Health Care Financing Administration, HHS

§ 430.104 Decisions that affect FFP.

(a) Scope of decisions. If the Administrator concludes that withholding of FFP is necessary because a State is out of compliance with Federal requirements, in accordance with §430.35, the decision also specifies—

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

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

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

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

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

Sec. 431.18 Availability of agency program manuals.
431.20 Advance directives.

Subpart B—General Administrative Requirements

431.40 Basis and scope.
431.50 Statewide operation.
431.51 Free choice of providers.
431.52 Payments for services furnished out of State.
431.53 Assurance of transportation.
431.54 Exceptions to certain State plan requirements.
431.55 Waiver of other Medicaid requirements.
431.56 Special waiver provisions applicable to American Samoa and the Northern Marianas Islands.
431.57 Waiver of cost-sharing requirements.

Subpart C—Administrative Requirements: Provider Relations

431.105 Consultation to medical facilities.
431.107 Required provider agreements.
431.108 Effective date of provider agreements.
431.110 Participation by Indian Health Service facilities.
431.115 Disclosure of survey information and provider or contractor evaluation.
431.120 State requirements with respect to nursing facilities.

Subpart D—Appeals Process for NFs and ICFs/MR

431.151 Scope and applicability.
431.152 State plan requirements.
431.153 Evidentiary hearing.
431.154 Informal reconsideration for ICFs/MR.

Subpart E—Fair Hearings for Applicants and Recipients

GENERAL PROVISIONS

431.200 Basis and purpose.
431.201 Definitions.
431.202 State plan requirements.
431.205 Provision of hearing system.
431.206 Informing applicants and recipients.

NOTICE

431.210 Content of notice.
431.211 Advance notice.
431.213 Exceptions from advance notice.
431.214 Notice in cases of probable fraud.

RIGHT TO HEARING

431.220 When a hearing is required.
431.221 Request for hearing.
431.222 Group hearings.
431.223 Denial or dismissal of request for a hearing.
PROCEDURES

431.230 Maintaining services.
431.231 Reinstatement of services.
431.232 Adverse decision of local evidentiary hearing.
431.233 State agency hearing after adverse decision of local evidentiary hearing.
431.240 Conducting the hearing.
431.241 Matters to be considered at the hearing.
431.242 Procedural rights of the applicant or recipient.
431.243 Parties in cases involving an eligibility determination.
431.244 Notifying the applicant or recipient of a State agency decision.
431.245 Corrective action.

FEDERAL FINANCIAL PARTICIPATION

431.250 Federal financial participation.

Subpart F—Safeguarding Information on Applicants and Recipients

431.300 Basis and purpose.
431.301 State plan requirements.
431.302 Purposes directly related to State plan administration.
431.303 State authority for safeguarding information.
431.304 Publicizing safeguarding requirements.
431.305 Types of information to be safeguarded.
431.306 Release of information.
431.307 Distribution of information materials.

Subparts G—L [Reserved]

Subpart M—Relations With Other Agencies

431.610 Relations with standard-setting and survey agencies.
431.615 Relations with State health and vocational rehabilitation agencies and title V grantees.
431.620 Agreement with State mental health authority or mental institutions.
431.621 State requirements with respect to nursing facilities.
431.625 Coordination of Medicaid with Medicare part B.
431.630 Coordination of Medicaid with PROs.
431.635 Coordination of Medicaid with Special Supplemental Food Program for Women, Infants, and Children (WIC).

Subpart N—State Programs for Licensing Nursing Home Administrators

431.700 Basis and purpose.
431.701 Definitions.
431.702 State plan requirement.
431.703 Licensing requirement.

42 CFR Ch. IV (10-1-00 Edition)

431.704 Nursing homes designated by other terms.
431.705 Licensing authority.
431.706 Composition of licensing board.
431.707 Standards.
431.708 Procedures for applying standards.
431.709 Issuance and revocation of license.
431.710 Provisional licenses.
431.711 Compliance with standards.
431.712 Failure to comply with standards.
431.713 Continuing study and investigation.
431.714 Waivers.
431.715 Federal financial participation.

Subpart O [Reserved]

Subpart P—Quality Control

GENERAL PROVISIONS

431.800 Scope of subpart.
431.802 Basis.
431.804 Definitions.
431.806 State plan requirements.
431.808 Protection of recipient rights.

MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC) PROGRAM

431.810 Basic elements of the Medicaid eligibility quality control (MEQC) program.
431.812 Review procedures.
431.814 Sampling plan and procedures.
431.816 Case review completion deadlines and submittal of reports.
431.818 Access to records: MEQC program.
431.820 Corrective action under the MEQC program.
431.822 Resolution of differences in State and Federal case eligibility or payment findings.

MEDICAID QUALITY CONTROL (MQC) CLAIMS PROCESSING ASSESSMENT SYSTEM

431.830 Basic elements of the Medicaid quality control (MQC) claims processing assessment system.
431.832 Reporting requirements for claims processing assessment systems.
431.834 Access to records: Claims processing assessment systems.
431.836 Corrective action under the MQC claims processing assessment systems.

FEDERAL FINANCIAL PARTICIPATION

431.861–431.864 [Reserved]


SOURCE: 43 FR 45188, Sept. 29, 1978, unless otherwise noted.
§ 431.11 Organization for administration.

(a) Basis and purpose. This section, based on section 1902(a)(4) of the Act, prescribes the general organization and staffing requirements for the Medicaid agency and the State plan.

(b) Medical assistance unit. A State plan must provide for a medical assistance unit within the Medicaid agency, staffed with a program director and other appropriate personnel who participate in the development, analysis, and evaluation of the Medicaid program.

(c) Description of organization. (1) The plan must include—
§ 431.12 Medical care advisory committee.

(a) Basis and purpose. This section, based on section 1902(a)(4) of the Act, prescribes State plan requirements for establishment of a committee to advise the Medicaid agency about health and medical care services.

(b) State plan requirement. A State plan must provide for a medical care advisory committee meeting the requirements of this section to advise the Medicaid agency director about health and medical care services.

(c) Appointment of members. The agency director, or a higher State authority, must appoint members to the advisory committee on a rotating and continuous basis.

(d) Committee membership. The committee must include—

(1) Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care;

(2) Members of consumers' groups, including Medicaid recipients, and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; and

(3) The director of the public welfare department or the public health department, whichever does not head the Medicaid agency.

(e) Committee participation. The committee must have opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the agency program.

(f) Committee staff assistance and financial help. The agency must provide the committee with—

(1) Staff assistance from the agency and independent technical assistance as needed to enable it to make effective recommendations; and

(2) Financial arrangements, if necessary, to make possible the participation of recipient members.

(g) Federal financial participation. FFP is available at 50 percent in expenditures for the committee's activities.
proper and efficient operation of the plan. The records must include—

(1) Individual records on each applicant and recipient that contain information on—

(i) Date of application;

(ii) Date of and basis for disposition;

(iii) Facts essential to determination of initial and continuing eligibility;

(iv) Provision of medical assistance;

(v) Basis for discontinuing assistance;

(vi) The disposition of income and eligibility verification information received under §§435.940 through 435.960 of this subchapter; and

(2) Statistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary.

(c) Retention of records. The plan must provide that the records required under paragraph (b) of this section will be retained for the periods required by the Secretary.

(d) Conditions for optional use of microfilm copies. The agency may substitute certified microfilm copies for the originals of substantiating documents required for Federal audit and review, if the conditions in paragraphs (d)(1) through (4) of this section are met.

(1) The agency must make a study of its record storage and must show that the use of microfilm is efficient and economical.

(2) The microfilm system must not hinder the agency’s supervision and control of the Medicaid program.

(3) The microfilm system must—

(i) Enable the State to audit the propriety of expenditures for which FFP is claimed; and

(ii) Enable the HHS Audit Agency and HCFA to properly discharge their respective responsibilities for reviewing the manner in which the Medicaid program is being administered.

(4) The agency must obtain approval from the HCFA regional office indicating—

(i) The system meets the conditions of paragraphs (d)(2) and (3) of this section; and

(ii) The microfilming procedures are reliable and are supported by an adequate retrieval system.

§431.18 Availability of agency program manuals.

(a) Basis and purpose. This section, based on section 1902(a)(4) of the Act, prescribes State plan requirements for facilitating access to Medicaid rules and policies by individuals outside the State Medicaid agency.

(b) State plan requirements. A State plan must provide that the Medicaid agency meets the requirements of paragraphs (c) through (g) of this section.

(c) Availability in agency offices. (1) The agency must maintain, in all its offices, copies of its current rules and policies that affect the public, including those that govern eligibility, provision of medical assistance, covered services, and recipient rights and responsibilities.

(2) These documents must be available upon request for review, study, and reproduction by individuals during regular working hours of the agency.

(d) Availability through other entities. The agency must provide copies of its current rules and policies to—

(1) Public and university libraries;

(2) The local or district offices of the Bureau of Indian Affairs;

(3) Welfare and legal services offices; and

(4) Other entities that—

(i) Request the material in order to make it accessible to the public;

(ii) Are centrally located and accessible to a substantial number of the recipient population they serve; and

(iii) Agree to accept responsibility for filing all amendments or changes forwarded by the agency.

(e) Availability in relation to fair hearings. The agency must make available to an applicant or recipient, or his representative, a copy of the specific policy materials necessary—

(1) To determine whether to request a fair hearing; or

(2) To prepare for a fair hearing.

(f) Availability for other purposes. The agency must establish rules for making program policy materials available to individuals who request them for other purposes.

(g) Charges for reproduction. The agency must make copies of its program policy materials available without
§ 431.20 Advance directives.

(a) Basis and purpose. This section, based on section 1902(a) (57) and (58) of the Act, prescribes State plan requirements for the development and distribution of a written description of State law concerning advance directives.

(b) A State Plan must provide that the State, acting through a State agency, association, or other private non-profit entity, develop a written description of the State law (whether statutory or as recognized by the courts of the State) concerning advance directives, as defined in §489.100 of this chapter, to be distributed by Medicaid providers and health maintenance organizations (as specified in section 1903(m)(1)(A) of the Act) in accordance with the requirements under part 489, subpart I of this chapter. Revisions to the written descriptions as a result of changes in State law must be incorporated in such descriptions and distributed as soon as possible, but no later than 60 days from the effective date of the change in State law, to Medicaid providers and health maintenance organizations.

[57 FR 8202, Mar. 6, 1992, as amended at 60 FR 33293, June 27, 1995]

Subpart B—General Administrative Requirements

SOURCE: 56 FR 8847, Mar. 1, 1991, unless otherwise noted.

§ 431.40 Basis and scope.

(a) This subpart sets forth State plan requirements and exceptions that pertain to the following administrative requirements and provisions of the Act:

(1) Statewideness—section 1902(a)(1);

(2) Proper and efficient administration—section 1902(a)(4);

(3) Comparability of services—section 1902(a)(10) (B)–(E);

(4) Payment for services furnished outside the State—section 1902(a)(16);

(5) Free choice of providers—section 1902(a)(23);

(6) Special waiver provisions applicable to American Samoa and the Northern Mariana Islands—section 1902(j);

(7) Exceptions to, and waiver of, State plan requirements—sections 1915 (a)-(c) and 1916 (a)(3) and (b)(3).

(b) Other applicable regulations include the following:

(1) Section 430.25 Waivers of State plan requirements.

(2) Section 440.250 Limits on comparability of services.

§ 431.50 Statewide operation.

(a) Statutory basis. Section 1902(a)(1) of the Act requires a State plan to be in effect throughout the State, and section 1915 permits certain exceptions.

