[4110-35-M]

Title 42—Public Health

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SUBCHAPTER C—MEDICAL ASSISTANCE PROGRAM

MEDICAID PROGRAM

Redesignation and Rewrite

AGENCY: Health Care Financing Administration (HCFA), HEW.

ACTION: Final rules with comment period.

SUMMARY: These regulations redesignate and clarify, without substantive change, policies contained in 45 CFR Parts 205, 206, and 208 as they apply to the Medicaid program under title XIX of the Social Security Act. Those policies deal with: 1. Application, eligibility determination, and furnishing of assistance; 2. Hearings for applicants and recipients; 3. Safeguarding information; 4. Certain other administrative and fiscal requirements imposed on State agencies; and 5. Assistance to individuals age 65 and over in institutions for mental diseases.

The redesignation is being made because, effective October 1, 1977, the vast majority of HCFA regulations were transferred to a new 42 CFR Chapter IV. The redesignation of these regulations will help complete the transfer and will preclude any confusion that might arise from having a few Medicaid regulations in a different chapter and title.

EFFECTIVE: March 23, 1979. Although these regulations are final, comments may be submitted as described in the "Supplementary Information" below.

ADDRESSES: Send comments to: Administrator, Health Care Financing Administration, Department of Health, Education, and Welfare, Post Office Box 2366, Washington, D.C. 20013.

In commenting, please refer to PCO-184-R. Comments will be available for public inspection beginning approximately 2 weeks from today in room 5231 of the Department's offices at 330 C Street S.W., Washington, D.C., Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (202-245-0950).

FOR FURTHER INFORMATION CONTACT:

Luisa V. Iglesias (202) 245-0950.

SUPPLEMENTARY INFORMATION:

REASON FOR REDESIGNATION

This redesignation is one in a series initiated last year to separate the provisions of 45 CFR Chapter II that are applicable to Medicaid and consolidate them in 42 CFR Chapter IV with the other regulations pertaining to HCFA. 45 CFR Chapter II was previously promulgated by the Social and Rehabilitation Service (SRS) and applied to a variety of State grant programs of public assistance (including titles I, IV-A, VI, X, XIV, XVI and XIX of the Social Security Act). On March 9, 1977, HEW was reorganized: SRS ceased to exist; HCFA was created and assigned responsibility for the Medicaid program; and the other programs administered by SRS were transferred to other HEW components. Since then, HCFA has been recodifying regulations applicable to its programs in Title 42 of the Code of Federal Regulations. A major reorganization and recodification of the Medicaid regulations was published on September 29, 1978 (43 FR 45176). A revision and recodification of 45 CFR Parts 201 and 213 and portions of 204 and 205 was published as an NPRM on August 25, 1978 (43 FR 38345).

CONFORMING AMENDMENTS

Conforming amendments to 45 CFR Parts 205, 206, and 208, making them inapplicable to Medicaid, are published in today's Federal Register (see table of contents). Those regulations remain in effect for the other programs previously administered by SRS.

REVOCATION OF PROVISION

We are not recodifying the provisions under 45 CFR 205.170 on State standards for office space, equipment, and facilities. We believe it is not necessary that we impose these requirements in order to achieve proper State administration of the Medicaid program. Therefore, to conform with our Operation Common Sense efforts to remove unnecessary requirements on States, we are deleting these requirements as they apply to Medicaid. They remain applicable to the other programs specified in § 205.170.

TECHNICAL CORRECTIONS

We have also made some technical changes to correct cross references to the redesignated sections already published in other Medicaid regulations in the Code of Federal Regulations.

EFFECT OF REDESIGNATION ON CURRENT PRACTICES

This redesignation is not intended to change policies affecting Medicaid or the other programs. Therefore, we do not intend for the States and HEW Regional Offices to interpret and apply them differently than they did before the redesignation.

MAINTAINING UNIFORM POLICIES

We are reviewing all of the regulations previously codified in 45 CFR Chapter II, to determine whether policy changes are desirable, as well as to improve organization and clarity. Any further changes in these regulations will be published as Notices of Proposed Rulemaking. We expect these to be issued within the next few months. To the extent possible under our statutory authorities, we will maintain uniform policies and wording for all programs administered by HEW.

NOTICE AND OPPORTUNITY FOR PUBLIC COMMENT

We find that there is good cause to waive notice of proposed rulemaking and a delayed effective date because no substantive change has been made, other than the deletion discussed above. However, we will consider comments or objections received by May 22, 1979, from anyone who believes that existing policy is changed by these regulations. We will promptly make any corrections necessary because of inadvertent changes.

DERIVATION TABLE

This list includes only new sections based on regulations existing before redesignation. Sections containing new material that is introductory or explanatory have not been included.

New Section in 42 CFR	Old Section in 45 CFR
431.10	205.100.
431.11	205.101.
431.15	205.30.
431.16	205.60(a)(2).
431.17	205.60(a) (1) and (b).
431.18	205.70.
431.50	205.120.
431.202	205.10(a) (Introductory paragraph).
431.205	205.10(a)(1).
431.206	205.10(a) (2) and (3).
431.210	205.10(a)(4)(i)(B).
431.211	205.10(a)(4)(i)(A).
431.213	205.10(a)(4)(ii).
431.214	205.10(a)(4)(iv).
431.220	205.10(a)(5).
431.221	205.10(a)(5) (i)-(iii).
431.222	205.10(a)(5)(iv).
431.223	205.10(a)(5)(v).
431.230	205.10(a)(6).

