

§ 431.56

for the administration, management, or provision of medical services.

[56 FR 8847, Mar. 1, 1991, as amended at 59 FR 4599, Feb. 1, 1994; 59 FR 36084, July 15, 1994; 67 FR 41094, June 14, 2002]

§ 431.56 Special waiver provisions applicable to American Samoa and the Northern Mariana Islands.

(a) *Statutory basis.* Section 1902(j) of the Act provides for waiver of all but three of the title XIX requirements, in the case of American Samoa and the Northern Mariana Islands.

(b) *Waiver provisions.* American Samoa or the Northern Mariana Islands may request, and CMS may approve, a waiver of any of the title XIX requirements except the following:

(1) The Federal medical assistance percentage specified in section 1903 of the Act and § 433.10(b) of this chapter.

(2) The limit imposed by section 1108(c) of the Act on the amount of Federal funds payable to American Samoa or the Northern Mariana Islands for care and services that meet the section 1905(a) definition for Medicaid assistance.

(3) The requirement that payment be made only with respect to expenditure made by American Samoa or the Northern Mariana Islands for care and services that meet the section 1905(a) definition of medical assistance.

§ 431.57 Waiver of cost-sharing requirements.

(a) Sections 1916(a)(3) and 1916(b)(3) of the Act specify the circumstances under which the Secretary is authorized to waive the requirement that cost-sharing amounts be nominal.

(b) For nonemergency services furnished in a hospital emergency room, the Secretary may by waiver permit a State to impose a copayment of up to double the “nominal” copayment amounts determined under § 447.54(a)(3) of this subchapter.

(c) Nonemergency services are services that do not meet the definition of emergency services at § 447.53(b)(4) of this subchapter.

(d) In order for a waiver to be approved under this section, the State must establish to the satisfaction of CMS that alternative sources of non-emergency, outpatient services are

42 CFR Ch. IV (10–1–12 Edition)

available and accessible to beneficiaries.

(e) Although, in accordance with § 431.55(b)(3) of this part, a waiver will generally be granted for a 2-year duration, CMS will reevaluate waivers approved under this section if the State increases the nominal copayment amounts in effect when the waiver was approved.

(f) A waiver approved under this section cannot apply to services furnished before the waiver was granted.

[59 FR 4600, Feb. 1, 1994]

Subpart C—Administrative Requirements: Provider Relations

§ 431.105 Consultation to medical facilities.

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

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

(1) Qualify for payments under the maternal and child health and crippled children’s program (title V of the Act), Medicaid or Medicare;

(2) Establish and maintain fiscal records necessary for the proper and efficient administration of the Act; and

(3) Provide information needed to determine payments due under the Act for services furnished to beneficiaries.

(c) *State plan option: Consultation to other facilities.* The plan may provide that health agencies and other appropriate State agencies furnish consultation to other types of facilities if those facilities are specified in the plan and provide medical care to individuals receiving services under the programs specified in paragraph (b) of this section.

§ 431.107 Required provider agreement.

(a) *Basis and purpose.* This section sets forth State plan requirements,

based on sections 1902(a)(4), 1902(a)(27), 1902(a)(57), and 1902(a)(58) of the Act, that relate to the keeping of records and the furnishing of information by all providers of services (including individual practitioners and groups of practitioners).

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

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

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

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

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

(5)(i) Furnish to the State agency its National Provider Identifier (NPI) (if eligible for an NPI); and

(ii) Include its NPI on all claims submitted under the Medicaid program.

[44 FR 41644, July 17, 1979, as amended at 57 FR 8202, Mar. 6, 1992; 75 FR 24449, May 5, 2010]

§ 431.108 Effective date of provider agreements.

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

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

(ii) Are deemed to meet Federal requirements on the basis of accreditation by an accrediting organization whose program has CMS approval at

the time of accreditation survey and accreditation decision.

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

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

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

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

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

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

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

(ii) CMS or the State survey agency receives from the NF, if applicable, an approvable waiver request.

(2) For an agreement with any other provider, the effective date is the earlier of the following:

(i) The date on which the provider meets all requirements.

(ii) The date on which a provider is found to meet all conditions of participation but has lower level deficiencies, and CMS or the State survey agency receives from the provider an acceptable plan of correction for the lower level deficiencies, or an approvable waiver request, or both. (The date of receipt is the effective date of the agreement, regardless of when CMS approves the plan of correction or waiver request, or both.)