers that are initially discovered by the provider and made known to the State agency; and

(3) Overpayments that are discovered through Federal reviews.

(b) *Third party payments and probate collections.* The requirements of this subpart do not apply to—

(1) Cases involving third party liability because, in these situations, recovery is sought for a Medicaid payment that would have been made had another party not been legally responsible for payment; and

(2) Probate collections from the estates of deceased Medicaid beneficiaries, as they represent the recovery of payments properly made from resources later determined to be available to the State.

(c) *Unallowable costs paid under rate-setting systems.* (1) Unallowable costs for a prior year paid to an institutional provider under a rate-setting system that a State recovers through an adjustment to the per diem rate for a subsequent period do not constitute overpayments that are subject to the requirements of this subpart.

In such cases, the State is not required to refund the Federal share explicitly related to the original overpayment in accordance with the regulations in this subpart. Refund of the Federal share occurs when the State claims future expenditures made to the provider at a reduced rate.

(2) Unallowable costs for a prior year paid to an institutional provider under a rate-setting system that a State seeks to recover in a lump sum, by an installment repayment plan, or through reduction of future payments to which the provider would otherwise be entitled constitute overpayments that are subject to the requirements of this subpart.

(d) *Recapture of depreciation upon gain on the sale of assets.* Depreciation payments are considered overpayments for purposes of this subpart if a State requires their recapture in a discrete amount(s) upon gain on the sale of assets.

§ 433.312 Basic requirements for refunds.

(a) *Basic rules.* (1) Except as provided in paragraph (b) of this section, the State Medicaid agency has 1 year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.

(2) The State Medicaid agency must refund the Federal share of overpayments at the end of the 1-year period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider.

(b) *Exception.* The agency is not required to refund the Federal share of an overpayment made to a provider when the State is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business in accordance with § 433.318.

(c) *Applicability.* (1) The requirements of this subpart apply to overpayments made to Medicaid providers that occur and are discovered in any quarter that begins on or after October 1, 1985.

(2) The date upon which an overpayment occurs is the date upon which a State, using its normal method of reimbursement for a particular class of provider (e.g., check, interfund transfer), makes the payment involving unallowable costs to a provider.

[54 FR 5460, Feb. 3, 1989, as amended at 77 FR 31511, May 29, 2012]

§ 433.316 When discovery of overpayment occurs and its significance.

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) *Requirements for notification.* Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of—

(1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider

without having first notified the provider in writing.

(d) *Overpayments resulting from fraud.* (1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in §433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by §455.15, §455.21, or §455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

(e) *Overpayments identified through Federal reviews.* If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) *Overpayments identified through the disproportionate share hospital (DSH) independent certified audit.* In the case of an overpayment identified through the independent certified audit required under part 455, subpart D, of this chapter, CMS will consider the overpayment as discovered on the earliest of the following:

(1) The date that the State submits the independent certified audit report required under §455.304(b) of this chapter to CMS.

(2) Any of the dates specified in paragraph (c)(1), (2), or (3) of this section.

(g) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(h) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(i) *Effect of administrative or judicial appeals.* Any appeal rights extended to

a provider do not extend the date of discovery.

[54 FR 5460, Feb. 3, 1989; 54 FR 8435, Feb. 28, 1989, as amended at 77 FR 31511, May 29, 2012; 89 FR 13945, Feb. 23, 2024]

§ 433.318 Overpayments involving providers who are bankrupt or out of business.

(a) *Basic rules.* (1) The agency is not required to refund the Federal share of an overpayment made to a provider as required by § 433.312(a) to the extent that the State is unable to recover the overpayment because the provider has been determined bankrupt or out of business in accordance with the provisions of this section.

(2) The agency must notify the provider that an overpayment exists in any case involving a bankrupt or out-of-business provider and, if the debt has not been determined uncollectable, take reasonable actions to recover the overpayment during the 1-year recovery period in accordance with policies prescribed by applicable State law and administrative procedures.

(b) *Overpayment debts that the State need not refund.* Overpayments are considered debts that the State is unable to recover within the 1-year period following discovery if the following criteria are met:

(1) The provider has filed for bankruptcy, as specified in paragraph (c) of this section; or

(2) The provider has gone out of business and the State is unable to locate the provider and its assets, as specified in paragraph (d) of this section.

(c) *Bankruptcy.* The agency is not required to refund to CMS the Federal share of an overpayment at the end of the 1-year period following discovery, if—

(1) The provider has filed for bankruptcy in Federal court at the time of discovery of the overpayment or the provider files a bankruptcy petition in Federal court before the end of the 1-year period following discovery; and

(2) The State is on record with the court as a creditor of the petitioner in the amount of the Medicaid overpayment.

