and the authority or institution, including arrangements for—
(1) Joint planning between the parties to the agreement;
(2) Development of alternative methods of care;
(3) Immediate readmission to an institution when needed by a beneficiary who is in alternative care;
(4) Access by the agency to the institution, the beneficiary, and the beneficiary’s records when necessary to carry out the agency’s responsibilities;
(5) Recording, reporting, and exchanging medical and social information about beneficiaries; and
(6) Other procedures needed to carry out the agreement.

§ 431.621 State requirements with respect to nursing facilities.

(a) Basis and purpose. This section implements sections 1919(b)(3)(F) and 1919(e)(7) of the Act by specifying the terms of the agreement the State must have with the State mental health and Intellectual Disability authorities concerning the operation of the State’s preadmission screening and annual resident review (PASARR) program.

(b) State plan requirement. The State plan must provide that the Medicaid agency has in effect a written agreement with the State mental health and Intellectual Disability authorities that meets the requirements specified in paragraph (c) of this section.

(c) Provisions required in an agreement. The agreement must specify the respective responsibilities of the agency and the State mental health and Intellectual Disability authorities, including arrangements for—(1) Joint planning between the parties to the agreement;
(2) Access by the agency to the State mental health and Intellectual Disability authorities’ records when necessary to carry out the agency’s responsibilities;
(3) Recording, reporting, and exchanging medical and social information about individuals subject to PASARR;
(4) Ensuring that preadmission screenings and annual resident reviews are performed timely in accordance with §§483.112(c) and 483.114(c) of this part;
(5) Ensuring that, if the State mental health and Intellectual Disability authorities delegate their respective responsibilities, these delegations comply with §483.106(e) of this part;
(6) Ensuring that PASARR determinations made by the State mental health and Intellectual Disability authorities are not countermanded by the State Medicaid agency, except through the appeals process, but that the State mental health and Intellectual Disability authorities do not use criteria which are inconsistent with those adopted by the State Medicaid agency under its approved State plan;
(7) Designating the independent person or entity who performs the PASARR evaluations for individuals with MI; and
(8) Ensuring that all requirements of §§483.100 through 483.136 are met.

§ 431.625 Coordination of Medicaid with Medicare part B.

(a) Basis and purpose. (1) Section 1843(a) of the Act requires the Secretary to have entered into an agreement with any State that requested that agreement before January 1, 1970, or during calendar year 1981, under which the State could enroll certain Medicare-eligible beneficiaries under Medicare Part B and agree to pay their premiums.
(2) Section 1902(a)(10) of the Act (in clause (II) following subparagraph (D)), allows the State to pay the premium, deductibles, cost sharing, and other charges for beneficiaries enrolled under Medicare Part B without obligating itself to provide the range of Part B benefits to other beneficiaries; and
(3) Section 1903 (a)(1) and (b) of the Act authorizes FFP for State payment of Medicare Part B premiums for certain beneficiaries.

(b) This section—
(i) Specifies the exception, relating to Part B coverage, from the requirement to provide comparable services to all beneficiaries; and
(ii) Prescribes FFP rules concerning State payment for Medicare premiums.
and for services that could have been covered under Medicare.

(5) Section 1902(a)(15) of the Act requires that if a State chooses to pay only a portion of deductibles, cost sharing or other charges for beneficiaries enrolled under Medicare Part B, the portion that is to be paid by a Medicaid beneficiary must be reasonably related to the beneficiary’s income and resources.

(b) Exception from obligation to provide comparable services; State plan requirement. (1) The State’s payment of premiums, deductibles, cost sharing, or similar charges under Part B does not obligate it to provide the full range of Part B services to beneficiaries not covered by Medicare.

(2) The State plan must specify this exception if it applies.

(c) Effect of payment of premiums on State liability for cost sharing. (1) State payment of Part B premiums on behalf of a Medicaid beneficiary does not obligate it to pay on the beneficiary’s behalf the Part B deductible and coinsurance amounts for those Medicare Part B services not covered in the Medicaid State plan.

(2) If a State pays on a beneficiary’s behalf any portion of the deductible or cost sharing amounts under Medicare Part B, the portion paid by a State must be reasonably related to the beneficiary’s income and resources.

(d) Federal financial participation: Medicare Part B premiums—(1) Basic rule. Except as provided in paragraph (d)(2) of this section, FFP is not available in State expenditures for Medicare Part B premiums for Medicaid beneficiaries unless the beneficiaries receive money payments under title I, IV–A, X, XIV, XVI (AABD or SSI) of the Act, or State supplements as permitted under section 1616(a) of the Act, or as required by section 212 of Pub. L. 93-66.

