

§ 431.105

(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 available and accessible to recipients.

(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 recipients.

(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 re-

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ceiving 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 recipients;

(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.

[44 FR 41644, July 17, 1979, as amended at 57 FR 8202, Mar. 6, 1992]

§ 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