New Section in 42 CFR	Old Section in 45 CFR
431.231	205.10(a)(7).
431.232	205.10(a)(6)(iii) (1st Sentence).
431.233	205.10(a)(6)(iii) (2nd Sentence).
431.240	205.10(a) (8)-(10).
431.241	205.10(a)(12) (i) and (ii)(B).
431.242	205.10(a)(13).
431.243	205.10(a)(11) (1st Sentence).
431.244	205.10(a) (14), (15) and (16).
431.245	205.10(a)(17).
431.246	205.10(a)(18).
431.250	205.10(b).
431.301	205.50(a)(1)(i)(A) (1st Sentence) and 205.50 (b) and (c).
431.302	205.50(a)(1)(i)(A) (2nd Sentence).
431.303	205.50(a)(1)(ii).
431.304	205.50(a)(3).
431.305	205.50(a)(2)(i).
431.306	205.50(a)(2) (ii)-(v).
431.307	205.50(a)(4).
431.620	208.1(a)(1).
433.32	205.145.
433.33	205.130.
433.34	205.150.
433.35	205.160.
435.902	206.10(a)(10).
435.903	206.10(a)(11).
435.904	206.10(a)(12).
435.905	206.10(a)(2)(i).
435.906	206.10(a)(1) (Introductory paragraph).
435.907	206.10(a)(1)(ii) (words before "from the applicant").
435.908	206.10(a)(1)(ii) (words after "State agency") and (iii).
435.909	206.10(a)(1)(iv) (A) and (B).
435.910	206.10(a)(1)(v) (A) and (C).
435.911	206.10(a)(3).
435.912	206.10(a)(4).
435.913	206.10(a)(8).
435.914	206.10(a)(6).
435.916	206.10(a)(2)(ii) and 206.10(a)(9) (i)-(iii).
435.919	206.10(a)(7).
435.920	206.10(a)(9)(iii) (A) and (B).
435.930	206.10(a)(5).
436.901	206.10.
436.909	206.10(a)(1)(iv) (A) and (B).
441.101	208.1(a) (words before "(1) Having in effect * * *").
441.102	208.1(a)(2).
441.103	208.1(a) (3) and (4).
441.105	208.1(a) (5) and (6).
441.106	208.1(a)(7).

REDESIGNATION TABLE

This redesignation table has been developed as a reference tool only. The redesignations of specific sections and paragraphs from 45 CFR Parts 205, 206, and 208 apply only to the Medicaid program. The regulatory provisions under Parts 205, 206, and 208 that apply to the financial assistance programs (Title I, IV-A, X, XIV, and XVI of the Social Security Act) and the social services programs (title XX of the Act) remain in these parts.

Old Section in 45 CFR	New Section in 42 CFR
205.10(a) to words before "where a State agency adopts."	431.205.
205.10(a)(1)(ii) words after "right of appeal to a State agency hearing".	431.205.
205.10(a)(1)(ii) words after "* * * 397 U.S. 254 (1970)	431.202.
205.10(a) (2)-(3)	431.206.
205.10(a)(4)(i)(A)	431.211.
205.10(a)(4)(i)(B)	431.210.
205.10(a)(4)(ii) words before "or of the AFDC * * *"	431.213.
205.10(a)(4)(ii) words after "* * * death of a recipient * * *" to words before "(B) the agency * * *".	Deleted—unnecessary.
205.10(a)(4)(ii) (B), (C), (E), (F), (H)	431.213.
205.10(a)(4)(ii) (D), (G), (I)	Deleted—unnecessary.
205.10(a)(4)(iii)	431.206; 431.210.
205.10(a)(4)(iv)	431.214.
205.10(a)(5) to words before "* * * unless the reason for * * *"	431.220.
205.10(a)(5) words after "* * * classes of recipients * * *" to words before "* * * (i) A request * * *".	Deleted—unnecessary.
205.10(a)(5) (i), (ii), and (iii)	431.221.
205.10(a)(5)(iv)	431.222.
205.10(a)(5)(v) to words before "* * * where the sole issue is one * * *" Also words after "* * * action for such refusal.".	431.223.
205.10(a)(5)(v) words after "* * * by the claimant in writing," to words before "* * * or where it is abandoned".	Deleted—unnecessary.
205.10(a)(6)(i)(A) to words before "* * * and not one of incorrect grant * * *".	431.230 (a)(1) and (b).

Old Section in 45 CFR	New Section in 42 CFR
205.10(a)(6)(i)(A) words after "* * * change in State or Federal Law <* * * to words before "(ii) The agency shall * * *".	Deleted—unnecessary.
205.10(a)(6)(ii)	431.230(a)(2).
205.10(a)(6)(iii) to words before "Unless a de novo * * *" and words after "* * * substantial evidence in the record".	431.232.
205.10(a)(6)(iii) words after "right to request a de novo hearing * * *" to words before "assistance shall not be * * *".	431.233.
205.10(a)(7)	431.231.
205.10(a) (8)–(10)	431.240.
205.10(a)(11) to words before "In respect to title IV–C."	431.243.
205.10(a)(11) words after "* * * in the conduct of the hearing"	Not applicable to Medicaid.
205.10(a)(12) to words before "* * * or in making a payment,"	431.241.
205.10(a)(12) words after "* * * decision on eligibility * * *" to words before "(ii) Agency * * *".	Deleted—unnecessary.
205.10(a)(12)(ii), introductory paragraph, (A), and (B) first word and words after "* * * of financial or * * *" and before "or change".	431.241.
205.10(a)(12)(ii)(B) words after "Amount" and before "* * * medical assistance * * *" and words after "* * * medical assistance".	Not applicable to Medicaid.
205.10(a)(12)(ii)(C)	Not applicable to Medicaid.
205.10(a)(13) to words before "(ii) At his * * *"	431.242.
205.10(a)(13)(i)	431.242(a).
205.10(a)(13)(ii)	Deleted—redundant.
205.10(a)(13)(iii)	431.242(b).
205.10(a)(13)(iv)	431.242(c).
205.10(a)(13)(v)	431.242(d).
205.10(a)(13)(vi)	431.242(e).
205.10(a) (14)–(16)	431.244.
205.10(a)(17)	431.245.
205.10(a)(18)	431.246.
205.10(a)(19)	431.244.
205.10(b) (1)–(2)	431.250.
205.10(b)(3)	Deleted—unnecessary.
205.10(b)(4)	431.250.
205.30	431.15.
205.50(a) words before "(A) The administration * * *"	431.301.
205.50(a)(1)(i)(A) after words "such purposes include"	431.302 (a)–(c).
205.50(a)(1)(i)(B)	431.302(d).
205.50(a)(1)(i)(C)	Not applicable to Medicaid.
205.50(a)(1)(ii)	431.303.
205.50(a)(1)(iii)	431.306(c).
205.50(a)(2)	431.305(a).
205.50(a)(2)(i)	431.305(b).
205.50(a)(2)(ii)	431.306(b).
205.50(a)(2)(iii)	431.306(d).
205.50(a)(2)(iv)	431.306(f).
205.50(a)(2)(v)	431.306(e).
205.50(a)(3)	431.304.
205.50(a)(4)	431.307.
205.50(b)	431.301.
205.50(c)	Not applicable to Medicaid.
205.50(d)	Not applicable to Medicaid.
205.60(a)(1)	431.17 (b)–(c).
205.60(a)(2)	431.16.
205.60(b)	431.17(d).
205.70(a)	431.18(c).
205.70(b) (1)–(2)	431.18(d).
205.70(c) words before "* * * and will establish * * *"	431.18 (e) and (g).
205.70(c) words after "* * * or to prepare for a fair hearing; * * *"	431.18(f).
205.100(a)(1) (i)–(ii)	431.10(b).
205.100(a)(2)(i)	431.10(c).
205.100(a)(2)(ii)	431.10(d).
205.100(b)	431.10(e).
205.101(c)(1)	431.11(b).
205.101(c) (2)–(3)	431.11(c).
205.101(c)(4)	431.11(d).
205.120(a)	431.50(b).
205.120(b)	431.50(c).
205.130(a)(1)	433.33(a).
205.130(a)(2)	433.33(c)(1).
205.145 to words before "Under this requirement * * *"	433.32(a).
205.145 words after "* * * in accord with applicable Federal requirements." and (a).	433.32(b).
205.145(b)	433.32(c).
205.145(c)	433.32(d).
205.150(a)(1)	433.34(b) through (d)(1).
205.150(a)(1)(i) words before "(The estimated costs are included * * *)".	433.34(d) (2)–(4).
205.150(a)(1)(i) words after "* * * activities with justification for each; * * *," to words before "(ii)".	433.34(e)(3).
205.150(a)(1)(ii)	433.34(d)(5).
205.150(a)(1)(iii)	433.34(d)(6).
205.150(a)(2)	433.34(e)(1).
205.150(b)(1)	433.34(f)(1).
205.150(b)(2)	433.34(f)(2).
205.150(b)(3)	433.34(f)(3).
205.150(b)(4)	433.34(f)(4).
205.150(b)(5)	433.34(e)(2).
205.150(b)(6)	433.34(f)(5).
205.160(a)	433.35(c).
205.160(a) (1) through (3)	433.35(d).