(b) State plan requirements. A State plan must provide that the following requirements are met:

(1) The plan will be in operation statewide through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the State.

(2) If administered by political subdivisions of the State, the plan will be mandatory on those subdivisions.

(3) The agency will ensure that the plan is continuously in operation in all local offices or agencies through—

(i) Methods for informing staff of State policies, standards, procedures, and instructions;

(ii) Systematic planned examination and evaluation of operations in local offices by regularly assigned State staff who make regular visits; and

(iii) Reports, controls, or other methods.

(c) Exceptions. (1) “Statewide operation” does not mean, for example, that every source of service must furnish the service State-wide. The requirement does not preclude the agency from contracting with a comprehensive health care organization (such as an HMO or a rural health clinic) that serves a specific area of the State, to furnish services to Medicaid recipients who live in that area and chose to receive services from that HMO or rural health clinic. Recipients who live in other parts of the State may receive their services from other sources.
§ 431.51 Free choice of providers.

(a) Statutory basis. This section is based on sections 1902(a)(23), 1902(e)(2), and 1915(a) and (b) of the Act.

(1) Section 1902(a)(23) of the Act provides that recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.

(2) Section 1915(a) of the Act provides that a State shall not be found out of compliance with section 1902(a)(23) solely because it imposes certain specified allowable restrictions on freedom of choice.

(3) Section 1915(b) of the Act authorizes waiver of the section 1902(a)(23) freedom of choice of providers requirement in certain specified circumstances, but not with respect to providers of family planning services.

(4) Section 1902(a)(23), as amended by section 4113(c) of OBRA ’87, provides that a State shall not be found out of compliance with section 1902(a)(23) solely because it imposes certain specified allowable restrictions on freedom of choice.

(b) State plan requirements. A State plan, except the plan for Puerto Rico, the Virgin Islands, or Guam, must provide as follows:

(1) Except as provided under paragraph (c) of this section, a recipient may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is—

(i) Qualified to furnish the services; and

(ii) Willing to furnish them to that particular recipient.

This includes an organization that furnishes, or arranges for the furnishing of, Medicaid services on a prepayment basis.

(2) A recipient enrolled in a primary care case-management system, an HMO, or other similar entity will not be restricted in freedom of choice of providers of family planning services.

(c) Exceptions. Paragraph (b) of this section does not prohibit the agency from—

(1) Establishing the fees it will pay providers for Medicaid services;

(2) Setting reasonable standards relating to the qualifications of providers; or

(3) Subject to paragraph (b)(2) of this section, restricting recipients’ free choice of providers in accordance with one or more of the exceptions set forth in §431.54, or under a waiver as provided in §431.55.

(d) Certification requirement. (1) Content of certification. If a State implements a project under one of the exceptions allowed under §431.54(d), (e) or (f), it must certify to HCFA that the statutory safeguards and requirements for an exception under section 1915(a) of the Act are met.

(2) Timing of certification. (i) For an exception under §431.54(d), the State may not institute the project until after it has submitted the certification and HCFA has made the findings required under the Act, and so notified the State.

(ii) For exceptions under §431.54(e) or (f), the State must submit the certificate by the end of the quarter in which it implements the project.

§ 431.52 Payments for services furnished out of State.

(a) Statutory basis. Section 1902(a)(16) of the Act authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State.

(b) Payment for services. A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the State, and any of the following conditions is met:

(1) Medical services are needed because of a medical emergency;
(2) Medical services are needed and the recipient’s health would be endangered if he were required to travel to his State of residence;

(3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;

(4) It is general practice for recipients in a particular locality to use medical resources in another State.

c) Cooperation among States. The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan.

§ 431.53 Assurance of transportation.
A State plan must—
(a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and
(b) Describe the methods that the agency will use to meet this requirement.

(Sec. 1902(a)(4) of the Act)

§ 431.54 Exceptions to certain State plan requirements.

(a) Statutory basis. Section 1915(a) of the Act provides that a State shall not be deemed to be out of compliance with the requirements of sections 1902(a)(1), (10), or (23) of the Act solely because it has elected any of the exceptions set forth in paragraphs (b) and (d) through (f) of this section.

(b) Additional services under a prepayment system. If the Medicaid agency contracts on a prepayment basis with an organization that provides services additional to those offered under the State plan, the agency may restrict the provision of the additional services to recipients who live in the area served by the organization and wish to obtain services from it.

(c) [Reserved]

(d) Special procedures for purchase of medical devices and laboratory and X-ray tests. The Medicaid agency may establish special procedures for the purchase of medical devices or laboratory and X-ray tests (as defined in §440.30 of this chapter) through a competitive bidding process or otherwise, if the State assures, in the certification required under §431.5(d), and HCFA finds, as follows:

(1) Adequate services or devices are available to recipients under the special procedures.

(2) Laboratory services are furnished through laboratories that meet the following requirements:

(i) They are independent laboratories, or inpatient or outpatient hospital laboratories that provide services for individuals who are not hospital patients, or physician laboratories that process at least 100 specimens for other physicians during any calendar year.

(ii) They meet the requirements of subpart M of part 405 or part 482 of this chapter.

(iii) Laboratories that require an interstate license under 42 CFR part 74 are licensed by HCFA or receive an exemption from the licensing requirement by the College of American Pathologists. (Hospital and physician laboratories may participate in competitive bidding only with regard to services to non-hospital patients and other physicians' patients, respectively.)

(3) Any laboratory from which a State purchases services under this section has no more than 75 percent of its charges based on services to Medicare beneficiaries and Medicaid recipients.

(e) Lock-in of recipients who over-utilize Medicaid services. If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only. The agency may impose these restrictions only if the following conditions are met:

(1) The agency gives the recipient notice and opportunity for a hearing (in accordance with procedures established by the agency) before imposing the restrictions.

(2) The agency ensures that the recipient has reasonable access (taking into account geographic location and
reasonable travel time) to Medicaid services of adequate quality.

(3) The restrictions do not apply to emergency services furnished to the recipient.

(f) Lock-out of providers. If a Medicaid agency finds that a Medicaid provider has abused the Medicaid program, the agency may restrict the provider, through suspension or otherwise, from participating in the program for a reasonable period of time.

Before imposing any restriction, the agency must meet the following conditions:

(1) Give the provider notice and opportunity for a hearing, in accordance with procedures established by the agency.

(2) Find that in a significant number or proportion of cases, the provider has:

(i) Furnished Medicaid services at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the agency; or

(ii) Furnished Medicaid services of a quality that does not meet professionally recognized standards of health care.

(3) Notify HCFA and the general public of the restriction and its duration.

(4) Ensure that the restrictions do not result in denying recipients reasonable access (taking into account geographic location: and reasonable travel time) to Medicaid services of adequate quality, including emergency services.

§ 431.55 Waiver of other Medicaid requirements.

(a) Statutory basis. Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act to the extent he or she finds proposed improvements or specified practices in the provision of services under Medicaid to be cost effective, efficient, and consistent with the objectives of the Medicaid program. Sections 1915(f) and (h) prescribe how such waivers are to be approved, continued, monitored, and terminated. Section 1902(b)(2) of the Act conditions FFP in payments to an entity under a section 1915(b)(1) waiver on the State's provision for exclusion of certain entities from participation.

(b) General requirements. (1) General requirements for submittal of waiver requests, and the procedures that HCFA follows for review and action on those requests are set forth in §430.25 of this chapter.

(2) In applying for a waiver to implement an approvable project under paragraph (c), (d), (e), or (f) of this section, a Medicaid agency must document in the waiver request and maintain data regarding:

(i) The cost-effectiveness of the project;

(ii) The effect of the project on the accessibility and quality of services;

(iii) The anticipated impact of the project on the State's Medicaid program;

(iv) Assurances that the restrictions on free choice of providers do not apply to family planning services.

(3) No waiver under this section may be granted for a period longer than 2 years, unless the agency requests a continuation of the waiver.

(4) HCFA monitors the implementation of waivers granted under this section to ensure that requirements for such waivers are being met.

(i) If monitoring demonstrates that the agency is not in compliance with the requirements for a waiver under this section, HCFA gives the agency notice and opportunity for a hearing.

(ii) If, after a hearing, HCFA finds an agency to be out of compliance with the requirements of a waiver, HCFA terminates the waiver and gives the agency a specified date by which it must demonstrate that it meets the applicable requirements of section 1902 of the Act.

(5) The requirements of section 1902(s) of the Act, with regard to adjustments in payments for inpatient hospital services furnished to infants who have not attained age 1 and to children who have not attained age 6 and who receive these services in disproportionate share hospitals, may not be waived under a section 1915(b) waiver.

(c) Case-management system. (1) Waivers of appropriate requirements of section 1902 of the Act may be authorized for a State to implement a primary care case-management system or specialty physician services system.
(i) Under a primary care case-management system the agency assures that a specific person or persons or agency will be responsible for locating, coordinating, and monitoring all primary care or primary care and other medical care and rehabilitative services on behalf of a recipient.

(ii) A specialty physician services system allows States to restrict recipients of specialty services to designated providers of such services, even in the absence of a primary care case-management system.

(2) A waiver under this paragraph (c) may not be approved unless the State's request assures that the restrictions—

(i) Do not apply in emergency situations; and

(ii) Do not substantially impair access to medically necessary services of adequate quality.

(d) Locality as central broker. Waivers of appropriate requirements of section 1902 of the Act may be authorized for a State to allow a locality to act as a central broker to assist recipients in selecting among competing health care plans. States must ensure that access to medically necessary services of adequate quality is not substantially impaired.

(1) A locality is any defined jurisdiction, e.g., district, town, city, borough, county, parish, or State.

(2) A locality may use any agency or agent, public or private, profit or nonprofit, to act on its behalf in carrying out its central broker function.

(e) Sharing of cost savings. (1) Waivers of appropriate requirements of section 1902 of the Act may be authorized for States to share with recipients the cost savings resulting from the recipients' use of more cost-effective medical care.

(2) Sharing is through the provision of additional services, including—

(i) Services furnished by a plan selected by the recipient; and

(ii) Services expressly offered by the State as an inducement for recipients to participate in a primary care case-management system, a competing health care plan or other system that furnishes health care services in a more cost-effective manner.

(f) Restriction of freedom of choice—(1) Waiver of appropriate requirements of section 1902 of the Act may be authorized for States to restrict recipients to obtaining services from (or through) qualified providers or practitioners that meet, accept, and comply with the State reimbursement, quality and utilization standards specified in the State's waiver request.

(2) An agency may qualify for a waiver under this paragraph (f) only if its applicable State standards are consistent with access, quality and efficient and economic provision of covered care and services and the restrictions it imposes—

(i) Do not apply to recipients residing at a long-term care facility when a restriction is imposed unless the State arranges for reasonable and adequate recipient transfer.

(ii) Do not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services; and

(iii) Do not apply in emergency circumstances.

(3) Demonstrated effectiveness and efficiency refers to reducing costs or slowing the rate of cost increase and maximizing outputs or outcomes per unit of cost.

(4) The agency must make payments to providers furnishing services under a freedom of choice waiver under this paragraph (f) in accordance with the timely claims payment standards specified in §447.45 of this chapter for health care practitioners participating in the Medicaid program.

(g) [Reserved]

(h) Waivers approved under section 1915(b)(1) of the Act—(1) Basic rules. (i) An agency must submit, as part of its waiver request, assurance that the entities described in paragraph (h)(2) of this section will be excluded from participation under an approved waiver.

(ii) FFP is available in payments to an entity that furnishes services under a section 1915(b)(1) waiver only if the agency excludes from participation any entity described in paragraph (h)(2) of this section.

