

§ 430.2

plan (section 1902(a)(4)), those statutory provisions are simply cited without further description.

§ 430.2 Other applicable Federal regulations.

Other regulations applicable to State Medicaid programs include the following:

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

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

Part 16—Procedures of the Departmental Appeals Board.

Part 74—Administration of Grants.

Part 80—Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services: Effectuation of Title VI of the Civil Rights Act of 1964.

Part 81—Practice and Procedure for Hearings Under 45 CFR part 80.

Part 84—Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting From Federal Financial Assistance.

Part 95—General Administration—grant programs (public assistance and medical assistance).

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

§ 430.3 Appeals under Medicaid.

Three distinct types of disputes may arise under Medicaid.

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

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

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

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pendix A, lists all the types of disputes that the Board hears.

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

§ 430.5 Definitions.

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

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

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

[67 FR 41094, June 14, 2002]

Subpart B—State Plans

§ 430.10 The State plan.

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

§ 430.12 Submittal of State plans and plan amendments.

(a) *Format.* A State plan for Medicaid consists of preprinted material that covers the basic requirements, and individualized content that reflects the characteristics of the particular State's program.

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

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

(ii) The plan must provide that the Governor will be given a specific period

of time to review State plan amendments, long-range program planning projections, and other periodic reports on the Medicaid program, excluding periodic statistical, budget and fiscal reports.

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

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

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

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

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

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

(2) Prompt submittal of amendments is necessary—

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

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

[53 FR 36571, Sept. 21, 1988, as amended at 60 FR 33293, June 27, 1995]

§ 430.14 Review of State plan material.

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

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

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

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

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

(c) *Disapproval authority.* (1) The Administrator retains authority for determining that proposed plan material is not approvable or that previously approved material no longer meets the requirements for approval.

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

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

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

(i) Written notice of disapproval; or

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

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

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

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

§ 430.18 Administrative review of action on State plan material.

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

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