Old Section in 45 CFR	New Section in 42 CFR
205.160(b) (1) and (2), first sentence	433.35(b).
205.160(b)(2), second and third sentences	433.35(f)(1).
205.160(b)(3)	433.35(f)(2).
205.160(c)(1)	433.35(e).
205.160(c)(2)	433.35(f)(3).
205.160(c)(3)	433.35(f)(3).
205.170	Deleted—unnecessary
206.10(a)(1)(i)	435.909 and 436.901.
206.10(a)(1)(ii)	435.907 and 436.901.
206.10(a)(1)(iii)	435.908 and 436.901.
206.10(a)(1)(iv) (A) and (B)	435.909 and 436.909.
206.10(a)(1)(iv)(C)	435.907 and 436.901.
206.10(a)(1)(v) (A) and (C)	435.910 and 436.901.
206.10(a)(1)(v)(B)	Not applicable to Medicaid.
206.10(a)(2)(i)	435.905 and 436.901.
206.10(a)(2)(ii)	435.910(b) and 436.901.
206.10(a)(3)	435.911 and 436.901.
206.10(a)(4)	435.912 and 436.901.
206.10(a)(5)	435.930 and 436.901.
206.10(a)(6)(i)	Not applicable to Medicaid.
206.10(a)(6)(ii)	435.914 and 436.901.
206.10(a)(7)	435.910 and 436.901.
206.10(a)(8)	435.913 and 436.901.
206.10(a)(9) (i) and (ii)	435.910(c) and 436.901.
206.10(a)(9)(iii) words before "* * * and every 12 months * * *"	Not applicable to Medicaid.
206.10(a)(9)(iii) words after "* * * than every 6 months in AFDC * * *"	435.910(c) and 436.901.
206.10(a)(9)(iii) (A) and (B)	435.930 and 436.901.
206.10(a)(10)	435.932 and 436.901.
206.10(a)(11)	435.903 and 436.901.
206.10(a)(12)	435.904 and 436.901.
206.10(b)(1)	Redundant—430.1.
206.10(b)(2)	Redundant—435.907.
208.1(a)	441.101.
208.1(a)(1)	431.620.
208.1(a)(2)	441.102(a).
208.1(a)(2)(i), first sentence	441.102(b)(2).
208.1(a)(2)(i), second sentence	441.102(b)(1).
208.1(a)(2)(ii)	441.102(b)(4).
208.1(a)(2)(iii)	441.102(b)(3).
208.1(a)(2)(iv)	441.102(b)(5).
208.1(a)(3) and (4)	441.103.
208.1(a)(5) and (6)	441.105.
208.1(a)(7)	441.106.
208.1(b)	Not applicable to Medicaid.

PART 430—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

A. 42 CFR Section 430.0 is amended by revising paragraph (b)(3) to read as follows:

§ 430.0 Introduction to Subchapter C.

* * * * *

(b) *Federal regulations.*

* * * * *

(3) Regulations in 45 CFR Parts 201 and 213 also apply to the Medicaid program, to the extent specified.

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

B. 42 CFR Part 431 is amended as set forth below:

1. The table of contents is amended by revising Subparts A, B, and M and adding new Subparts E and F to read as follows:

* * * * *

Subpart A—Single State Agency

Sec.
431.10 Single State agency.
431.11 Organization for administration.
431.12 Medical care advisory committee.
431.15 Methods of administration.
431.16 Reports.
431.17 Maintenance of records.
431.18 Availability of agency program manuals.

Subpart B—Administrative Requirements: General Program Services

431.50 Statewide operation.
431.51 Free choice of providers.
431.52 Payments for services furnished out of State.
431.53 Assurance of transportation.

* * * * *

Subpart D [Reserved]

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 hearing.

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Subpart A is amended by adding new §§ 431.10, 431.11, and 431.15 through 431.18, to read as follows:

Subpart A—Single State Agency

§ 431.10 Single State agency.

(a) *Basis and purpose.* This section implements section 1902(a)(5) of the Act, which provides for designation of a single State agency for the Medicaid program.

(b) *Designation and certification.* A State plan must—

(1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and

(2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to—

(i) Administer or supervise the administration of the plan; and

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

(c) *Determination of eligibility.* (1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is—

(i) The Medicaid agency; or

(ii) The single State agency for the financial assistance program under title IV-A (in the 50 States or the District of Columbia), or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands.

(2) The plan must specify whether the agency that determines eligibility for the aged, blind, or disabled is—

(i) The Medicaid agency;

(ii) The single State agency for the financial assistance program under title IV-A (in the 50 States or the District of Columbia) or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands; or

(iii) The Federal agency administering the supplemental security income program under title XVI (SSI). In this case, the plan must also specify whether the Medicaid agency or the title IV-A agency determines eligibility for any groups whose eligibility is not determined by the Federal agency.