(d) *Out of business.* (1) The agency is not required to refund to CMS the Federal share of an overpayment at the end of the 1-year period following discovery if the provider is out of business on the date of discovery of the overpayment or if the provider goes out of business before the end of the 1-year period following discovery.

(2) A provider is considered to be out of business on the effective date of a determination to that effect under State law. The agency must—

(i) Document its efforts to locate the party and its assets. These efforts must be consistent with applicable State policies and procedures; and

(ii) Make available an affidavit or certification from the appropriate State legal authority establishing that the provider is out of business and that the overpayment cannot be collected under State law and procedures and citing the effective date of that determination under State law.

(3) A provider is not out of business when ownershp is transferred within the State unless State law and procedures deem a provider that has transferred ownership to be out of business and preclude collection of the overpayment from the provider.

(e) *Circumstances requiring refunds.* If the 1-year recovery period has expired before an overpayment is found to be uncollectable under the provisions of this section, if the State recovers an overpayment amount under a court-approved discharge of bankruptcy, or if a bankruptcy petition is denied, the agency must refund the Federal share of the overpayment in accordance with the procedures specified in § 433.320 of this subpart.

[54 FR 5460, Feb. 3, 1989; 54 FR 8435, Feb. 28, 1989, as amended at 77 FR 31512, May 29, 2012]

§ 433.320 Procedures for refunds to CMS.

(a) *Basic requirements.* (1) The agency must refund the Federal share of overpayments that are subject to recovery to CMS through a credit on its Quarterly Statement of Expenditures (Form CMS–64).

(2) The agency must credit CMS with the Federal share of overpayments subject to recovery on the earlier of—

(i) The Form CMS–64 submission due to CMS for the quarter in which the State recovers the overpayment from the provider; or

(ii) The Form CMS–64 due to CMS for the quarter in which the 1-year period following discovery, established in accordance with §433.316, ends.

(3) A credit on the Form CMS–64 must be made whether or not the overpayment has been recovered by the State from the provider.

(4) If the State does not refund the Federal share of such overpayment as indicated in paragraph (a)(2) of this section, the State will be liable for interest on the amount equal to the Federal share of the non-recovered, non-refunded overpayment amount. Interest during this period will be at the Current Value of Funds Rate (CVFR), and will accrue beginning on the day after the end of the 1-year period following discovery until the last day of the quarter for which the State submits a CMS–64 report refunding the Federal share of the overpayment.

(b) *Effect of reporting collections and submitting reduced expenditure claims.* (1) The State is not required to refund the Federal share of an overpayment at the end of the 1-year period if the State has already reported a collection or submitted an expenditure claim reduced by a discrete amount to recover the overpayment prior to the end of the 1-year period following discovery.

(2) The State is not required to report on the Form CMS–64 any collections made on overpayment amounts for which the Federal share has been refunded previously.

(3) If a State has refunded the Federal share of an overpayment as required under this subpart and the State subsequently makes recovery by reducing future provider payments by a discrete amount, the State need not reflect that reduction in its claim for Federal financial participation.

(c) *Reclaiming overpayment amounts previously refunded to CMS.* If the amount of an overpayment is adjusted downward after the agency has credited CMS with the Federal share, the agency may reclaim the amount of the downward adjustment on the Form CMS–64. Under this provision—

(1) Downward adjustment to an overpayment amount previously credited to CMS is allowed only if it is properly based on the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution processes specified in State administrative policies and procedures.

(2) The 2-year filing limit for retroactive claims for Medicaid expenditures does not apply. A downward adjustment is not considered a retroactive claim but rather a reclaiming of costs previously claimed.

(d) *Expiration of 1-year recovery period.* If an overpayment has not been determined uncollectable in accordance with the requirements of §433.318 of this subpart at the end of the 1-year period following discovery of the overpayment, the agency must refund the Federal share of the overpayment to CMS in accordance with the procedures specified in paragraph (a) of this section.

(e) *Court-approved discharge of bankruptcy.* If the State recovers any portion of an overpayment under a court-approved discharge of bankruptcy, the agency must refund to CMS the Federal share of the overpayment amount collected on the next quarterly expenditure report that is due to CMS for the period that includes the date on which the collection occurs.

(f) *Bankruptcy petition denied.* If a provider's petition for bankruptcy is denied in Federal court, the agency must credit CMS with the Federal share of the overpayment on the later of—

(1) The Form CMS–64 submission due to CMS immediately following the date of the decision of the court; or

(2) The Form CMS–64 submission for the quarter in which the 1-year period following discovery of the overpayment ends.