(2) Entities that must be excluded. The agency must exclude an entity that meets any of the following conditions:
§ 431.105 Consultation to medical facilities.

(a) Basis and purpose. This section implements section 1902(a)(24) of the Act, which requires that the State plan provide for consultative services by State agencies to certain institutions furnishing Medicaid services.

(b) State plan requirements. A State plan must provide that health agencies and other appropriate State agencies furnish consultative services to hospitals, nursing homes, home health agencies, clinics, and laboratories in order to assist these facilities to—
§ 431.107 Required provider agreement.

(a) Basis and purpose. This section sets forth State plan requirements, based on sections 1902(a)(4), 1902(a)(27), 1902(a)(57), and 1902(a)(58) of the Act, that relate to the keeping of records and the furnishing of information by all providers of services (including individual practitioners and groups of practitioners).

(b) Agreements. A State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to:

(1) Keep any records necessary to disclose the extent of services the provider furnishes to recipients;

(2) On request, furnish to the Medicaid agency, the Secretary, or the State Medicaid fraud control unit (if such a unit has been approved by the Secretary under § 455.300 of this chapter), any information maintained under paragraph (b)(1) of this section and any information regarding payments claimed by the provider for furnishing services under the plan;

(3) Comply with the disclosure requirements specified in part 455, subpart B of this chapter; and

(4) Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in part 489, subpart I, and § 417.436(d) of this chapter.

[44 FR 41644, July 17, 1979, as amended at 57 FR 8202, Mar. 6, 1992]

§ 431.108 Effective date of provider agreements.

(a) Applicability—(1) General rule. Except as provided in paragraph (a)(2) of this section, this section applies to Medicaid provider agreements with entities that, as a basis for participation in Medicaid—

(i) Are subject to survey and certification by HCFA or the State survey agency; or

(ii) Are deemed to meet Federal requirements on the basis of accreditation by an accrediting organization whose program has HCFA approval at the time of accreditation survey and accreditation decision.

(2) Exception. A Medicaid provider agreement with a laboratory is effective only while the laboratory has in effect a valid CLIA certificate issued under part 493 of this chapter, and only for the specialty and subspecialty tests it is authorized to perform.

(b) All requirements are met on the date of survey. The agreement is effective on the date the onsite survey (including the Life Safety Code survey if applicable) is completed, if on that date the provider meets—

(1) All applicable Federal requirements as set forth in this chapter; and

(2) Any other requirements imposed by the State for participation in the Medicaid program. (If the provider has a time-limited agreement, the new agreement is effective on the day following expiration of the current agreement.)

(c) All requirements are not met on the date of survey. If on the date the survey is completed the provider fails to meet any of the requirements specified in paragraph (b) of this section, the following rules apply:

(1) An NF provider agreement is effective on the date on which—

(i) The NF is found to be in substantial compliance as defined in § 488.301 of this chapter; and

(ii) HCFA or the State survey agency receives from the NF, if applicable, an approvable waiver request.
§ 431.110 Participation by Indian Health Service facilities.

(a) Basis. This section is based on section 1902(a)(4) of the Act, proper and efficient administration; 1902(a)(23), free choice of provider; and 1911, reimbursement of Indian Health Service facilities.

(b) State plan requirements. A State plan must provide that an Indian Health Service facility meeting State requirements for Medicaid participation must be accepted as a Medicaid provider on the same basis as any other qualified provider. However, when State licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure. In determining whether a facility meets these standards, a Medicaid agency or State licensing authority may not take into account an absence of licensure of any staff member of the facility.

§ 431.115 Disclosure of survey information and provider or contractor evaluation.

(a) Basis and purpose. This section implements—

(1) Section 1902(a)(36) of the Act, which requires a State plan to provide that the State survey agency will make publicly available the findings from surveys of health care facilities, laboratories, agencies, clinics, or organizations; and

(2) Section 1106(d) of the Act, which places certain restrictions on the Medicaid agency’s disclosure of contractor and provider evaluations.

(b) Definition of State survey agency. The State survey agency referred to in this section means the agency specified under section 1902(a)(9) of the Act as responsible for establishing and maintaining health standards for private or public institutions in which Medicaid recipients may receive services.

(c) State plan requirements. A State plan must provide that the requirements of this section and §488.325 of this chapter are met.

(d) Disclosure procedure. The Medicaid agency must have a procedure for disclosing pertinent findings obtained from surveys made by the State survey agency to determine if a health care facility, laboratory, agency, clinic or
§ 431.120 State requirements with respect to nursing facilities.

(a) State plan requirements. A State plan must—

(1) Provide that the requirements of subpart D of part 483 of this chapter are met; and

(2) Specify the procedures and rules that the State follows in carrying out the specified requirements, including review and approval of State-operated programs.

(b) Basis and scope of requirements. The requirements set forth in part 483 of this chapter pertain to the following aspects of nursing facility services and are required by the indicated sections of the Act.

(1) Nurse aide training and competency programs, and evaluation of nurse aide competency (1919(e)(1) of the Act).
Subpart D—Appeals Process for NFs and ICFs/MR

SOURCE: 44 FR 9753, Feb. 15, 1979, unless otherwise noted.

§ 431.151 Scope and applicability.

(a) General rules. This subpart sets forth the appeals procedures that a State must make available as follows:

(1) To a nursing facility (NF) that is dissatisfied with a State's finding of noncompliance that has resulted in one of the following adverse actions:

(i) Denial or termination of its provider agreement.

(ii) Imposition of a civil money penalty or other alternative remedy.

(2) To an intermediate care facility for the mentally retarded (ICF/MR) that is dissatisfied with a State's finding of noncompliance that has resulted in the denial, termination, or nonrenewal of its provider agreement.

(3) To an NF or ICF/MR that is dissatisfied with a determination as to the effective date of its provider agreement.

(b) Special rules. This subpart also sets forth the special rules that apply in particular circumstances, the limitations on the grounds for appeal, and the scope of review during a hearing.

§ 431.152 State plan requirements.

The State plan must provide for appeals procedures that, as a minimum, satisfy the requirements of §§431.153 and 431.154.

§ 431.153 Evidentiary hearing.

(a) Right to hearing. Except as provided in paragraph (b) of this section, and subject to the provisions of paragraphs (c) through (j) of this section, the State must give the facility a full evidentiary hearing for any of the actions specified in §431.151.

(b) Limit on grounds for appeal. The following are not subject to appeal:

(1) The choice of sanction or remedy.

(2) The State monitoring remedy.

(3) [Reserved]

(4) The level of noncompliance found by a State except when a favorable final administrative review decision would affect the range of civil money penalty amounts the State could collect.

(5) A State survey agency's decision as to when to conduct an initial survey of a prospective provider.

(c) Notice of deficiencies and impending remedies. The State must give the facility a written notice that includes:

(1) The basis for the decision; and

(2) A statement of the deficiencies on which the decision was based.

(d) Request for hearing. The facility or its legal representative or other authorized official must file written request for hearing within 60 days of receipt of the notice of adverse action.

(e) Special rules: Denial, termination or nonrenewal of provider agreement. If an ICF/MR requests a hearing on denial, termination, or nonrenewal of its provider agreement—

(i) The evidentiary hearing must be completed either before, or within 120 days after, the effective date of the adverse action; and

(ii) If the hearing is made available only after the effective date of the action, the State must, before that date, offer the ICF/MR an informal reconsideration that meets the requirements of §431.154.

(f) Special rules: Imposition of remedies. If a State imposes a civil money penalty or other remedies on an NF, the following rules apply:

(1) Basic rule. Except as provided in paragraph (f)(2) of this section (and notwithstanding any provision of State law), the State must impose all remedies timely on the NF, even if the NF requests a hearing.

(2) Exception. The State may not collect a civil money penalty until after
§ 431.154 Informal reconsideration for ICFs/MR.

The informal reconsideration must, at a minimum, include—

(a) Written notice to the facility of the denial, termination or nonrenewal and the findings upon which it was based;

(b) A reasonable opportunity for the facility to refute those findings in writing, and

(c) A written affirmation or reversal of the denial, termination, or nonrenewal.


Subpart E—Fair Hearings for Applicants and Recipients

SOURCE: 44 FR 17932, Mar. 29, 1979, unless otherwise noted.

GENERAL PROVISIONS

§ 431.200 Basis and purpose.

This subpart implements section 1902(a)(3) of the Act, which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly. This subpart also prescribes procedures for an opportunity for hearing if the Medicaid agency takes action to suspend, terminate, or reduce services. This subpart also implements sections 1819(f)(3), 1919(f)(3), and 1919(e)(7)(F) of the Act by providing an appeals process for individuals proposed to be transferred or discharged from skilled nursing facilities and nursing facilities and those adversely affected by the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

[57 FR 56505, Nov. 30, 1992]

§ 431.201 Definitions.

For purposes of this subpart:
Action means a termination, suspension, or reduction of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

Adverse determination means a determination made in accordance with sections 1919(b)(3)(F) or 1919(e)(7)(B) of the Act that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.

Date of action means the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective. It also means the date of the determination made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

De novo hearing means a hearing that starts over from the beginning.

Evidentiary hearing means a hearing conducted so that evidence may be presented.

Notice means a written statement that meets the requirements of §431.210.

Request for a hearing means a clear expression by the applicant or recipient, or his authorized representative, that he wants the opportunity to present his case to a reviewing authority.

§ 431.202 State plan requirements.
A State plan must provide that the requirements of §§431.205 through 431.246 of this subpart are met.

§ 431.205 Provision of hearing system.
(a) The Medicaid agency must be responsible for maintaining a hearing system that meets the requirements of this subpart.

(b) The State’s hearing system must provide for—
(1) A hearing before the agency; or
(2) An evidentiary hearing at the local level, with a right of appeal to a State agency hearing.

(c) The agency may offer local hearings in some political subdivisions and not in others.

(d) The hearing system must meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970), and any additional standards specified in this subpart.

§ 431.206 Informing applicants and recipients.
(a) The agency must issue and publicize its hearing procedures.

(b) The agency must, at the time specified in paragraph (c) of this section, inform every applicant or recipient in writing—
(1) Of his right to a hearing;
(2) Of the method by which he may obtain a hearing; and
(3) That he may represent himself or use legal counsel, a relative, a friend, or other spokesman.

(c) The agency must provide the information required in paragraph (b) of this section—
(1) At the time the individual applies for Medicaid;
(2) At the time of any action affecting his or her claim;
(3) At the time a skilled nursing facility or a nursing facility notifies a resident in accordance with §483.12 of this chapter that he or she is to be transferred or discharged; and
(4) At the time an individual receives an adverse determination by the State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

NOTICE

§ 431.210 Content of notice.
A notice required under §431.206(c)(2), (c)(3), or (c)(4) of this subpart must contain—
(a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;
(b) The reasons for the intended action;
§431.211 Advance notice.

The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§431.213 and 431.214 of this subpart.

§431.213 Exceptions from advance notice.

The agency may mail a notice not later than the date of action if—
(a) The agency has factual information confirming the death of a recipient;
(b) The agency receives a clear written statement signed by a recipient that—
(1) He no longer wishes services; or
(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
(c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;
(d) The recipient’s whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See §431.231 (d) of this subpart for procedure if the recipient’s whereabouts become known);
(e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
(f) A change in the level of medical care is prescribed by the recipient’s physician;
(g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or
(h) The date of action will occur in less than 10 days, in accordance with §483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of §483.12(a)(5)(i).

§431.214 Notice in cases of probable fraud.

The agency may shorten the period of advance notice to 5 days before the date of action if—
(a) The agency has facts indicating that action should be taken because of probable fraud by the recipient; and
(b) The facts have been verified, if possible, through secondary sources.