(d) *Agreement with Federal or State agencies.* The plan must provide for written agreements between the Medicaid agency and the Federal or other State agencies that determine eligibility for Medicaid, stating the relationships and respective responsibilities of the agencies.

(e) *Authority of the single State agency.* In order for an agency to qualify as the Medicaid agency—

(1) The agency must not delegate, to other than its own officials, authority to—

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

§ 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—

(i) A description of the organization and functions of the Medicaid agency and an organization chart;

(ii) A description of the organization and functions of the medical assistance unit and an organization chart; and

(iii) A description of the kinds and number of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) *Eligibility determined by other agencies.* If eligibility is determined by State agencies other than the Medicaid agency or by local agencies under the supervision of other State agencies, the plan must include a description of the staff designated by those other agencies and the functions they perform in carrying out their responsibility.

§ 431.15 Methods of administration.

A State plan must provide for methods of administration that are found by the Secretary to be necessary for the proper and efficient operation of the plan.

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

§ 431.16 Reports.

A State plan must provide that the Medicaid agency will—

(a) Submit all reports required by the Secretary;

(b) Follow the Secretary's instructions with regard to the form and content of those reports; and

(c) Comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports.

§ 431.17 Maintenance of records.

(a) *Basis and purpose.* This section, based on section 1902(a)(4) of the Act, prescribes the kinds of records a Medicaid agency must maintain, the retention period, and the conditions under which microfilm copies may be substituted for original records.

(b) *Content of records.* A State plan must provide that the Medicaid agency will maintain or supervise the maintenance of the records necessary for the 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; and

(v) Basis for discontinuing assistance; 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 HEW 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 charge or at a charge related to the cost of reproduction.

3. Subpart B is amended by adding a new § 431.50 to read as follows:

§ 431.50 Statewide operation.

(a) *Basis and purpose.* This section implements section 1902(a)(1) of the Act, which requires a State plan to be in effect throughout the State, and section 1902(a)(23), which permits certain exceptions.

(b) *State plan requirements.* A State plan must provide that the following requirements will be 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 assure 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.* The requirements of paragraph (b) of this section do not apply with respect to services offered by comprehensive health services organizations (see § 440.250(g) of this subchapter) or by rural health clinics (see § 440.20(b)).

4. A new Subpart E is added to read as follows:

Subpart E—Fair Hearings for Applicants and Recipients

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.

§ 431.201 Definitions.

For purposes of this subpart:

"Action" means a termination, suspension, or reduction of Medicaid eligibility or covered services.

"Date of action" means the intended date on which a termination, suspension, or reduction becomes effective.

"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. 245 (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 that the individual applies for Medicaid; and

(2) At the time of any action affecting his claim.

Notice

§ 431.210 Content of notice.

A notice required under § 431.206(c)(2) of this subpart must contain—

(a) A statement of what action the agency intends to take;

(b) The reasons for the intended action;

(c) The specific regulations that support, or the change in Federal or State law that requires, the action;

(d) An explanation of—

(1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or

(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

§ 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; or

(f) A change in the level of medical care is prescribed by the recipient's physician.

§ 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; and

(2) Any recipient who requests it because he believes the agency has taken an action erroneously.

(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.

(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 hearings.

§ 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.

PROCEDURES

§ 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 applicant or 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 applicant or 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.

§ 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, the State agency hearing may consist of a review by the agency hearing officer of the record of the local evidentiary hearing to determine whether the decision of the local hearing officer was supported by substantial evidence in the record.

(b) A person who participates in the local decision being appealed may not participate in the State agency hearing decision.

§ 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; and

(b) Agency decisions regarding changes in the type or amount of services.

§ 431.242 Procedural rights of the applicant or recipient.

The applicant or recipient, or his representative, must be given an opportunity to—

(a) Examine at a reasonable time before the date of the hearing and during the hearing:

(1) The content of the applicant's or recipient's case file; and

(2) All documents and records to be used by the State or local agency at the hearing;

(b) Bring witnesses;

(c) Establish all pertinent facts and circumstances;

(d) Present an argument without undue interference; and

(e) Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

§ 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 from the date of the request for a hearing.

(g) The public must have access to all agency hearing decisions, subject to the requirements of Subpart F of this part for safeguarding of information.

§ 431.245 Notifying the applicant or recipient of a State agency decision.

The agency must notify the applicant or recipient in writing of—

(a) The decision; and

(b) His right to request a State agency hearing or seek judicial review, to the extent that either is available to him.

§ 431.246 Corrective action.

The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, if—

(a) The hearing decision is favorable to the applicant or recipient; or

(b) The agency decides in the applicant's or recipient's favor before the hearing.

FEDERAL FINANCIAL PARTICIPATION

§ 431.250 Federal financial participation.

FFP is available in expenditures for—

(a) Payments for services continued pending a hearing decision;

(b) Payments made to carry out hearing decisions;

(c) Payments made to take corrective action prior to a hearing;

(d) Payments made to extend the benefit of a hearing decision or court order to individuals in the same situation as those directly affected by the decision or order;

(e) Retroactive payments under paragraphs (b), (c), and (d) of this section in accordance with applicable Federal policies on corrective payments; and

(f) Administrative costs incurred by the agency for—

(1) Transportation for the applicant or recipient, his representative, and witnesses to and from the hearing;

(2) Meeting other expenses of the applicant or recipient in connection with the hearing; and

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

5. A new Subpart F is added to read as follows:

Subpart F—Safeguarding Information on Applicants and Recipients

§ 431.300 Basis and purpose.

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.

§ 431.301 State plan requirements.

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.

§ 431.302 Purposes directly related to State plan administration.

Purposes directly related to plan administration include—

(a) Establishing eligibility;

(b) Determining the amount of medical assistance;

(c) Providing services for recipients; and

(d) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to 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; and

(5) Medical data, including diagnosis and past history of disease or disability.

§ 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. If, because of an emergency situation, times 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.

(f) If a court issues a subpoena for a case record or for any agency representative to testify concerning an applicant or recipient, the agency must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

§ 431.307 Distribution of information materials.

(a) All materials distributed to applicants, recipients, or medical providers must—

(1) Directly relate to the administration of the Medicaid program;

(2) Have no political implications;

(3) Contain the names only of individuals directly connected with the administration of the plan; and

(4) Identify those individuals only in their official capacity with the State or local agency.

(b) The agency must not distribute materials such as "holiday" greetings, general public announcements, voting information, and alien registration notices.

(c) The agency may distribute materials directly related to the health and welfare of applicants and recipients, such as announcements of free medical examinations, availability of surplus food, and consumer protection information.

