

imposes on Medicaid enrollees are in accordance with the requirements set forth in §§ 447.50 and 447.53 through 447.58 for cost-sharing charges imposed by the State agency.

[67 FR 41116, June 14, 2002]

**§ 447.88 Options for claiming FFP payment for section 1920A presumptive eligibility medical assistance payments.**

(a) The FMAP rate for medical assistance payments made available to a child during a presumptive eligibility period under section 1920A of the Act is the regular FMAP under title XIX, based on the category of medical assistance; that is, the enhanced FMAP is not available for section 1920A presumptive eligibility expenditures.

(b) States have the following 3 options for identifying Medicaid section 1920A presumptive eligibility expenditures and the application of payments for those expenditures:

(1) A State may identify Medicaid section 1920A presumptive eligibility expenditures in the quarter expended with no further adjustment based on the results of a subsequent actual eligibility determination (if any).

(2) A State may identify Medicaid section 1920A presumptive eligibility expenditures in the quarter expended but may adjust reported expenditures based on results of the actual eligibility determination (if any) to reflect the actual eligibility status of the individual, if other than presumptively eligible.

(3) A State may elect to delay submission of claims for payments of section 1920A presumptive eligibility expenditures until after the actual eligibility determination (if any) is made and, at that time identify such expenditures based on the actual eligibility status of individuals if other than presumptively eligible. At that time, the State would, as appropriate, recategorize the medical assistance expenditures made during the section 1920A presumptive eligibility period based on the results of the actual eligibility determination, and claim them appropriately.

[65 FR 33622, May 24, 2000]

**Subpart B—Payment Methods:  
General Provisions**

**§ 447.200 Basis and purpose.**

This subpart prescribes State plan requirements for setting payment rates to implement, in part, section 1902(a)(30) of the Act, which requires that payments for services be consistent with efficiency, economy, and quality of care.

[46 FR 48560, Oct. 1, 1981]

**§ 447.201 State plan requirements.**

(a) A State plan must provide that the requirements in this subpart are met.

(b) The plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program.

**§ 447.202 Audits.**

The Medicaid agency must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials.

**§ 447.203 Documentation of payment rates.**

(a) The agency must maintain documentation of payment rates and make it available to HHS upon request.

(b) The agency must record, in State manuals or other official files, the following information for increases in payment rates for individual practitioner services:

(1) An estimate of the percentile of the range of customary charges to which the revised payment structure equates and a description of the methods used to make the estimate.

(2) An estimate of the composite average percentage increase of the revised payment rates over the preceding rates.

**§ 447.204 Encouragement of provider participation.**

The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.