RIGHT TO HEARING

§431.220 When a hearing is required.

(a) The agency must grant an opportunity for a hearing to:
(1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness;
(2) Any recipient who requests it because he or she believes the agency has taken an action erroneously;
(3) Any resident who requests it because he or she believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged; and
(4) Any individual who requests it because he or she believes the State has made an erroneous determination with regard to the preadmission and annual resident review requirements of section 1919(e)(7) of the Act.

(b) The agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients.

§431.221 Request for hearing.

(a) The agency may require that a request for a hearing be in writing.
(b) The agency may not limit or interfere with the applicant’s or recipient’s freedom to make a request for a hearing.
Health Care Financing Administration, HHS

§ 431.233

(c) The agency may assist the applicant or recipient in submitting and processing his request.

(d) The agency must allow the applicant or recipient a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to request a hearing.

§ 431.222 Group hearings.

The agency—

(a) May respond to a series of individual requests for hearing by conducting a single group hearing;

(b) May consolidate hearings only in cases in which the sole issue involved is one of Federal or State law or policy;

(c) Must follow the policies of this subpart and its own policies governing hearings in all group hearings; and

(d) Must permit each person to present his own case or be represented by his authorized representative.

§ 431.223 Denial or dismissal of request for a hearing.

The agency may deny or dismiss a request for a hearing if—

(a) The applicant or recipient withdraws the request in writing; or

(b) The applicant or recipient fails to appear at a scheduled hearing without good cause.

§ 431.230 Maintaining services.

(a) If the agency mails the 10-day or 5-day notice as required under §431.211 or §431.214 of this subpart, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless—

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

(b) If the agency’s action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.

[44 FR 17932, Mar. 29, 1979, as amended at 45 FR 24882, Apr. 11, 1980]

§ 431.231 Reinstatement of services.

(a) The agency may reinstate services if a recipient requests a hearing not more than 10 days after the date of action.

(b) The reinstated services must continue until a hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.

(c) The agency must reinstate and continue services until a decision is rendered after a hearing if—

(1) Action is taken without the advance notice required under §431.211 or §431.214 of this subpart;

(2) The recipient requests a hearing within 10 days of the mailing of the notice of action; and

(3) The agency determines that the action resulted from other than the application of Federal or State law or policy.

(d) If a recipient’s whereabouts are unknown, as indicated by the return of unforwardable agency mail directed to him, any discontinued services must be reinstated if his whereabouts become known during the time he is eligible for services.

§ 431.232 Adverse decision of local evidentiary hearing.

If the decision of a local evidentiary hearing is adverse to the applicant or recipient, the agency must—

(a) Inform the applicant or recipient of the decision;

(b) Inform the applicant or recipient that he has the right to appeal the decision to the State agency, in writing, within 15 days of the mailing of the notice of the adverse decision;

(c) Inform the applicant or recipient of his right to request that his appeal be a de novo hearing; and

(d) Discontinue services after the adverse decision.

§ 431.233 State agency hearing after adverse decision of local evidentiary hearing.

(a) Unless the applicant or recipient specifically requests a de novo hearing,
§ 431.240 Conducting the hearing.
(a) All hearings must be conducted—
(1) At a reasonable time, date, and place;
(2) Only after adequate written notice of the hearing; and
(3) By one or more impartial officials or other individuals who have not been directly involved in the initial determination of the action in question.
(b) If the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision, and if the hearing officer considers it necessary to have a medical assessment other than that of the individual involved in making the original decision, such a medical assessment must be obtained at agency expense and made part of the record.

§ 431.241 Matters to be considered at the hearing.
The hearing must cover—
(a) Agency action or failure to act with reasonable promptness on a claim for services, including both initial and subsequent decisions regarding eligibility;
(b) Agency decisions regarding changes in the type or amount of services;
(c) A decision by a skilled nursing facility or nursing facility to transfer or discharge a resident; and
(d) A State determination with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

§ 431.243 Parties in cases involving an eligibility determination.
If the hearing involves an issue of eligibility and the Medicaid agency is not responsible for eligibility determinations, the agency that is responsible for determining eligibility must participate in the hearing.

§ 431.244 Hearing decisions.
(a) Hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing.
(b) The record must consist only of—
(1) The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;
(2) All papers and requests filed in the proceeding; and
(3) The recommendation or decision of the hearing officer.
(c) The applicant or recipient must have access to the record at a convenient place and time.
(d) In any evidentiary hearing, the decision must be a written one that—
(1) Summarizes the facts; and
(2) Identifies the regulations supporting the decision.
(e) In a de novo hearing, the decision must—
(1) Specify the reasons for the decision; and
(2) Identify the supporting evidence and regulations.
(f) The agency must take final administrative action within 90 days.
§ 431.300 Basis and purpose.
(a) Section 1902(a)(7) of the Act requires that a State plan must provide safeguards that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. This subpart specifies State plan requirements, the types of information to be safeguarded, the conditions for release of safeguarded information, and restrictions on the distribution of other information.

(b) Section 1137 of the Act, which requires agencies to exchange information in order to verify the income and eligibility of applicants and recipients (see §435.940ff), requires State agencies to have adequate safeguards to assure that—

(1) Information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving the information, and information received under section 6103(l) of the Internal Revenue Code of 1954 is exchanged only with agencies authorized to receive that information under that section of the Code; and

(2) Carrying out the hearing procedures, including expenses of obtaining the additional medical assessment specified in §431.240 of this subpart; and

(3) Hearing procedures for Medicaid and non-Medicaid individuals appealing transfers, discharges and determinations of preadmission screening and annual resident reviews under part 483, subparts C and E of this chapter.

[44 FR 17932, Mar. 29, 1979, as amended at 45 FR 24882, Apr. 11, 1980; 57 FR 56506, Nov. 30, 1992]
§ 431.301 State plan requirements.

(2) The information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.

[51 FR 7210, Feb. 28, 1986]

§ 431.302 Purposes directly related to plan administration.

A State plan must provide, under a State statute that imposes legal sanctions, safeguards meeting the requirements of this subpart that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

§ 431.303 State authority for safeguarding information.

The Medicaid agency must have authority to implement and enforce the provisions specified in this subpart for safeguarding information about applicants and recipients.

§ 431.304 Publicizing safeguarding requirements.

(a) The agency must publicize provisions governing the confidential nature of information about applicants and recipients, including the legal sanctions imposed for improper disclosure and use.

(b) The agency must provide copies of these provisions to applicants and recipients and to other persons and agencies to whom information is disclosed.

§ 431.305 Types of information to be safeguarded.

(a) The agency must have criteria that govern the types of information about applicants and recipients that are safeguarded.

(b) This information must include at least—

(1) Names and addresses;
(2) Medical services provided;
(3) Social and economic conditions or circumstances;
(4) Agency evaluation of personal information;
(5) Medical data, including diagnosis and past history of disease or disability; and
(6) Any information received for verifying income eligibility and amount of medical assistance payments (see §435.940f). Income information received from SSA or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data.

(7) Any information received in connection with the identification of legally liable third party resources under §435.138 of this chapter.


§ 431.306 Release of information.

(a) The agency must have criteria specifying the conditions for release and use of information about applicants and recipients.

(b) Access to information concerning applicants or recipients must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the agency.

(c) The agency must not publish names of applicants or recipients.

(d) The agency must obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of medical assistance payment under section 1137 of this Act and §§435.940 through 435.965 of this chapter.

If, because of an emergency situation, time does not permit obtaining consent before release, the agency must notify the family or individual immediately after supplying the information.

(e) The agency's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials.
§ 431.610 Relations with standard-setting and survey agencies.

(a) Basis and purpose. This section implements—

(1) Section 1902(a)(9) of the Act, concerning the designation of State authorities to be responsible for establishing and maintaining health and other standards for institutions participating in Medicaid; and

(2) Section 1902(a)(33) of the Act, concerning the designation of the State licensing agency to be responsible for determining whether institutions and agencies meet requirements for participation in Medicaid.

(b) Designated agency responsible for health standards. A State plan must designate, as the State authority responsible for establishing and maintaining health standards for private or public institutions that provide services to Medicaid recipients, the same State agency that is used by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare (see 42 CFR 405.1902). The requirement for establishing and maintaining standards does not apply with respect to religious nonmedical institutions as defined in §440.170(b) of this chapter.

(c) Designated agency responsible for standards other than health standards. The plan must designate the Medicaid examination, availability of surplus food, and consumer protection information.

(d) Under NVRA, the agency must distribute voter information and registration materials as specified in NVRA.


Subpart M—Relations With Other Agencies

§ 431.610 Relations with standard-setting and survey agencies.

(a) Basis and purpose. This section implements—

(1) Section 1902(a)(9) of the Act, concerning the designation of State authorities to be responsible for establishing and maintaining health and other standards for institutions participating in Medicaid; and

(2) Section 1902(a)(33) of the Act, concerning the designation of the State licensing agency to be responsible for determining whether institutions and agencies meet requirements for participation in the State’s Medicaid program.

(3) Section 1919(g)(1)(A) of the Act, concerning responsibilities of the State for certifying the compliance of non-State operated NFs with requirements of participation in the State’s Medicaid program.

(b) Designated agency responsible for health standards. A State plan must designate, as the State authority responsible for establishing and maintaining health standards for private or public institutions that provide services to Medicaid recipients, the same State agency that is used by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare (see 42 CFR 405.1902). The requirement for establishing and maintaining standards does not apply with respect to religious nonmedical institutions as defined in §440.170(b) of this chapter.

(c) Designated agency responsible for standards other than health standards. The plan must designate the Medicaid...
agency or other appropriate State authority or authorities to be responsible for establishing and maintaining standards, other than those relating to health, for private or public institutions that provide services to Medicaid recipients.

(d) Description and retention of standards. (1) The plan must describe the standards established under paragraphs (b) and (c) of this section.

(2) The plan must provide that the Medicaid agency keeps these standards on file and makes them available to the Administrator upon request.

(e) Designation of survey agency. The plan must provide that—

(1) The agency designated in paragraph (b) of this section, or another State agency responsible for licensing health institutions in the State, determines for the Medicaid agency whether institutions and agencies meet the requirements for participation in the Medicaid program; and

(2) The agency staff making the determination under paragraph (e)(1) of this section is the same staff responsible for making similar determinations in institutions or agencies participating under Medicare; and

(3) The agency designated in paragraph (e)(1) of this section makes recommendations regarding the effective dates of provider agreements, as determined under § 431.108.

(f) Written agreement required. The plan must provide for a written agreement (or formal written intra-agency arrangement) between the Medicaid agency and the survey agency designated under paragraph (e) of this section, covering the activities of the survey agency in carrying out its responsibilities. The agreement must specify that—

(1) Federal requirements and the forms, methods and procedures that the Administrator designates will be used to determine provider eligibility and certification under Medicaid;

(2) Inspectors surveying the premises of a provider will—

(i) Complete inspection reports;

(ii) Note on completed reports whether or not each requirement for which an inspection is made is satisfied; and

(iii) Document deficiencies in reports;

(3) The survey agency will keep on file all information and reports used in determining whether participating facilities meet Federal requirements; and

(4) The survey agency will make the information and reports required under paragraph (f)(3) of this section readily accessible to HHS and the Medicaid agency as necessary—

(i) For meeting other requirements under the plan; and

(ii) For purposes consistent with the Medicaid agency’s effective administration of the program.