6. In Subpart L, § 431.503 is amended by revising paragraph (n) to read as follows:

§ 431.503 All contracts.

A State plan must provide that contracts under this subpart—

* * * * *

(n) Provide that the contractor safeguards information about recipients as required by Subpart F, part 431 of this subchapter;

* * * * *

7. Subpart M is amended as follows:

a. A new § 431.620 is added to read as follows:

§ 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 subchapter 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 concernd 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 institution, the recipient, and the recipient's 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.

b. Section 431.625 is amended by revising paragraph (c)(2) to read as follows:

§ 431.625 Coordination of Medicaid with Medicare part B.

* * * * *

(c) *Federal financial participation.* * * *

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

8. In Subpart P, § 431.800 is amended by revising paragraph (h) to read as follows:

§ 431.800 Medicaid quality control (MQC) system.

* * * * *

(h) *Protection of recipient rights.* Any individual performing activities under the Medicaid quality control program must do so in a manner consistent with §§ 435.902 and 436.901 of this subchapter concerning the rights of the recipient.

PART 432—STATE PERSONNEL ADMINISTRATION

C. 42 CFR Part 432 is amended as follows:

1. Section 432.55 is amended by revising paragraph (b)(3) to read as follows:

§ 432.55 Reporting training and administrative costs.

* * * * *

(b) *Activities and costs to be reported on training expenditures.* * * *

(3) For State and local Medicaid agency staff development personnel (including supporting staff) assigned fulltime training functions: Salaries, fringe benefits, travel, and per diem. Costs for staff spending less than full time on training for the Medicaid program must be allocated between training and administration in accordance with § 433.34 of this subchapter.

* * * * *

2. Section 432.60 is amended by revising paragraph (c) to read as follows:

§ 432.60 Sources of State share of training expenditures and cost allocation.

* * * * *

(c) *Cost allocation.* Costs of training are chargeable to Medicaid only to the extent that the training benefits that program. If the training benefits both federally funded programs and other programs financed solely with State or local funds, the training costs must be allocated among programs as specified in 45 CFR part 74, appendix C and § 433.34 of this subchapter.

PART 433—STATE FISCAL ADMINISTRATION

D. 42 CFR Part 433 is amended as follows:

1. The table of contents is amended by adding §§ 433.32 through 433.35 to read as follows:

* * * * *

Subpart B—General Administrative Requirements

Sec.
433.32 Fiscal policies and accountability.
433.33 State financial participation.
433.34 Cost allocation.
433.35 Nonexpendable personal property: Conditions for FFP.
433.36 Liens and recoveries.
433.37 Reporting provider payments to Internal Revenue Service.

* * * * *

2. New §§ 433.32 through 433.35 are added to read as follows:

§ 433.32 Fiscal policies and accountability.

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

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

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

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

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

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

§ 433.33 State financial participation.

A State plan must provide that—

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

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

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

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

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

(Sec. 1902(a)(2) of the Act)

§ 433.34 Cost allocation.

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

prescribes requirements for submitting and revising cost allocation plans relating to Medicaid expenditures, specifies their content, and sets forth the effect on FFP if requirements are not met.

(b) *State plan requirement.* A State plan must provide that the requirements of paragraphs (c) through (e) of this section will be met.

(c) *Filing cost allocation plan.* The Medicaid agency must have a cost allocation plan approved by HCFA on file with the HCFA Regional Office.

(d) *Content of plan.* The cost allocation plan must include—

(1) Methods and procedures for properly charging the costs of administration, medical assistance, and training incurred under the plan, in accordance with 45 CFR Part 74, Appendix C and any other requirements specified by HEW or HCFA;

(2) Descriptions of functions and activities, by organizational units;

(3) Estimated costs for one year, by cost centers or pools, including costs of all organizational units of the State department in which the Medicaid agency is located (unless specifically waived by HCFA);

(4) The basis used for allocating the various pools of costs to program and activities, with justification for each;

(5) Other information necessary to document the validity of the cost allocation methods and procedures; and

(6) Methods and procedures for—

(i) Allocating costs of the State department in which the Medicaid agency is located between federally-aided and all other programs; and

(ii) Identifying costs applicable to more than one of the federally-aided programs and segregating these costs in accordance with program or other classifications specified by the Secretary.

(e) *Revision and approval.* (1) The agency must revise the plan whenever the allocation method is outdated because of organizational changes within the agency, changes in Federal law or regulations, or other similar changes.

(2) Within 60 days of receipt of a plan, the HCFA Regional Office will give the agency written notice of approval or of changes required for approval.

(3) Approval of the cost allocation plan does not constitute approval of the plan's estimated cost for purposes of calculating claims for FFP.

(f) *Federal financial participation.* (1) FFP is not available in expenditures for administration, medical assistance, and training for any quarterly period unless the State's claims for those expenditures are in accord with a cost allocation plan approved for that period and on file with HCFA.

(2) If the agency fails to submit for any quarter a revision to an outdated cost allocation plan, or if the submitted revision has not been approved, HCFA will—

(i) Defer payment of any amount it believes to be overstated; and

(ii) Disallow any amount it determines to be overstated.

(3) If no approved cost allocation plan is on file with HCFA, FFP will be made available only for those costs of administration, medical assistance, and training which are entirely chargeable to a particular function or activity that has a single rate of FFP. Claims for other costs that require allocation will be disallowed.

(4) Any costs disallowed under paragraphs (f) (2) and (3) of this section may by reclaimed after HCFA approves a cost allocation plan for the quarter for which the expenditures were claimed, to the extent that the reclaimed amounts are supported by the approved plan.

(5) The time frames and the procedures in 45 CFR 201.15* are applicable to deferrals made under paragraph (f)(2) of this section.

§ 433.35 Nonexpendable personal property: Conditions for FFP.

(a) *Basis and purpose.* This section, based on sec. 1102 of the Act, prescribes rules on availability of FFP for acquisition and depreciation of nonexpendable personal property, and on accounting for and managing the property.

(b) *Definitions.* As used in this section, unless the context indicates otherwise—

"Acquisition cost" means the amount expended for property (minus interest) plus, in the case of property acquired with a trade-in, the book value of the property traded in.

"Book value" of property traded in means acquisition cost minus the amount depreciated through the date of trade-in. (If the State claimed FFP in the acquisition cost when it acquired the property, the book value is zero.)

"Depreciation expense" means the portion of the acquisition cost assignable to a particular time period of the estimated useful service life of the property.