(g) *Reclaim of refunds.* (1) If a provider is determined bankrupt or out of business under this section after the 1-year period following discovery of the overpayment ends and the State has not been able to make complete recovery, the agency may reclaim the amount of the Federal share of any unrecovered overpayment amount previously refunded to CMS. CMS allows the reclaim of a refund by the agency if the agency submits to CMS documentation that it has made reasonable efforts to obtain recovery.

(2) If the agency reclaims a refund of the Federal share of an overpayment—

(i) In bankruptcy cases, the agency must submit to CMS a statement of its efforts to recover the overpayment during the period before the petition for bankruptcy was filed; and

(ii) In out-of-business cases, the agency must submit to CMS a statement of its efforts to locate the provider and its assets and to recover the overpayment during any period before the provider is found to be out of business in accordance with § 433.318.

(h) *Supporting reports.* The agency must report the following information to support each Quarterly Statement of Expenditures Form CMS–64:

(1) Amounts of overpayments not collected during the quarter but refunded because of the expiration of the 1-year period following discovery;

(2) Upward and downward adjustments to amounts credited in previous quarters;

(3) Amounts of overpayments collected under court-approved discharges of bankruptcy;

(4) Amounts of previously reported overpayments to providers certified as bankrupt or out of business during the quarter; and

(5) Amounts of overpayments previously credited and reclaimed by the State.

[54 FR 5460, Feb. 3, 1989, as amended at 77 FR 31512, May 29, 2012]

§ 433.322 Maintenance of Records.

The Medicaid agency must maintain a separate record of all overpayment activities for each provider in a manner that satisfies the retention and access requirements of 2 CFR 200.334 through 200.338.

[77 FR 31512, May 29, 2012, as amended at 81 FR 3011, Jan. 20, 2016; 89 FR 80069, Oct. 2, 2024]

Subpart G—Temporary FMAP Increase During the Public Health Emergency for COVID–19

SOURCE: 85 FR 71197, Nov. 6, 2020, unless otherwise noted.

§ 433.400 Continued enrollment for temporary FMAP increase.

(a) *Statutory basis.* This subpart interprets and implements section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) and section 1902(a)(4) and (a)(19) of the Social Security Act.

(b) *Definitions.* For purposes of this subpart—

COVID–19 means Coronavirus Disease 2019.

Medicare Savings Program means the coverage of Medicare premiums and cost sharing furnished to individuals described in, and determined by the state to be eligible under, section 1902(a)(10)(E)(i), 1902(a)(10)(E)(iii), or 1902(a)(10)(E)(iv) of the Act.

Minimum essential coverage (MEC) has the meaning provided under section 5000A(f)(1) of the Internal Revenue Code and implementing regulations at 26 CFR 1.5000A–2 and includes minimum essential coverage determined by the Secretary under 26 CFR 1.5000A–2(f).

Public Health Emergency for COVID–19 has the same definition provided in § 400.200 of this chapter.

Temporary FMAP increase means the 6.2 percentage point increase in the State's Federal medical assistance percentage (FMAP) that is authorized under section 6008(a) of the FFCRA through the end of the fiscal quarter in which the Public Health Emergency for COVID–19 ends.

Validly enrolled means that the beneficiary was enrolled in Medicaid based on a determination of eligibility. A beneficiary is not validly enrolled if the agency determines the eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility (if such last redetermination or renewal was completed prior to March 18, 2020) because of agency error or fraud (as evidenced by a fraud conviction) or abuse (as determined following the completion of an investigation pursuant to §§ 455.15 and 455.16 of this chapter) attributed to the beneficiary or the beneficiary's representative, which was material to the determination of eligibility. Individuals receiving medical assistance during a presumptive eligibility period in accordance with part 435, subpart L,

of this chapter have not received a determination of eligibility by the state under the state plan and are not considered validly enrolled beneficiaries for purposes of this section.

(c) *General requirements.* (1) In order to claim the temporary FMAP increase for:

(i) The quarter in which November 2, 2020, falls, a state must meet the requirements described in paragraph (c)(2) of this section from November 2, 2020, through the end of the quarter.

(ii) Any quarter beginning after November 2, 2020, through the quarter in which the public health emergency for COVID–19, including any extensions, ends, a state must meet the requirements described in paragraphs (c)(2) of this section.

(2) Except as provided in paragraph (d) of this section, for all beneficiaries validly enrolled for benefits under the state plan, a waiver of such plan, or a demonstration project under section 1115(a) of the Act as of or after March 18, 2020, the state must maintain the beneficiary's enrollment as follows, through the end of the month in which the public health emergency for COVID–19 ends:

(i)(A) For beneficiaries whose Medicaid coverage meets the definition of MEC in paragraph (b) of this section as of or after March 18, 2020, the state must continue to provide Medicaid coverage that meets the definition of MEC, except as provided in paragraph (c)(2)(i)(B) of this section.