(g) Responsibilities of survey agency. The plan must provide that, in certifying NFs and ICFs/MR, the survey agency designated under paragraph (e) of this section will—

(1) Review and evaluate medical and independent professional review team reports obtained under part 456 of this subchapter as they relate to health and safety requirements;

(2) Have qualified personnel perform on-site inspections periodically as appropriate based on the timeframes in the correction plan and—

(i) At least once during each certification period or more frequently if there is a compliance question; and

(ii) For non-State operated NFs, within the timeframes specified in § 488.308 of this chapter.

(3) Have qualified personnel perform on-site inspections—

(i) At least once during each certification period or more frequently if there is a compliance question; and

(ii) For intermediate care facilities with deficiencies as described in §§ 442.112 and 442.113 of this subchapter, within 6 months after initial correction plan approval and every 6 months thereafter as required under those sections.

(h) FFP for survey responsibilities. (1) FFP is available in expenditures that the survey agency makes to carry out its survey and certification responsibilities under the agreement specified in paragraph (f) of this section.

(2) FFP is not available in any expenditures that the survey agency makes that are attributable to the State’s overall responsibilities under
§ 431.615 Relations with State health and vocational rehabilitation agencies and title V grantees.

(a) Basis and purpose. This section implements section 1902(a)(11) and (22)(C) of the Act, by setting forth State plan requirements for arrangements and agreements between the Medicaid agency and—
(1) State health agencies;
(2) State vocational rehabilitation agencies; and
(3) Grantees under title V of the Act, Maternal and Child Health and Crippled Children’s Services.

(b) Definitions. For purposes of this section—
``Title V grantee’’ means the agency, institution, or organization receiving Federal payments for part or all of the cost of any service program or project authorized by title V of the Act, including—
(1) Maternal and child health services;
(2) Crippled children’s services;
(3) Maternal and infant care projects;
(4) Children and youth projects; and
(5) Projects for the dental health of children.

(c) State plan requirements. A state plan must—
(1) Describe cooperative arrangements with the State agencies that administer, or supervise the administration of, health services and vocational rehabilitation services designed to make maximum use of these services;
(2) Provide for arrangements with title V grantees, under which the Medicaid agency will utilize the grantee to furnish services that are included in the State plan;
(3) Provide that all arrangements under this section meet the requirements of paragraph (d) of this section; and
(4) Provide, if requested by the title V grantee in accordance with the arrangements made under this section, that the Medicaid agency reimburse the grantee or the provider for the cost of services furnished recipients by or through the grantee.

(d) Content of arrangements. The arrangements referred to in paragraph (c) must specify, as appropriate—
(1) The mutual objectives and responsibilities of each party to the arrangement;
(2) The services each party offers and in what circumstances;
(3) The cooperative and collaborative relationships at the State level;
(4) The kinds of services to be provided by local agencies; and
(5) Methods for—
(i) Early identification of individuals under 21 in need of medical or remedial services;
(ii) Reciprocal referrals;
(iii) Coordinating plans for health services provided or arranged for recipients;
(iv) Payment or reimbursement;
(v) Exchange of reports of services furnished to recipients;
(vi) Periodic review and joint planning for changes in the agreements;
(vii) Continuous liaison between the parties, including designation of State and local liaison staff; and
(viii) Joint evaluation of policies that affect the cooperative work of the parties.

(e) Federal financial participation. FFP is available in expenditures for Medicaid services provided to recipients through an arrangement under this section.

§ 431.620 Agreement with State mental health authority or mental institutions.

(a) Basis and purpose. This section implements section 1902(a)(20)(A) of the Act, for States offering Medicaid services in institutions for mental diseases for recipients aged 65 or older, by specifying the terms of the agreement those States must have with other State authorities and institutions. (See part 441, subpart C of this chapter for regulations implementing section 1902(a)(20)(B) and (C).)

(b) Definition. For purposes of this section, an “institution for mental diseases” means an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental
diseases. This includes medical attention, nursing care, and related services.

(c) State plan requirement. A State plan that includes Medicaid for persons aged 65 or older in institutions for mental diseases must provide that the Medicaid agency has in effect a written agreement with—

(1) The State authority or authorities concerned with mental diseases; and

(2) Any institution for mental diseases that is not under the jurisdiction of those State authorities, and that provides services under Medicaid to recipients aged 65 or older.

(d) Provisions required in an agreement. The agreement must specify the respective responsibilities of the agency and the authority or institution, including arrangements for—

(1) Joint planning between the parties to the agreement;

(2) Development of alternative methods of care;

(3) Immediate readmission to an institution when needed by a recipient who is in alternative care;

(4) Access by the agency to the State mental health and mental retardation authorities' records when necessary to carry out the agency's responsibilities;

(5) Recording, reporting, and exchanging medical and social information about recipients; and

(6) Other procedures needed to carry out the agreement.

[44 FR 17935, Mar. 23, 1979]

§ 431.621 State requirements with respect to nursing facilities.

(a) Basis and purpose. This section implements sections 1919(b)(3)(F) and 1919(e)(7) of the Act by specifying the terms of the agreement the State must have with the State mental health and mental retardation authorities concerning the operation of the State's preadmission screening and annual resident review (PASARR) program.

(b) State plan requirement. The State plan must provide that the Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meets the requirements specified in paragraph (c) of this section.

(c) Provisions required in an agreement. The agreement must specify the respective responsibilities of the agency and the State mental health and mental retardation authorities, including arrangements for—

(1) Joint planning between the parties to the agreement;

(2) Access by the agency to the State mental health and mental retardation authorities' records when necessary to carry out the agency's responsibilities;

(3) Recording, reporting, and exchanging medical and social information about individuals subject to PASARR;

(4) Ensuring that preadmission screenings and annual resident reviews are performed timely in accordance with §§ 483.112(c) and 483.114(c) of this part;

(5) Ensuring that, if the State mental health and mental retardation authorities delegate their respective responsibilities, these delegations comply with § 483.106(e) of this part;

(6) Ensuring that PASARR determinations made by the State mental health and mental retardation authorities are not countermanded by the State Medicaid agency, except through the appeals process, but that the State mental health and mental retardation authorities do not use criteria which are inconsistent with those adopted by the State Medicaid agency under its approved State plan;

(7) Designating the independent person or entity who performs the PASARR evaluations for individuals with MI; and

(8) Ensuring that all requirements of §§ 483.100 through 483.136 are met.

[57 FR 56506, Nov. 30, 1992; 58 FR 25784, Apr. 28, 1993]

§ 431.625 Coordination of Medicaid with Medicare part B.

(a) Basis and purpose. (1) Section 1943(a) of the Act requires the Secretary to have entered into an agreement with any State that requested that agreement before January 1, 1970, or during calendar year 1981, under which the State could enroll certain Medicare-eligible recipients under Medicare Part B and agree to pay their premiums.

(b) State plan requirement. The State plan must provide that the Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meets the requirements specified in paragraph (c) of this section.

(c) Provisions required in an agreement. The agreement must specify the respective responsibilities of the agency and the State mental health and mental retardation authorities, including arrangements for—

(1) Joint planning between the parties to the agreement;

(2) Access by the agency to the State mental health and mental retardation authorities' records when necessary to carry out the agency's responsibilities;

(3) Recording, reporting, and exchanging medical and social information about individuals subject to PASARR;
charges for recipients enrolled under Medicare Part B without obligating itself to provide the range of Part B benefits to other recipients; and

(3) Section 1903 (a)(1) and (b) of the Act authorizes FFP for State payment of Medicare Part B premiums for certain recipients.

(4) This section—

(i) Specifies the exception, relating to Part B coverage, from the requirement to provide comparable services to all recipients; and

(ii) Prescribes FFP rules concerning State payment for Medicare premiums and for services that could have been covered under Medicare.

(5) Section 1902(a)(15) of the Act requires that if a State chooses to pay only a portion of deductibles, cost sharing or other charges for recipients enrolled under Medicare Part B, the portion that is to be paid by a Medicaid recipient must be reasonably related to the recipient's income and resources.

(b) Exception from obligation to provide comparable services; State plan requirement.

(1) The State's payment of premiums, deductibles, cost sharing, or similar charges under Part B does not obligate it to provide the full range of Part B services to recipients not covered by Medicare.

(2) The State plan must specify this exception if it applies.

(c) Effect of payment of premiums on State liability for cost sharing.

(1) State payment of Part B premiums on behalf of a Medicaid recipient does not obligate it to provide the full range of Part B services to recipients not covered by Medicare.

(2) If a State pays on a recipient's behalf any portion of the deductible or cost sharing amounts under Medicare Part B, the portion paid by a State must be reasonably related to the recipient's income and resources.

(d) Federal financial participation: Medicare Part B premiums—(1) Basic rule. Except as provided in paragraph (d)(2) of this section, FFP is not available in State expenditures for Medicare Part B premiums for Medicaid recipients unless the recipients receive money payments under title I, IV-A, X, XIV, XVI (AABD or SSI) of the Act, or State supplements as permitted under section 1616(a) of the Act, or as required by section 212 of Pub. L. 93-66.

(2) Exception. FFP is available in expenditures for Medicare Part B premiums for the following groups:

(i) AFDC families required to be covered under §§435.112 and 436.116 of this subchapter, those eligible for continued Medicaid coverage despite increased income from employment;

(ii) Recipients required to be covered under §§435.114, 435.134, and 436.112 of this subchapter, those eligible for continued Medicaid coverage despite increased income from monthly insurance benefits under title II of the Act;

(iii) Recipients required to be covered under §435.135 of this subchapter, those eligible for continued Medicaid coverage despite increased income from cost-of-living increases under title II of the Act;

(iv) Recipients of foster care maintenance payments or adoption assistance payments who, under Part E of title IV of the Act are considered as receiving AFDC;

(v) Individuals required to be covered under §435.120 of this chapter, that is, blind or disabled individuals who, under section 1619(b) of the Act, are considered to be receiving SSI;

(vi) Individuals who, in accordance with §§435.115 and 436.114 of this chapter, are, for purposes of Medicaid eligibility, considered to be receiving AFDC. These are participants in a work supplementation program, or individuals denied AFDC because the payment would be less than $10;

(vii) Certain recipients of Veterans Administration pensions during the limited time they are, under section 310(b) of Pub. L. 96-272, considered as receiving SSI, mandatory State supplements, or AFDC;

(viii) Disabled children living at home to whom the State provides Medicaid under section 1902(e)(3) of the Act;

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

(x) Individuals who become ineligible for AFDC because they are no longer
§ 431.630 Coordination of Medicaid with PROs.

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

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

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

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

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

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

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

(a) Basis. This section implements sections 1902(a)(13)(C) and 1902(a)(53) of the Act, which provide for coordination of Medicaid with the Special Supplemen-
Subpart N—State Programs for Licensing Nursing Home Administrators

§ 431.700 Basis and purpose.

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

§ 431.701 Definitions.

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

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

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

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

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

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

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

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

(a) Has an ownership interest in the home; or

(b) Shares his functions and duties with one or more other persons.

§ 431.702 State plan requirement.

A State plan must provide that the State has a program for licensing administrators of nursing homes that meets the requirements of §§ 431.703 through 431.713 of this subpart.

§ 431.703 Licensing requirement.

The State licensing program must provide that only nursing homes supervised by an administrator licensed in accordance with the requirements of this subpart may operate in the State.

§ 431.704 Nursing homes designated by other terms.

If a State licensing law does not use the term “nursing home,” the HCFA Administrator will determine the term or terms equivalent to “nursing home” for purposes of applying the requirements of this subpart. To obtain this determination, the Medicaid agency must submit to the Regional Medicaid Director copies of current State laws that define institutional health care facilities for licensing purposes.

§ 431.705 Licensing authority.