(2) Exception. FFP is available in expenditures for Medicare Part B premiums for the following groups:

(i) AFDC families required to be covered under §§ 435.112 and 436.116 of this subchapter, those eligible for continued Medicaid coverage despite increased income from employment;

(ii) Beneficiaries required to be covered under §§ 435.114, 435.134, and 436.112 of this subchapter, those eligible for continued Medicaid coverage despite increased income from cost-of-living increases under title II of the Act;

(iii) Beneficiaries required to be covered under § 435.135 of this subchapter, those eligible for continued Medicaid coverage despite increased income under title II of the Act;

(iv) Beneficiaries of foster care maintenance payments or adoption assistance payments who, under Part E of title IV of the Act are considered as receiving AFDC;

(v) Individuals required to be covered under § 435.120 of this chapter, that is, blind or disabled individuals who, under section 1619(b) of the Act, are considered to be receiving SSI;

(vi) Individuals who, in accordance with §§ 435.115 and 436.114 of this chapter are, for purposes of Medicaid eligibility, considered to be receiving AFDC. These are participants in a work supplementation program, or individuals denied AFDC because the payment would be less than $10;

(vii) Certain beneficiaries of Veterans Administration pensions during the limited time they are, under section 310(b) of Pub. L. 96–272, considered as receiving SSI, mandatory State supplements, or AFDC;

(viii) Disabled children living at home to whom the State provides Medicaid under section 1902(e)(3) of the Act;

(ix) Individuals who become ineligible for AFDC because of the collection or increased collection of child or spousal support, but, in accordance with section 406(h) of the Act, remain eligible for Medicaid for four more months; and

(x) Individuals who become ineligible for AFDC because they are no longer eligible for the disregard of earnings of $30 or of $30 plus one-third of the remainder, but, in accordance with section 402(a)(37) of the Act, are considered as receiving AFDC for a period of 9 to 15 months.

(3) No FFP is available in State Medicaid expenditures that could have been paid for under Medicare Part B but were not because the person was not enrolled in Part B. This limit applies
§ 431.630 Coordination of Medicaid with QIOs.
(a) The State plan may provide for the review of Medicaid services through a contract with a QIO designated under Part 462 of this chapter. Medicaid requirements for medical and utilization review are deemed to be met for those services or providers subject to review under the contract.
(b) The State plan must provide that the contract with the QIO—
(1) Meets the requirements of § 434.6(a) of this part;
(2) Includes a monitoring and evaluation plan by which the State ensures satisfactory performance by the QIO;
(3) Identifies the services and providers subject to QIO review;
(4) Ensures that the review activities performed by the QIO are not inconsistent with QIO review activities of Medicare services and includes a description of whether and to what extent QIO determinations will be considered conclusive for Medicaid payment purposes.

§ 431.635 Coordination of Medicaid with Special Supplementation Food Program for Women, Infants, and Children (WIC).
(a) Basis. This section implements sections 1902(a)(11)(C) and 1902(a)(53) of the Act, which provide for coordination of Medicaid with the Special Supplemental Food Program for Women, Infants, and Children (WIC) under section 17 of the Child Nutrition Act of 1966.
(b) Definitions. As used in this section, the terms breastfeeding women, postpartum women, and pregnant women mean women as defined in section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)).
(c) State plan requirements. A State Plan must provide for—
(1) Coordinating operation of the Medicaid program with the State’s operation of the Special Supplementation Food Program for Women, Infants, and Children;
(2) Providing timely written notice of the availability of WIC benefits to all individuals in the State who are determined to be eligible (including presumptively eligible) for Medicaid and who are:
(i) Pregnant women;
(ii) Postpartum women;
(iii) Breastfeeding women; and
(iv) Children under the age of 5.
(3) Referring individuals described under paragraphs (c)(2)(i) through (iv) of this section to the local agency responsible for administering the WIC program.
(d) Notification requirements. (1) The agency must give the written notice required under paragraph (c) of this section as soon as the agency identifies the individual (e.g., at the time of an eligibility determination for Medicaid) or immediately thereafter (e.g., at the time of notice of eligibility).
(2) The agency, no less frequently than annually, must also provide written notice of the availability of WIC benefits, including the location and telephone number of the local WIC agency or instructions for obtaining further information about the WIC program, to all Medicaid beneficiaries (including those found to be presumptively eligible) who are under age 5 or who are women who might be pregnant, postpartum, or breastfeeding as described in paragraphs (c)(2)(i) through (iv) of this section.
(3) The agency must effectively inform those individuals who are blind or deaf or who cannot read or understand the English language.

§ 431.636 Coordination of Medicaid with the Children's Health Insurance Program (CHIP).
(a) Statutory basis. This section implements—
(1) Section 2102(b)(3)(B) of the Act, which provides that children who apply for coverage under a separate child health plan under title XXI, but are