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

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

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

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

(e) The agency's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials.

(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.

(g) Before requesting information from, or releasing information to, other agencies to verify income, eligibility and the amount of assistance under §§ 435.940 through 435.965 of this chapter, the agency must execute data exchange agreements with those agencies, as specified in § 435.945(f).

(h) Before requesting information from, or releasing information to, other agencies to identify legally liable third party resources under § 433.138(d) of this chapter, the agency must execute data exchanges agreements, as specified in § 433.138(h)(2) of this chapter.

[44 FR 17934, Mar. 29, 1979, as amended at 51 FR 7210, Feb. 28, 1986; 52 FR 5975, Feb. 27, 1987]

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§ 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 except to the extent required to implement the National Voter Registration Act of 1993 (NVRA) Pub. L. 103–931; for States that are exempt from the requirements of NVRA, voter registration may be a voluntary activity so long as the provisions of section 7(a)(5) of NVRA are observed;

(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, partisan 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.

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

[44 FR 17934, Mar. 29, 1979, as amended at 61 FR 58143, Nov. 13, 1996]

Subparts G–L [Reserved]

Subpart M—Relations With Other Agencies

§ 431.610 Relations with standard-setting and survey agencies.

(a) *Basis and purpose.* This section implements—

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

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

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

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

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

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

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

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

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

(2) The agency staff making the determination under paragraph (e)(1) of

this section is the same staff responsible for making similar determinations for institutions or agencies participating under Medicare; and

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

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

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

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

(i) Complete inspection reports;

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

(iii) Document deficiencies in reports;

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) FFP is not available in any expenditures that the survey agency makes that are attributable to the State's overall responsibilities under State law and regulations for establishing and maintaining standards.

[43 FR 45188, Sept. 29, 1978, as amended at 45 FR 24883, Apr. 11, 1980; 53 FR 20494, June 3, 1988; 57 FR 43923, Sept. 23, 1992; 59 FR 56233, Nov. 10, 1994; 62 FR 43936, Aug. 18, 1997; 64 FR 67052, Nov. 30, 1999]

§ 431.615 Relations with State health and vocational rehabilitation agencies and title V grantees.

(a) *Basis and purpose.* This section implements section 1902(a)(11) and (22)(C) of the Act, by setting forth State plan requirements for arrangements and agreements between the Medicaid agency and—

(1) State health agencies;

(2) State vocational rehabilitation agencies; and

(3) Grantees under title V of the Act, Maternal and Child Health and Crippled Children's Services.

(b) *Definitions.* For purposes of this section—

“Title V grantee” means the agency, institution, or organization receiving

Federal payments for part or all of the cost of any service program or project authorized by title V of the Act, including—

(1) Maternal and child health services;

(2) Crippled children's services;

(3) Maternal and infant care projects;

(4) Children and youth projects; and

(5) Projects for the dental health of children.

(c) *State plan requirements.* A state plan must—

(1) Describe cooperative arrangements with the State agencies that administer, or supervise the administration of, health services and vocational rehabilitation services designed to make maximum use of these services;

(2) Provide for arrangements with title V grantees, under which the Medicaid agency will utilize the grantee to furnish services that are included in the State plan;

(3) Provide that all arrangements under this section meet the requirements of paragraph (d) of this section; and

(4) Provide, if requested by the title V grantee in accordance with the arrangements made under this section, that the Medicaid agency reimburse the grantee or the provider for the cost of services furnished recipients by or through the grantee.

(d) *Content of arrangements.* The arrangements referred to in paragraph (c) must specify, as appropriate—

(1) The mutual objectives and responsibilities of each party to the arrangement;

(2) The services each party offers and in what circumstances;

(3) The cooperative and collaborative relationships at the State level;

(4) The kinds of services to be provided by local agencies; and

(5) Methods for—

(i) Early identification of individuals under 21 in need of medical or remedial services;

(ii) Reciprocal referrals;

(iii) Coordinating plans for health services provided or arranged for recipients;

(iv) Payment or reimbursement;

(v) Exchange of reports of services furnished to recipients;