(a) The State licensing program must provide for licensing of nursing home administrators by—

(1) The agency designated under the healing arts act of the State; or

(2) A State licensing board.

(b) The State agency or board must perform the functions and duties specified in §§ 431.707 through 431.713 and the board must meet the membership requirements specified in § 431.706 of this subpart.

§ 431.706 Composition of licensing board.

(a) The board must be composed of persons representing professions and institutions concerned with the care and treatment of chronically ill or infirm elderly patients. However—

(1) A majority of the board members may not be representative of a single profession or category of institution; and
(2) Members not representative of institutions may not have a direct financial interest in any nursing home.

(b) For purposes of this section, nursing home administrators are considered representatives of institutions.

§ 431.707 Standards.

(a) The agency or board must develop, impose, and enforce standards that must be met by individuals in order to be licensed as a nursing home administrator.

(b) The standards must be designed to insure that nursing home administrators are—

(1) Of good character;

(2) Otherwise suitable; and

(3) Qualified to serve because of training or experience in institutional administration.

§ 431.708 Procedures for applying standards.

The agency or board must develop and apply appropriate procedures and techniques, including examinations and investigations, for determining if a person meets the licensing standards.

§ 431.709 Issuance and revocation of license.

Except as provided in § 431.714 of this subpart, the agency or board must—

(a) Issue licenses to persons who meet the agency’s or board’s standards; and

(b) Revoke or suspend a license if the agency or board determines that the person holding the license substantially fails to meet the standards.

§ 431.710 Provisional licenses.

To fill a position of nursing home administrator that unexpectedly becomes vacant, the agency or board may issue one provisional license, for a single period not to exceed 6 months. The license may be issued to a person who does not meet all of the licensing requirements established under § 431.707 but who—

(a) Is of good character and otherwise suitable; and

(b) Meets any other standards established for provisional licensure by the agency or board.

§ 431.711 Compliance with standards.

The agency or board must establish and carry out procedures to insure that licensed administrators comply with the standards in this subpart when they serve as nursing home administrators.

§ 431.712 Failure to comply with standards.

The agency or board must investigate and act on all complaints it receives of violations of standards.

§ 431.713 Continuing study and investigation.

The agency or board must conduct a continuing study of nursing homes and administrators within the State to improve—

(a) Licensing standards; and

(b) The procedures and methods for enforcing the standards.

§ 431.714 Waivers.

The agency or board may waive any standards developed under § 431.707 of this subpart for any person who has served in the capacity of a nursing home administrator during all of the 3 calendar years immediately preceding the calendar year in which the State first meets the requirements in this subpart.

§ 431.715 Federal financial participation.

No FFP is available in expenditures by the licensing board for establishing and maintaining standards for the licensing of nursing home administrators.
reduce erroneous expenditures by monitoring eligibility determinations and a claims processing assessment system that monitors claims processing operations.

(b) Establishes rules and procedures for disallowing Federal financial participation (FFP) in erroneous Medicaid payments due to eligibility and recipient liability errors as detected through the MEQC program.

§ 431.802 Basis.
This subpart implements the following sections of the Act, which establish requirements for State plans and for payment of Federal financial participation (FFP) to States:

1902(a)(4) Administrative methods for proper and efficient operation of the State plan.
1903(u) Limitation of FFP for erroneous medical assistance expenditures.

§ 431.804 Definitions.
As used in this subpart—
Active case means an individual or family determined to be currently authorized as eligible for Medicaid by the agency.
Administrative period means the period of time recognized by the MEQC program for State agencies to reflect changes in case circumstances, i.e., a change in a common program area, during which no case error based on the circumstance change would be cited. This period consists of the review month and the month prior to the review month.
Claims processing error means FFP has been claimed for a Medicaid payment that was made—
(1) For a service not authorized under the State plan;
(2) To a provider not certified for participation in the Medicaid program;
(3) For a service already paid for by Medicaid; or
(4) In an amount above the allowable reimbursement level for that service.
Eligibility error means that Medicaid coverage has been authorized or payment has been made to a recipient or family under review who—
(1) Was ineligible when authorized or when he received services; or
(2) Was eligible for Medicaid but was ineligible for certain services he received; or
(3) Had not met recipient liability requirements when authorized eligible for Medicaid; that is, he had not incurred medical expenses equal to the amount of his excess income over the State’s financial eligibility level or he had incurred medical expenses that exceeded the amount of excess income over the State’s financial eligibility level, or was making an incorrect amount of payment toward the cost of services.
Negative case action means an action that was taken to deny or otherwise dispose of a Medicaid application without a determination of eligibility (for instance, because the application was withdrawn or abandoned) or an action to deny, suspend, or terminate an individual or family.
State agency means either the State Medicaid agency or a State agency that is responsible for determining eligibility for Medicaid.

§ 431.806 State plan requirements.
(a) MEQC program. A State plan must provide for operating a Medicaid eligibility quality control program that meets the requirements of §§ 431.810 through 431.822 of this subpart.
(b) Claims processing assessment system. Except in a State that has an approved Medicaid Management Information System (MMIS) under subpart C of part 433 of this subchapter, a State plan must provide for operating a Medicaid quality control claims processing assessment system that meets the requirements of §§ 431.830 through 431.836 of this subpart.

§ 431.808 Protection of recipient rights.
Any individual performing activities under the MEQC program or the claims processing assessment system specified in this subpart must do so in a manner that is consistent with the provisions of §§ 435.902 and 436.901 of this subchapter concerning the rights of recipients.

MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC) PROGRAM

SOURCE: Sections 431.810 through 431.822 appear at 55 FR 22167, May 31, 1990, unless otherwise noted.
§ 431.810 Basic elements of the Medicaid eligibility quality control (MEQC) program.

(a) General requirements. The agency must operate the MEQC program in accordance with this section and §§431.812 through 431.822 and other instructions established by HCFA.

(b) Review requirements. The agency must conduct MEQC reviews in accordance with the requirements specified in §431.812 and other instructions established by HCFA.

(c) Sampling requirements. The agency must conduct MEQC sampling in accordance with the requirements specified in §431.814 and other instructions established by HCFA.

§ 431.812 Review procedures.

(a) Active case reviews. (1) Except as provided in paragraph (a)(2) of this section, the agency must review all active cases selected from the State agency's lists of cases authorized eligible for the review month, to determine if the cases were eligible for services during all or part of the month under review, and, if appropriate, whether the proper amount of recipient liability was computed.

(2) The agency is not required to conduct reviews of the following cases:
   (i) Supplemental Security Income (SSI) recipient cases in States with contracts under section 1634 of the Act for determining Medicaid eligibility;
   (ii) Foster care and adoption assistance cases under title IV-E of the Act found eligible for Medicaid; and
   (iii) Cases under programs that are 100 percent federally funded.

(b) Negative case reviews. Except as provided in paragraph (c) of this section, the agency must conduct ME QC reviews of all negative cases selected from the State agency's lists of cases that are denied, suspended, or terminated in the review month to determine if the reason for the denial, suspension, or termination was correct and if requirements for timely notice of negative action were met. A State's negative case sample size is determined on the basis of the number of negative case actions in the universe.

(c) Alternate systems of negative case reviews—(1) Basic provision. A State may be exempt from the negative case review requirements specified in paragraphs (b) and (e)(2) of this section and in §431.814(d) upon HCFA's approval of a plan for the use of a superior system.

(2) Submittal of plan for alternate system. An agency must submit its plan for the use of a superior system to HCFA for approval at least 60 days before the beginning of the review period in which it is to be implemented. If a plan is unchanged from a previous period, the agency is not required to resubmit it.

The agency must receive approval for a plan before it can be implemented.

(3) Requirement for alternate system. To be approved, the State's plan must—
   (i) Clearly define the purpose of the system and demonstrate how the system is superior to the current negative case review requirements.
   (ii) Contain a methodology for identifying significant problem areas that could result in erroneous denials, suspensions, and terminations of applicants and recipients. Problem areas selected for review must contain at least as many applicants and recipients as were included in the negative case sample size previously required for the State.
   (iii) Provide a detailed methodology describing how the extent of the problem area will be measured through sampling and review procedures, the findings expected from the review, and planned corrective actions to resolve the problem.
   (iv) Include documentation supporting the use of the system methodology. Documentation must include the timeframes under which the system will be operated.
   (v) Provide a superior means of monitoring denials, terminations, and suspensions than that required under paragraph (b) of this section.
   (vi) Provide a statistically valid error rate that can be projected to the universe that is being studied.

(d) Reviews for erroneous payments. The agency must review all claims for services furnished during the review month and paid within 4 months of the review month to all members of each active case related in the sample to identify erroneous payments resulting from—
   (1) Ineligibility for Medicaid;
§431.814 Sampling plan and procedures.

(a) Plan approval. The agency must submit a basic MEQC sampling plan (or revisions to a current plan) that meets the requirements of this section to the appropriate HCFA regional office for approval at least 60 days before the beginning of the review period in which it is to be implemented. If a plan is unchanged from a previous period, the agency is not required to resubmit the entire plan. Universe estimates and sampling intervals are required 2 weeks before the first monthly sample selection for each review period. The agency must receive approval for a plan before it can be implemented.

(b) Plan requirements. The agency must have an approved sampling plan in effect for the full 6-month sampling period that includes the following:

(1) The population to be sampled;

(2) The list(s) from which the sample is selected and the following characteristics of the list(s):

(i) Sources;

(ii) All types of cases in the selection lists;

(iii) Accuracy and completeness of sample lists in reference to the population(s) of interest;

(iv) Whether or not the selection list was constructed by combining more than one list;

(v) The form of the selection list (whether the list or part of the list is automated);

(vi) Frequency and length of delays in updating the selection lists or their sources;

(vii) Number of items on the lists and proportion of listed-in-error items;

(viii) Methods of deleting unwanted items from the selection lists; and

(ix) Structure of the selection lists.

(3) The sample size, including the minimum number of reviews to be completed and the expected number of cases to be selected. Minimum sample sizes are based on the State's relative level of Medicaid annual expenditures for services for active cases, and on the total number of negative case actions in the universe for negative cases. When the sample is substratified, there
§431.814 42 CFR Ch. IV (10–1–00 Edition)

can be no fewer than 75 cases in each substratum, except as provided in paragraph (c) of this section or as provided in an exception documented in an approved sampling plan which contains a statement accepting the precision and reliability of the reduced sample.

(4) The sample selection procedure. Systematic random sampling is recommended. Alternative procedures must provide a representative sample, conform to principles of probability sampling, and yield estimates with the same or better precision than achieved in systematic random sampling.

(5) Procedures used to identify amounts paid for services received in the review month.

(6) Specification as to whether the agency chooses to—

(i) Use billed amounts to offset recipient liability toward cost of care (No indication will be interpreted to mean that the agency will use paid claims); and

(ii) Use denied claims to offset recipient liability toward cost in the payment review. (No indication will be interpreted to mean denied claims will not be used.)

(7) Indication of whether the agency opts to drop or complete cases selected more than once in a sample period. (No indication will be interpreted to mean that the agency will complete cases selected more than once.)

(c) Eligibility universe—active cases. The MEQC universe for active cases must be divided into two strata, the Aid to Families with Dependent Children (AFDC) stratum and the Medical Assistance Only (MAO) stratum.

(1) All States must use the AFDC quality control sample for the AFDC stratum.

(2) States must include in the MAO stratum all cases certified as eligible for Medicaid that are not in the AFDC stratum, excluding individuals specified in paragraph (c)(4) of this section.

