§ 436.900 Scope.

This subpart sets forth requirements for processing applications, determining eligibility, and furnishing Medicaid.

§ 436.901 General requirements.

The Medicaid agency must comply with all the requirements of part 435, subpart J, of this subchapter, except those specified in § 435.909.

§ 436.909 Automatic entitlement to Medicaid following a determination of eligibility under other programs.

The agency may not require a separate application for Medicaid from an individual if the individual receives cash assistance under a State plan for OAA, AFDC, AB, APTD, or AABD.

Subpart K—Federal Financial Participation (FFP)

§ 436.1000 Scope.

This subpart specifies when, and the extent to which, FFP is available in expenditures for determining eligibility and for Medicaid services to individuals determined eligible under this part, and prescribes limitations and conditions on FFP for those expenditures.

§ 436.1001 FFP for administration.

(a) FFP is available in the necessary administrative costs the State incurs in—

(1) Determining and redetermining Medicaid eligibility and in providing Medicaid to eligible individuals; and

(2) Determining presumptive eligibility for children and providing services to presumptively eligible children.

(b) Administrative costs include any costs incident to an eye examination or medical examination to determine whether an individual is blind or disabled.

§ 436.1002 FFP for services.

(a) FFP is available in expenditures for Medicaid services for all recipients whose coverage is required or allowed under this part.

(b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided, except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient’s liability.

(c) FFP is available in expenditures for services covered under the plan that are furnished—

(1) To children who are determined by a qualified entity to be presumptively eligible;

(2) During a period of presumptive eligibility;

(3) By a provider that is eligible for payment under the plan; and

(4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.