

§ 433.123

percent level beginning with the quarter following the review determination that the system again meets conditions of reapproval.

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

[54 FR 41974, Oct. 13, 1989]

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

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

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

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

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

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

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

[57 FR 38782, Aug. 27, 1992]

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

CMS will terminate FFP at any time if the Medicaid agency fails to provide State and Federal representatives with full access to the system, including on-

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site inspection. CMS may request such access at any time to determine whether the conditions in this subpart are being met.

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

§ 433.130 Waiver of conditions of initial operation and approval.

(a) CMS will waive requirements for initial operation and approval of systems under § 433.113 for a State meeting the requirements of paragraph (b) of this section and that had a 1976 population of less than one million and made total Federal and State Medicaid expenditures of less than \$100 million in fiscal year 1976. Population figures are those reported by the Bureau of the Census. Expenditures for fiscal year 1976 are those reported by the State for that year.

(b) To be eligible for this waiver, the agency must submit its reasons to CMS in writing and demonstrate to CMS's satisfaction that a system will not significantly improve the efficiency of the administration of the State plan.

(c) If CMS denies the waiver request, the notice of denial will include—

(1) The findings of fact upon which the denial was made; and

(2) The procedures for appeal of the denial.

(d) If CMS determines, after granting a waiver, that a system would significantly improve the administration of the State Medicaid program, CMS may withdraw the waiver and require that a State obtain initial approval of a system within two years of the date of waiver withdrawal.

[50 FR 30848, July 30, 1985, as amended at 54 FR 41974, Oct. 13, 1989]

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

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

(a) *Good cause.* If CMS determines that good cause existed, CMS will waive the FFP reduction attributable to those items for which the good cause

existed. A waiver of FFP consequences of the failure to meet the conditions of approval or reapproval based upon good cause will not extend beyond two consecutive quarters.

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

[50 FR 30848, July 30, 1985, as amended at 54 FR 41974, Oct. 13, 1989]

Subpart D—Third Party Liability

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

§ 433.135 Basis and purpose.

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

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

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

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

[50 FR 46664, Nov. 12, 1985]

§ 433.136 Definitions.

For purposes of this subpart—

Private insurer means:

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

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

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

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

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

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

§ 433.137 State plan requirements.

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

(b) A State plan must provide that—

(1) The requirements of §§ 433.145 through 433.148 are met for assignment of rights to benefits, cooperation with the agency in obtaining medical support or payments, and cooperation in identifying and providing information to assist the State in pursuing any liable third parties; and

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

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

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

§ 433.138 Identifying liable third parties.

(a) *Basic provisions.* The agency must take reasonable measures to determine the legal liability of the third parties