(3) States that do not have an agreement with the Social Security Administration under section 1634 of the Act and do not have more restrictive eligibility criteria under section 1902(f) of the Act but require a separate Medicaid application for recipients of SSI and determine Medicaid eligibility using SSI criteria must divide the MAO stratum into two substrata: MAO cases and SSI cash cases for the first review period beginning after July 1, 1990 and for review periods thereafter. The SSI substratum sample size must be 75 cases or one-half of the total MAO sample, whichever is smaller. The non-SSI MAO substratum sample will be the remainder of the MAO stratum cases.

States may be exempt from this requirement when implementing an approved sampling option that does not accommodate this stratification method.

(4) States must exclude from the MEQC universe SSI beneficiaries whose eligibility determinations were made exclusively by the Social Security Administration under an agreement under section 1634 of the Act, individuals in foster care or receiving adoption assistance whose eligibility is determined under title IV-E of the Act, and individuals receiving Medicaid under programs that are 100 percent federally funded.

(d) Eligibility universe—negative cases. Unless the agency has an approved superior system under §431.812(c) that provides otherwise, the universe for negative Medicaid eligibility cases must consist of all denied applications, suspensions, and terminations occurring during the review month except transfers between counties without any break in eligibility, cases in which eligibility is exclusively determined by SSA under a section 1634 contract, cases determined eligible for foster care and adoption assistance under title IV-E of the Act, and cases under programs that are 100 percent federally funded.

(e) Sampling procedures. The agency must document all sampling procedures used by the State agency, including 98 percent accuracy of program identifier codes used in the sampling frame to separate listed-in-error cases from those in the population of interest, must make them available for review by HCFA, and must be able to demonstrate the integrity of its sampling procedures in accordance with this section.

(f) Sampling periods. The agency must use 6-month sampling periods, from April through September and from October through March.
(g) Statistical samples. The agency must select statistically valid samples of both active and negative case actions.

(h) Sample selection lists. The agency must submit to HCFA monthly a list of cases selected in the sample to be reviewed, after the state's sample selection and before commencing MEQC reviews on the cases in the sample.

(i) Universe estimates and sampling intervals. The agency must submit detailed universe estimates and sampling intervals to HCFA for approval at least 2 weeks before the first sample selection of the review period if the estimates differ from the previous period. The sampling intervals must be used continuously throughout the sampling period unless otherwise specified in an approved sampling plan. Final universe counts based on the actual sampling universe must be determined and reported to HCFA for each stratum/substratum designated in the sampling plan.

The agency also must submit universe counts for cases eligible for foster care and adoption assistance under title IV-E of the Act, and, for States with an agreement under section 1634 of the Act, for cases found eligible by the Social Security Administration.

(j) Sample size and methodology options. The agency may select a sample size in accordance with the minimum established under paragraph (b)(3) of this section or use one of the methodologies specified in paragraph (j)(1) or (2) of this section.

(1) Increase in size. The agency may, at its option, increase its sample size for a sampling period above the federally prescribed minimum sample size provided for under paragraph (b)(3) of this section, and receive FFP for any increased administrative costs the agency incurs by exercising this option.

(2) Retrospective sampling. The agency may, at its option, implement retrospective sampling in which cases are stratified by dollar value of claims paid. If the agency selects retrospective sampling, it must—

(i) Draw an initial case sample size each month that is no less than 5 times the required sample size. The sample will be selected from the universe of cases that were certified eligible in the fourth month prior to the month of case selection;

(ii) Identify claims paid for services furnished to all individuals during the review month (and, if indicated, any months prior to the review month in the agency's selected spenddown period) for these cases;

(iii) Stratify the cases by dollar value of the claims into three strata; and

(iv) Select a second statistically valid sample within each group subject to the sample size requirements specified in paragraph (b)(3) or (j)(1) of this section.

§ 431.816 Case review completion deadlines and submittal of reports.

(a) The agency must complete case reviews and submit reports of findings to HCFA as specified in paragraph (b) of this section in the form and at the time specified by HCFA.

(b) In addition to the reporting requirements specified in §431.814 relating to sampling, the agency must complete case reviews and submit reports of findings to HCFA in accordance with paragraphs (b)(1) through (6) of this section for review periods beginning after July 1, 1990. The agency must not combine or otherwise integrate case findings from the MAO and AFDC strata to meet the case percentage deadlines as specified in paragraphs (b)(1) through (6) of this section.

(1) Active case eligibility reviews—MAO stratum. (i) The agency must complete case eligibility reviews and report the findings electronically through the system prescribed by HCFA for 90 percent of all active MAO cases within 105 days of the end of the review month for which those cases were reviewed, within 125 days for 95 percent of all active MAO cases, and within 150 days for 100 percent of all MAO active cases.

(ii) The agency must submit a report on cases selected for the review month.

(2) Active case eligibility reviews—AFDC stratum. (i) The agency must complete case eligibility reviews for AFDC ineligible and overpaid error cases caused by ineligible individuals and report the findings electronically through the system prescribed by HCFA within 105 days of the end of the
§ 431.818 Access to records: MEQC program.

(a) The agency, upon written request, must mail to the HHS staff all records, including complete local agency eligibility case files or legible copies and all other documents pertaining to its MEQC reviews to which the State has access, including information available under part 435, subpart I, of this chapter.

(b) The agency must mail requested records within 10 working days of receipt of a request, unless the State has an alternate method of submitting these records that is approved by HCFA or has received, on an as-needed basis, approval from HCFA to extend this timeframe by 3 additional working days to allow for exceptional circumstances.

§ 431.820 Corrective action under the MEQC program.

The agency must—

(a) Take action to correct any active or negative case action errors found in the sample cases;

(b) Take administrative action to prevent or reduce the incidence of those errors; and

(c) By September 15 each year, submit to HCFA a report on its error rate analysis and a corrective action plan based on that analysis. The agency must submit revisions to the plan within 60 days of identification of additional error-prone areas, other significant changes in the error rate (that is, changes that the State experiences that increase or decrease its error rate and necessitate immediate corrective action or discontinuance of corrective actions that effectively control the cause of the error rate change), or changes in planned corrective action.

review month for which those cases were reviewed for 90 percent of the total reviews; within 125 days of the end of the review month for which those cases were reviewed for 95 percent of the total reviews; and within 150 days of the end of the review month for which those cases were reviewed for 100 percent of the total reviews.

(ii) The agency must report findings electronically through the system prescribed by HCFA for 100 percent of the State agency-reported eligible individuals within 30 days after the final timeframe required by the AFDC program as specified in program regulations at 45 CFR 205.40(b)(2)(ii).

(3) Negative case eligibility reviews. The agency must submit a monthly progress report on negative case reviews completed during the month unless the agency has an approved superior system in effect. The agency must submit a report on its findings by June 30 of each year for the previous April-September sampling period and by December 31, for the October-March sampling period.

(4) Payment reviews. (i) The agency must submit payment review findings electronically through the system prescribed by HCFA.

(ii) The agency must complete payment review findings for 100 percent of the active case reviews in its sample and report the findings within 60 days after the first day of the month in which the claims collection process begins. The agency must wait 5 months after the end of each review month before associating the amount of claims paid for each case for services furnished during the review month unless retrospective sampling is elected.

(iii) The agency must make any necessary corrections to claims payments during the month the claim is paid and the following month. HCFA will take necessary action to reject any State adjustment adversely affecting the error rate, for example, by not paying claims on error cases.

(5) Summary of reviews and findings. The agency must submit summary reports of the findings for all active cases in the 6-month sample by July 31 of each year for the previous April-September sampling period and by January 31 for the October-March sampling period. These summary reports must include findings changed in the Federal re-review process.

(6) Other data and reports. The agency must report other requested data and reports in a manner prescribed by HCFA.
§ 431.822 Resolution of differences in State and Federal case eligibility or payment findings.

(a) When a difference exists between State and Federal case eligibility or payment findings, the Regional Office will notify the agency by a difference letter.

(b) The agency must return the difference letter to the Regional Office within 28 calendar days of the date of the letter indicating either agreement with the Federal finding or reasons for disagreement and if the agency desires a conference to resolve the difference. This period may be shortened if the Regional Office finds that it is necessary to do so in order to meet a case completion deadline, and the State still has a reasonable period of time in which to respond to the letter. If the agency fails to submit the difference letter indicating its agreement or disagreement with the Federal findings within the 28 calendar days (or the shorter period designated as described above), the Federal findings will be sustained.

(c) If the Regional Office disagrees with the agency’s response, a difference conference will be scheduled within 20 days of the request of the agency. If a difference cannot be resolved, the State may request a direct presentation of its position to the Regional Administrator. The Regional Administrator has final authority for resolving the difference.

§ 431.830 Basic elements of the Medicaid quality control (MQC) claims processing assessment system.

An agency must—
(a) Operate the MQC claims processing assessment system in accordance with the policies, sampling methodology, review procedures, reporting forms, requirements, and other instructions established by HCFA;
(b) Identify deficiencies in the claims processing operations;
(c) Measure cost of deficiencies;
(d) Provide data to determine appropriate corrective action;
(e) Provide an assessment of the State’s claims processing or that of its fiscal agent;
(f) Provide for a claim-by-claim review where justifiable by data; and
(g) Produce an audit trail that can be reviewed by HCFA or an outside auditor.

§ 431.832 Reporting requirements for claims processing assessment systems.

(a) The agency must submit reports and data specified in paragraph (b) of this section to HCFA, in the form and at the time specified by HCFA.

(b) Except when HCFA authorizes less stringent reporting, States must submit:
(1) A monthly report on claims processing reviews sampled and or claims processing reviews completed during the month;
(2) A summary report on findings for all reviews in the 6-month sample to be submitted by the end of the 3rd month following the scheduled completion of reviews for that 6-month period; and
(3) Other data and reports as required by HCFA.

§ 431.834 Access to records: Claims processing assessment systems.

The agency, upon written request, must provide HHS staff with access to all records pertaining to its MQC claims processing assessment system reviews to which the State has access, including information available under part 435, subpart J, of this chapter.

§ 431.836 Corrective action under the MQC claims processing assessment system.

The agency must—
(a) Take action to correct those errors identified through the claims processing assessment system review and, if cost effective, to recover those funds erroneously spent;
(b) Take administrative action to prevent and reduce the incidence of those errors; and
(c) By August 31 of each year, submit to HCFA a report of its error analysis and a corrective action plan on the reviews conducted since the cut-off-date of the previous corrective action plan.

(a) Purpose and applicability—

(1) Purpose. This section establishes rules and procedures for disallowing Federal financial participation (FFP) in erroneous medical assistance payments due to eligibility and beneficiary liability errors, as detected through the Medicaid eligibility quality control (MEQC) program required under § 431.806 in effect on and after July 1, 1990.

(2) Applicability. This section applies to all States except Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa beginning July 1, 1990.

(b) Definitions. For purposes of this section—

Administrator means the Administrator, Health Care Financing Administration or his or her designee.

Annual assessment period means the 12-month period October 1 through September 30 and includes two 6-month sample periods (October-March and April-September).

Beneficiary liability means—

(1) The amount of excess income that must be offset with incurred medical expenses to gain eligibility; or

(2) The amount of payment a recipient must make toward the cost of services.

Erroneous payments means the Medicaid payment that was made for an individual or family under review who—

(1) Was ineligible for the review month or, in full month coverage is not provided, at the time services were received;

(2) Was ineligible to receive a service provided during the review month; or

(3) Had not properly met beneficiary liability prior to receiving Medicaid services.

National mean error rate means the payment weighted average of the eligibility payment error rates for all States.

National standard means a 3-percent eligibility payment error rate.