(B) For beneficiaries described in paragraph (c)(2)(i)(A) whom the state subsequently determines are eligible for coverage under a Medicare Savings Program eligibility group, the state satisfies the requirement described in paragraph (c)(2) of this section if it furnishes the medical assistance available through the Medicare Savings Program.

(ii) For beneficiaries whose Medicaid coverage as of or after March 18, 2020 does not meet the definition of MEC in paragraph (b) of this section but does include coverage for testing services and treatments for COVID–19, including vaccines, specialized equipment, and therapies, the state must continue to provide Medicaid coverage that includes such testing services and treatments.

(iii) For beneficiaries not described in paragraph (c)(2)(i) or (ii) of this section, the state must continue to provide at least the same level of medical assistance as was provided as of or after March 18, 2020.

(iv) If a state determines that a validly enrolled beneficiary is no longer eligible for Medicaid, including on a procedural basis, the state meets the requirements described in paragraph (c)(2)(i), (ii), or (iii) of this section by continuing to provide the same Medicaid coverage that the beneficiary would have received absent the determination of ineligibility.

(3) Otherwise permissible changes to beneficiary coverage, cost sharing, and post-eligibility treatment of income, including both changes affecting an individual beneficiary and approved changes to the state plan, a section 1115 demonstration and/or a waiver authorized under section 1915 of the Act impacting multiple beneficiaries, will not impact a state's ability to claim the temporary FMAP increase provided that any such changes do not violate the requirement to maintain beneficiary enrollment described at paragraph (c)(2) of this section or the requirement in section 6008(b)(4) of the FFCRA.

(d) *Exceptions.* (1) Consistent with the condition to claim the temporary FMAP increase described in paragraph (c)(2) of this section, a state may terminate a beneficiary's Medicaid enrollment prior to the first day of the month after the public health emergency for COVID–19 ends in the following circumstances:

(i) The beneficiary or the beneficiary's representative requests a voluntary termination of eligibility;

(ii) The beneficiary ceases to be a resident of the state; or

(iii) The beneficiary dies.

(2) States which have elected the option under section 1903(v)(4) of the Act to provide full benefits to lawfully residing children or pregnant women must limit coverage for such beneficiaries if they no longer meet the definition of a lawfully residing child or pregnant woman under such section to services necessary for treatment of an

emergency medical condition, as defined in section 1903(v)(3) of the Act.

(3)(i) For purposes of paragraph (d)(1)(i) of this section, a beneficiary may request a voluntary termination of eligibility from the Medicaid coverage in which the beneficiary is enrolled to transition to other Medicaid coverage for which the beneficiary is eligible, even if the transition to the new Medicaid coverage would not be consistent with paragraph (c)(2) of this section.

(ii) For purposes of paragraph (d)(1)(ii) of this section, beneficiaries who were identified through a data match with the Public Assistance Reporting Information System in accordance with §435.945(d) of this chapter indicating simultaneous enrollment in two or more states, and who fail to respond to a request for information to verify their residency, may be treated as not being a state resident for purposes of paragraph (d)(1)(ii) of this section, provided that the state takes all reasonably available measures to attempt to verify the beneficiary's state residency. If a beneficiary's enrollment is terminated under the exception at paragraph (d)(1)(ii) of this section based on a PARIS data match and the state subsequently obtains information verifying residency, the state must reinstate the beneficiary's Medicaid enrollment retroactive to the date of termination.

PART 434—CONTRACTS

Subpart A—General Provisions

Sec.

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AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

SOURCE: 48 FR 54020, Nov. 30, 1983, unless otherwise noted.

Subpart A—General Provisions

§434.1 Basis and scope.

(a) *Statutory basis.* This part is based on section 1902(a)(4) of the Act, which requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(b) *Scope.* This part sets forth the requirements for contracts with certain organizations for furnishing Medicaid services or processing or paying Medicaid claims, or enchancing the agency's capability for effective administration of the program.

[48 FR 54020, Nov. 30, 1983; 48 FR 55128, Dec. 9, 1983, as amended at 67 FR 41095, June 14, 2002]

§434.2 Definitions.

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

Fiscal agent means an entity that processes or pays vendor claims for the agency.

Health care projects grant center means an entity that—

(a) Is supported in whole or in part by Federal project grant financial assistance; and

(b) Provides or arranges for medical services to beneficiaries.

Private nonmedical institution means an institution (such as a child-care facility or a maternity home) that—

(a) Is not, as a matter of regular business, a health insuring organization or a community health care center;