"Nonexpendable personal property" means tangible property of any kind, except real property, that has a useful life of more than one year and an acquisition cost of $300 or more per unit.

(c) *Availability of FFP.* Except as provided in paragraph (d) of this section, FFP is available in expenditures for nonexpendable personal property only in the depreciation expense, or an annual use allowance of 6⅔ percent of acquisition cost, applicable to the period for which the property is used in the Medicaid program.

(d) *Exceptions based on acquisition cost and use of property.* (1) Except as specified in paragraphs (d)(2) and (d)(3) of this section, the Medicaid agency may claim FFP in full in expenditures for acquiring nonexpendable personal property costing less than $5,000.

(2) FFP is available only on the basis of paragraph (c) of this section if the property is acquired by a provider under a cost reimbursement contract with the agency, unless the State has title to the property and the contract provides for the return of the property or its residual value at the completion of the contract.

(3) In the case of property acquired by the agency for use by organizational units of that agency, or of a parent agency, that are treated as indirect cost centers or pools in an HCFA cost allocation plan, FFP is available only in accordance with paragraph (c) of this section or on the basis of indirect costs negotiated by HEW.

(e) *Distribution of costs.* (1) *Costs of property used in a single activity.* The agency may charge costs directly to a single activity that has a separate rate of FFP, if the property is being used exclusively for that activity at the time of expenditures for the property.

(2) *Costs of property used in more than one activity.* The agency must distribute costs by one of the following methods:

(i) Using cost centers or pools and allocation bases that will distribute the costs consistent with use of the property at the time of expenditures. The agency must distribute any credits for property sold or retained for use in non-Federal programs in a manner consistent with the method used to distribute expenditures when the property was acquired (see 45 CFR 74.139 for HEW policies on disposition).

(ii) Using a common distribution factor for all property or for classifications of property (e.g., costs of desks may be distributed by number of staff employed in each activity). For property sold or retained for use in non-Federal programs, the agency must distribute credits to programs or activities by using the same distribution factors that are applied to expenditures for property acquired in the quarter in which credits occurred.

(f) *Other administrative requirements.* (1) *Determination of depreciation expense.* The agency must determine annual depreciation expense by—

*See proposed rulemaking republishing 45 CFR 201.15 as 42 CFR 430.230 through 430.232, 43 FR 38345, August 25, 1978.

(i) Dividing the acquisition cost by the number of years of estimated useful service life of the property; or

(ii) Any other method that is shown by the agency to be more consistent with the use of the property and is approved by the HCFA Regional Administrator.

(2) *Estimated useful service life.* The agency must determine the estimated useful service life of property in accordance with Internal Revenue Service policies on depreciation for tax purposes, except that a shorter period may be approved by the HCFA Regional Administrator if the State agency can justify it.

(3) *Accountability and management.* The agency must account for and manage nonexpendable personal property in accordance with the provisions in 45 CFR 74.133 and 74.135 through 74.140.

3. Section 433.112 is amended by revising paragraph (b)(9) to read as follows:

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

* * * * *

(b) The Administrator will approve the system if the following conditions are met:

* * * * *

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

PART 435—ELIGIBILITY IN THE STATES AND DISTRICT OF COLUMBIA

E. 42 CFR Part 435 is amended as follows:

1. The table of contents is amended by adding a new Subpart J to read as follows:

Subpart J—Eligibility Administration: Applications, Determinations of Eligibility, and Furnishing Medicaid

* * * * *

§ 435.2 [Amended]

2. Section 435.2 is amended by deleting the uncoded paragraph in parenthesis following paragraph (e).

3. Section 435.531 is amended by revising paragraph (a)(3)(ii) to read as follows:

§ 435.531 Determinations of blindness.

(a) Except as specified in paragraph (b) of this section, in determining blindness—

* * * * *

(3) A physician skilled in the diseases of the eye (for example, an ophthalmologist or an eye, ear, nose, and throat specialist) must review the report and determine on behalf of the agency—

* * * * *

(ii) Whether and when re-examinations are necessary for periodic redeterminations of eligibility, as required under § 435.916 of this part.

* * * * *

4. Section 435.541 is amended by revising paragraphs (b) and (c) to read as follows:

§ 435.541 Determinations of disability.

* * * * *

(b) A physician and a social worker, qualified by professional training and experience, must review the medical report and social history and determine on behalf of the agency whether the individual meets the definition of disability. The physician must determine whether and when reexaminations will be necessary for periodic redeterminations of eligibility as required under § 435.916 of this part.

(c) In subsequently determining disability, the physician and social worker must review reexamination reports and the social history and determine whether the individual continues to meet the definition.

* * * * *

5. Section 435.724 is amended by revising paragraph (a) to read as follows:

§ 435.724 Financial responsibility of parents for blind or disabled children.

(a) If the agency provides Medicaid to SSI recipients, it must meet the requirements of this section in determining eligibility of blind and disabled children under the optional coverage provisions of §§ 435.210, 435.211, and 435.231.

* * * * *

6. A new Subpart J is added to read as follows:

Subpart J—Eligibility in the States and District of Columbia

§ 435.900 Scope.

This subpart sets forth requirements for processing applications, determining eligibility, and furnishing Medicaid.

GENERAL METHODS OF ADMINISTRATION

§ 435.902 Consistency with objectives and statutes.

The Medicaid agency's standards and methods for determining eligibility must be consistent with the objectives of the program and with the rights of individuals under the United States Constitution, the Social Security Act, title VI of the Civil Rights Act of 1964, sec. 504 of the Rehabilitation Act of 1973, and all other relevant provisions of Federal and State laws.

§ 435.903 Simplicity of administration.

The agency's policies and procedures must ensure that eligibility is determined in a manner consistent with simplicity of administration and the best interests of the applicant or recipient.

§ 435.904 Adherence of local agencies to State plan requirements.

The agency must—

(a) Have methods to keep itself currently informed of the adherence of local agencies to the State plan provisions and the agency's procedures for determining eligibility; and

(b) Take corrective action to ensure their adherence.

APPLICATIONS

§ 435.905 Availability of program information.

(a) The agency must furnish the following information in appropriate written or oral form to all applicants and to all other individuals who request it:

(1) The eligibility requirements.
(2) Available Medicaid services.
(3) The rights and responsibilities of applicants and recipients.
(b) The agency must publish in quantity and make available bulletins or pamphlets that explain the rules governing eligibility and appeals in simple and understandable terms.

§ 435.906 Opportunity to apply.

The agency must afford an individual wishing to do so the opportunity to apply for Medicaid without delay.