State payment error rate means the ratio of erroneous payments for medical assistance to total expenditures for medical assistance (less payments to Supplemental Security Income beneficiaries in section 1634 contract States and payments for children eligible for foster care and adoption assistance under title IV-E of the Act) for cases under review under the MEQC system for each assessment period.

Technical error means an error in an eligibility condition that, if corrected, would not result in a difference in the amount of medical assistance paid. These errors include work incentive program requirements, assignment of social security numbers, the requirement for a separate Medicaid application, monthly reporting requirements, assignment of rights to third party benefits, and failure to apply for benefits for which the family or individual is not eligible. Errors other than those listed in this definition, identified by HCFA in subsequent instructions, or approved by HCFA are not technical errors.

(c) Setting of State’s payment error rate.

(1) Each State must, for each annual assessment period, have a payment error rate no greater than 3 percent or be subject to a disallowance of FFP.

(2) A payment error rate for each State is determined by HCFA for each annual assessment period by computing the statistical estimate of the ratio of erroneous payments for medical assistance made on behalf of individuals or cases in the sample for services received during the review month to total expenditures for medical assistance for that State made on behalf of individuals or cases in the sample for services received during the review month. This ratio incorporates the findings of a federally re-reviewed subsample of the State’s review findings and is projected to the universe of total medical assistance payments for calculating the amount of disallowance under paragraph (d)(6) of this section.

(3) The State’s payment error rate does not include payments made on behalf of individuals whose eligibility determinations were made exclusively by the Social Security Administration under an agreement under section 1634 of the Act or children found eligible for
foster care and adoption assistance under title IV-E of the Act.

(4) The amount of erroneous payments is determined as follows:

(i) For ineligible cases resulting from excess resources, the amount of error is the lesser of—

(A) The amount of the payment made on behalf of the family or individual for the review month; or

(B) The difference between the actual amount of countable resources of the family or individual for the review month and the State's applicable resources standard.

(ii) For ineligible cases resulting from other than excess resources, the amount of error is the total amount of medical assistance payments made for the individual or family under review for the review month.

(iii) For erroneous payments resulting from failure to properly meet beneficiary liability, the amount of error is the lesser of—

(A) The amount of payments made on behalf of the family or individual for the review month; or

(B) The difference between the correct amount of beneficiary liability and the amount of beneficiary liability met by the individual or family for the review month.

(iv) The amount of payments made for services provided during the review month for which the individual or family was not eligible.

(5) In determining the amount of erroneous payments, errors caused by technical errors are not included.

(6) If a State fails to cooperate in completing a valid MEQC sample or individual reviews in a timely and appropriate fashion as required, HCFA will establish the State's payment error rate based on either—

(i) A special sample or audit;

(ii) The Federal subsample; or

(iii) Other arrangements as the Administrator may prescribe.

(7) When it is necessary for HCFA to exercise the authority in paragraph (c)(6) of this section, the amount that would otherwise be payable to the State under title XIX of the Act is reduced by the full costs incurred by HCFA in making these determinations. HCFA may make these determinations either directly or under contractual or other arrangements.

(d) Computation of anticipated error rate. (1) Before the beginning of each quarter, HCFA will project the anticipated medical assistance payment error rate for each State for that quarter. The anticipated error rate is the lower of the weighted average error rate of the two most recent 6-month review periods or the error rate of the most recent 6-month review period. In either case, cases in the review periods must have been completed by the State and HCFA. If a State fails to provide HCFA with information needed to project anticipated excess erroneous expenditures, HCFA will assign the State an error rate as prescribed in paragraph (c)(6) of this section.

(2) If the State believes that the anticipated error rate established in accordance with paragraph (d)(1) of this section is based on erroneous data, the State may submit evidence that demonstrates the data were erroneous. If the State satisfactorily demonstrates that HCFA's data were erroneous, the State's anticipated error rate will be adjusted accordingly. Submittal of evidence is subject to the following conditions:

(i) The State must inform HCFA of its intent to submit evidence at least 70 days prior to the beginning of the quarter.

(ii) The State may request copies of data that HCFA used to compute its anticipated error rate within 7 days of receiving notification of its projected error rate.

(iii) The State has up to 40 days before the quarter begins to present the evidence.

(iv) The evidence is restricted to documentation of suspected HCFA data entry errors, processing errors, and resolutions of Federal subsample difference cases subsequent to calculation of the error rate projection as contained in the original notice to the State.

(v) The State may not submit other evidence, such as that consisting of revisions to State errors as a result of changes to the original State review findings submitted to HCFA.
(vi) The State may not submit evidence challenging the error rate computational methodology.

(3) Based on the anticipated error rate established in paragraph (d)(1) or (d)(2) of this section, HCFA reduces its estimate of the State's requirements for FFP for medical assistance for the quarter by the percentage by which the anticipated payment error rate exceeds the 3-percent national standard. This reduction is applied against HCFA's total estimate of FFP for medical assistance expenditures (less payments to Supplemental Security Income beneficiaries in 1634 contract States and payments to children found eligible for foster care and adoption assistance under title IV-E of the Act) prior to any other required reductions. The reduction is noted on the State's grant award for the quarter and does not constitute a disallowance, and, therefore, is not appealable.

(4) After the end of each quarter, an adjustment to the reduction will be made based on the State's actual expenditures.

(5) After the actual payment error rate has been established for each annual assessment period, HCFA will compute the actual amount of the disallowance and adjust the FFP payable to each State based on the difference between the amounts previously withheld for each of the quarters during the appropriate assessment period and the amount that should have been withheld based on the State's actual final error rate. If HCFA determines that the amount withheld for the period exceeds the amount of the actual disallowance, the excess amount withheld will be returned to the States through the normal grant awards process within 30 days of the date the actual disallowance is calculated.

(6) HCFA will compute the amount to be withheld or disallowed as follows:

(i) Subtract the 3-percent national standard from the State's anticipated or actual payment error rate percentage.

(ii) If the difference is greater than zero, the Federal medical assistance funds for the period, excluding payments for those individuals whose eligibility for Medicaid was determined exclusively by the Social Security Administration under a section 1634 agreement and children found eligible for foster care and adoption assistance under title IV-E of the Act, are multiplied by that percentage. This product is the amount of the disallowance or withholding.

(7) A State's payment error rate for an annual assessment period is the weighted average of the payment error rates in the two 6-month review periods comprising the annual assessment period.

(8) The weights are established as the percent of the total annual payments, excluding payments for those individuals whose eligibility for Medicaid was determined exclusively by the Social Security Administration under a section 1634 agreement and children found eligible for foster care and adoption assistance under title IV-E of the Act, that occur in each of the 6-month periods.

(e) Notice to States and showing of good faith.

(1) When the actual payment error rate data are finalized for each annual assessment period ending after July 1, 1990, HCFA will establish each State's error rate and the amount of any disallowance. States that have error rates above the national standard will be notified by letter of their error rates and the amount of the disallowance.

(i) The State has 65 days from the date of receipt of this notification to show that this disallowance should not be made because it failed to meet the national standard despite a good faith effort to do so.

(ii) If HCFA is satisfied that the State did not meet the national standard despite a good faith effort, HCFA may reduce the funds being disallowed in whole or in part as it finds appropriate under the circumstances shown by the State.

(iii) A finding that a State did not meet the national standard despite a good faith effort was made rests entirely with the State.

(2) Some examples of circumstances under which HCFA may find that a State did not meet the national standard despite a good faith effort are—
(i) Disasters such as fire, flood, or civil disorders that—
   (A) Require the diversion of significant personnel normally assigned to Medicaid eligibility administration; or
   (B) Destroyed or delayed access to significant records needed to make or maintain accurate eligibility determinations;
(ii) Strikes of State staff or other government or private personnel necessary to the determination of eligibility or processing of case changes;
(iii) Sudden and unanticipated workload changes that result from changes in Federal law and regulation, or rapid, unpredictable caseload growth in excess of, for example, 15 percent for a 6-month period;
(iv) State actions resulting from incorrect written policy interpretations to the State by a Federal official reasonably assumed to be in a position to provide that interpretation; and
(v) The State has taken the action it believed was needed to meet the national standard, but the national standard was not met. HCFA will consider request for a waiver under this criterion only if a State has achieved an error rate for the preceding sample period that (after reducing the error rate by taking into account the cases determined by HCFA to be in error as a result of conditions listed in paragraphs (e)(2)(i) through (iv) of this section) is less than its error rate for the preceding sample year and does not exceed the national mean error rate for the sample period under review (unless that national mean error rate is at or below the 3-percent national standard). If the agency has met this error reduction requirement or had error rates of 3 percent or below for the prior two review periods, and its error rate for the review period under consideration is less than one-third above the national standard, HCFA will evaluate a request for a good faith waiver based on the following factors:
   (A) The State has fully met the performance standards in the operation of a quality control system in accordance with Federal regulations and HCFA guidelines (e.g., adherence to Federal case completion timeliness requirements and verification standards).
   (B) The State has achieved substantial performance in the formulation of error reduction initiatives based on the following processes:
      (1) Performance of an accurate and thorough statistical and program analysis for error reduction which utilized quality control and other data;
      (2) The translation of such analysis into specific and appropriate error reduction practices for major error elements; and
      (3) The use of monitoring systems to verify that the error reduction initiatives were implemented at the local office level;
   (C) The State has achieved substantial performance in the operation of the following systems supported by evidence of the timely utilization of their outputs in the determination of case eligibility:
      (1) The operation of the Income and Eligibility Verification System in accordance with the requirements of parts 431 and 435 of this chapter, and
      (2) The operation of systems that interface with Social Security data and, where State laws do not restrict agency access, records from agencies responsible for motor vehicles, vital statistics, and State or local income and property taxes (where these taxes exist).
   (D) The State has achieved substantial performance in the use of the following accountability mechanisms to ensure that agency staff adhere to error reduction initiatives. The following are minimum requirements:
      (1) Accuracy of eligibility and liability determinations and timely processing of case actions are used as quantitative measures of employee performance and reflected in performance standards and appraisal forms;
      (2) Selective second-party case reviews are conducted. The second-party review results are periodically reported to higher level management, as well as supervisors and workers and are used in performance standards and appraisal forms; and
      (3) Regular operational reviews of local offices are performed by the State to evaluate the offices' effectiveness in meeting error reduction goals with
periodic monitoring to ensure that review recommendations have been implemented.

(vi) A State that meets the performance standards specified in paragraphs (e)(2)(v) (A) through (D) of this section will be considered for a full or partial waiver of its disallowance amount. The State must submit only specific documentation that verifies that the necessary actions were accomplished. For example, a State could begin worker performance standards reflecting timeliness and case accuracy as quantitative measures of performance.

(3) The failure of a State to act upon necessary legislative changes or to obtain budget authorization for needed resources is not a basis for finding that a State failed to meet the national standard despite a good faith effort.

(f) Disallowance subject to appeal. (1) If a State does not agree with a disallowance imposed under paragraph (e) of this section, it may appeal to the Departmental Appeals Board within 30 days from the date of the final disallowance notice from HCFA. The regular procedures for an appeal of a disallowance will apply, including review by the Appeals Board under 45 CFR part 16.

(2) This appeal provision, as it applies to MEQC disallowances, is not applicable to the Administrator's decision on a State's waiver request provided for under paragraph (e) of this section.


PART 432—STATE PERSONNEL ADMINISTRATION

Subpart A—General Provisions

Sec. 432.1 Basis and purpose.
432.2 Definitions.
432.10 Standards of personnel administration.

Subpart B—Training Programs; Subprofessional and Volunteer Programs

432.30 Training programs: General requirements.
432.31 Training and use of subprofessional staff.
432.32 Training and use of volunteers.