§ 435.907 Written application.

The agency must require a written application from the applicant, an authorized representative or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The application must be on a form prescribed by the agency and signed under a penalty of perjury.

§ 435.908 Assistance with application.

The agency must allow an individual or individuals of the applicant's choice to accompany, assist, and represent the applicant in the application process or a redetermination of eligibility.

§ 435.909 Automatic entitlement to Medicaid following a determination of eligibility under other programs.

The agency must not require a separate application for Medicaid from an individual, if—
(a) The individual receives AFDC; or
(b) The agency has an agreement with the Social Security Administration (SSA) under sec. 1634 of the Act for determining Medicaid eligibility; and—
(1) The individual receives SSI;
(2) The individual receives a mandatory State supplement under either a federally-administered or State-administered program; or
(3) The individual receives an optional State supplement and the agency provides Medicaid to recipients of optional supplements under § 435.230.

§ 435.910 Use of social security number.

(a) The agency must request, on the application, the social security number (SSN) of each individual (including children) for whom Medicaid services are requested.
(b) The agency must advise the applicant of—
(1) Whether disclosure of the SSN is mandatory or voluntary;
(2) The statute or other authority under which the agency is requesting the applicant's SSN; and
(3) The uses the agency will make of the SSN.
(c) The agency must not make disclosure mandatory unless it had a system of records in operation before January 1, 1975, that met the following conditions:
(1) It was used in the administration of the Medicaid program; and
(2) Under statute or regulation, it required an applicant to disclose his SSN to verify his identity.
(d) If disclosure of the SSN is voluntary, the agency must not deny Medicaid to an otherwise eligible applicant for failure or refusal to disclose or apply for a SSN and must inform the applicant that he is not required to disclose or apply for a SSN.
(e) If an applicant cannot recall his SSN or has not been issued a SSN, and wishes to secure one, the agency must—
(1) Assist the applicant in completing an application for a SSN;
(2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and
(3) Either sent the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to verify the number.
(f) The agency must not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by SSA.

DETERMINATION OF MEDICAID ELIGIBILITY

§ 435.911 Timely determination of eligibility.

(a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed—
(1) Sixty days for applicants who apply for Medicaid on the basis of disability; and
(2) Forty-five days for all other applicants.
(b) The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant.
(c) The agency must determine eligibility within the standards except in unusual circumstances, for example—
(1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action;
(2) When there is an administrative or other emergency beyond the agency's control; or
(3) When there is a delay in the receipt of eligibility information from SSA in States in which SSA determines Medicaid eligibility.
(d) The agency must document the reasons for delay in the applicant's case record.
(e) The agency must not use the time standards—
(1) As a waiting period before determining eligibility; or
(2) As a reason for denying eligibility (because it has not determined eligibility within the time standards).

§ 435.912 Adequate notice.

The agency must send each applicant a written notice of the agency's decision on his application, and, if eligibility is denied, the reasons for the action, the specific regulation supporting the action, and an explanation of his right to request a hearing. (See Subpart E of Part 431 of this subchapter for rules on hearings.)

§ 435.913 Case documentation.

(a) The agency must include in each applicant's case record facts to support the agency's decision on his application.
(b) The agency must dispose of each application by a finding of eligibility or ineligibility, unless—
(1) There is an entry in the case record that the applicant voluntarily withdrew the application, and that the agency sent a notice confirming his decision;
(2) There is a supporting entry in the case record that the applicant has died; or
(3) There is a supporting entry in the case record that the applicant cannot be located.

§ 435.914 Effective date.

(a) The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual—
(1) Received Medicaid services, at any time during that period, of a type covered under the plan; and
(2) Would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made.
(b) The agency may make eligibility for Medicaid effective on the first day of a month if an individual was eligible at any time during that month.
(c) The State plan must specify the date on which eligibility will be made effective.

REDETERMINATIONS OF MEDICAID ELIGIBILITY

§ 435.916 Periodic redeterminations of Medicaid eligibility.

(a) The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months, However—
(1) The agency may consider blindness as continuing until the review physician under § 435.531 determines that a recipient's vision has improved beyond the definition of blindness contained in the plan; and

(2) The agency may consider disability as continuing until the review team under § 435.541 determines that a recipient's disability no longer meets the definition of disability contained in the plan.

(b) *Procedures for reporting changes.* The agency must have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility.

(c) *Agency action on information about changes.* (1) The agency must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility.

(2) If the agency has information about anticipated changes in a recipient's circumstances, it must redetermine eligibility at the appropriate time based on those changes.

§ 435.919 Timely and adequate notice.

(a) The agency must give recipients timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid.

(b) The notice must meet the requirements of Subpart J of Part 431 of this subchapter.

§ 435.920 Verification of SSNs.

(a) In redetermining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.

(b) If the case record does not contain the required SSNs, the agency must request them and meet other requirements of § 435.910.

(c) For any recipient whose SSN was established as part of the case record without evidence required under the SSA regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with § 435.910.

FURNISHING MEDICAID

§ 435.930 Furnishing Medicaid.

The agency must—

(a) Furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures;

(b) Continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible; and

(c) Make arrangements to assist applicants and recipients to get emergency medical care whenever needed, 24 hours a day and 7 days a week.

7. Section 435.1002 is amended by revising paragraph (b) to read as follows:

§ 435.1002 FFP for services.

* * * * *

(b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient's liability. (See § 435.914 and § 436.901 of this subchapter for regulations on retroactive eligibility for Medicaid.)

8. Section 435.1003 is amended by revising paragraphs (a)(1), (2) and (3) to read as follows:

§ 435.1003 Recipients determined ineligible for SSI.

(a) If the Social Security Administration (SSA) notifies an agency that a recipient has been determined ineligible for SSI, FFP is available in Medicaid expenditures for services to the recipient as follows:

(1) If the agency receives the SSA notice by the 10th day of the month, FFP is available under this section only through the end of the month unless the recipient requests a hearing under Subpart E, Part 431 of this subchapter.

(2) If the agency receives the SSA notice after the 10th day of the month, FFP is available only through the end of the following month, unless the recipient requests a hearing under Subpart E, Part 431 of this subchapter.

(3) If a recipient requests a hearing, FFP is available as specified in Subpart E, Part 431 of this subchapter.

* * * * *

PART 436—ELIGIBILITY IN GUAM; PUERTO RICO; AND THE VIRGIN ISLANDS

F. 42 CFR Part 436 is amended as follows:

1. The table of contents is amended by adding a new Subpart J to read as follows:

* * * * *

Subpart J—Eligibility Administration: Applications, Determinations of Eligibility, and Furnishing Medicaid

Sec.
436.900 Scope.
436.901 General requirements.
436.909 Automatic entitlement to Medicaid following a determination of eligibility under other programs.

§ 436.1 [Amended]

2. Section 436.1 is amended by deleting the uncoded paragraph following paragraph (d).

3. Section 436.531 is amended by revising paragraph (c)(2) to read as follow:

§ 436.531 Determination of blindness.

In determining blindness—

* * * * *

(c) A physician skilled in the diseases of the eye (for example, an ophthalmologist or an eye, ear, nose, and throat specialist) must review the report and determine on behalf of the agency—

(1) Whether the individual meets the definition of blindness; and

(2) Whether and when reexaminations are necessary for periodic redeterminations of eligibility, as required under § 435.916 of this subchapter. Blindness is considered to continue until the reviewing physician determines that the recipient's vision no longer meets the definition.

4. Section 436.541 is amended by revising paragraph (b) to read as follows:

§ 436.541 Determination of disability.

* * * * *

(b) A physician and social worker, qualified by professional training and experience, must review the medical report and social history and determine on behalf of the agency whether the individual meets the definition of disability. The physician must determine whether and when reexaminations will be necessary for periodic redeterminations of eligibility as required under § 435.916 of this subchapter.

* * * * *

5. A new Subpart J is added to read as follows:

Subpart J—Eligibility in Guam, Puerto Rico, and the Virgin Islands.

§ 436.900 Scope.

This subpart sets forth requirements for processing applications, determining eligibility, and furnishing Medicaid.

§ 436.901 General requirements.

The Medicaid agency must comply with all the requirements of Part 435, Subpart J, of this subchapter, except those specified in § 435.909.

§ 436.909 Automatic entitlement to Medicaid following a determination of eligibility under other programs.

The agency may not require a separate application for Medicaid from an individual if the individual receives cash assistance under a State plan for OAA, AFDC, AB, APTD, or AABD.

6. Section 436.1002 is amended by revising paragraph (b) to read as follows:

§ 436.1002 FFP for services.

* * * * *

(b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided, except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient's liability.

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

G. 42 CFR Part 441 is amended by adding a new Subpart C to read as follows:

* * * * *

Subpart C—Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Sec.
441.100 Basis and purpose.
441.101 State plan requirements.
441.102 Plan of care for institutionalized recipients.
441.103 Alternate plans of care.
441.105 Methods of administration.
405.106 Comprehensive mental health program

Subpart C—Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

§ 441.100 Basis and purpose.

This subpart implements section 1905(a)(14) of the Act, which authorizes State plans to provide for inpatient hospital services, skilled nursing services, and intermediate care facility services for individuals age 65 or older in an institution for mental diseases, and sections 1902(a)(20)(B) and (C) and 1902(a)(21), which prescribe the conditions a State must meet to offer these services. (See § 431.620 of this subchapter for regulations implementing section 1902(a)(20)(A), which prescribe interagency requirements related to these services.)

§ 441.101 State plan requirements.

A State plan that includes Medicaid for individuals age 65 or older in institutions for mental diseases must provide that the requirements of this subpart are met.

§ 441.102 Plan of care for institutionalized recipients.

(a) The Medicaid agency must provide for a recorded individual plan of treatment and care to ensure that institutional care maintains the recipient at, or restores him to, the greatest possible degree of health and independent functioning.

(b) The plan must include—

(1) An initial review of the recipient's medical, psychiatric, and social needs—

(i) Within 90 days after approval of the State plan provision for services in institutions for mental disease; and

(ii) After that period, within 30 days after the date payments are initiated for services provided a recipient.

(2) Periodic review of the recipient's medical, psychiatric, and social needs;

(3) A determination, at least quarterly, of the recipient's need for continued institutional care and for alternative care arrangements;

(4) Appropriate medical treatment in the institution; and

(5) Appropriate social services.

§ 441.103 Alternate plans of care.

(a) The agency must develop alternate plans of care for each recipient age 65 or older who would otherwise need care in an institution for mental diseases.

(b) These alternate plans of care must—

(1) Make maximum use of available resources to meet the recipient's medical, social, and financial needs; and

(2) In Guam, Puerto Rico, and the Virgin Islands, make available appropriate social services authorized under sections 3(a)(4) (i) and (ii) or 1603(a)(4)(A) (i) and (ii) of the Act.

§ 441.105 Methods of administration.

The agency must have methods of administration to ensure that its responsibilities under this subpart are met.

§ 441.106 Comprehensive mental health program.

(a) If the plan includes services in public institutions for mental diseases, the agency must show that the State is making satisfactory progress in developing and implementing a comprehensive mental health program.

(b) The program must—

(1) Cover all ages;

(2) Use mental health and public welfare resources; including—

(i) Community mental health centers;

(ii) Nursing homes; and

(iii) Other alternatives to public institutional care; and

(3) Include joint planning with State authorities.

(c) The agency must submit annual progress reports within 3 months after the end of each fiscal year in which Medicaid is provided under this subpart.

PART 456—UTILIZATION CONTROL

H. 42 CFR 456.608 is amended by revising paragraph (b)(2) to read as follows:

§ 456.608 Personal contact with and observation of recipients and review of records.

* * * * *

(b) For recipients age 65 or older in IMDs, the team's inspection must include—

(1) Review of each recipient's medical record; and

(2) If the record does not contain complete reports of periodic assessments required by § 441.102 of this subchapter or, if such reports are inadequate, personal contact with and observation of each recipient.

(Sec. 1102 of the Social Security Act, 42 U.S.C. 1302) (Catalog of Federal Domestic Assistance Program No. 13.714 Medical Assistance Program)

Dated: December 4, 1978.

LEONARD D. SCHAEFFER,
Administrator, Health Care Financing Adminstration.

Approved: March 18, 1979.

JOSEPH A. CALIFANO, Jr.,
Secretary.

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[4110-35-M]

Title 45—Public Welfare

CHAPTER II—OFFICE OF FAMILY ASSISTANCE (ASSISTANCE PROGRAMS), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC ASSISTANCE PROGRAMS; ASSISTANCE TO AGED INDIVIDUALS IN INSTITUTIONS FOR MENTAL DISEASES

Applicability of Regulations

AGENCY: Office of the Secretary, HEW.

ACTION: Final rule.

SUMMARY: These amendments revise 45 CFR Sections 205.10, 205.30, 205.50, 205.60, 205.70, 205.100, 205.101,