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.

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§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 access to care and service payment rates.

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

(b) In consultation with the medical care advisory committee under §431.12 of this chapter, the agency must develop a medical assistance access monitoring review plan and update it, in accordance with the timeline established in paragraph (b)(5) of this section. The plan must be published and made available to the public for review and comment for a period of no less than 30 days, prior to being finalized and submitted to CMS for review.

(1) *Access monitoring review plan data requirements.* The access monitoring review plan must include an access monitoring analysis that includes: Data sources, methodologies, baselines, assumptions, trends and factors, and thresholds that analyze and inform determinations of the sufficiency of access to care which may vary by geographic location within the state and will be used to inform state policies affecting access to Medicaid services such as provider payment rates, as well as the items specified in this section. The access monitoring review plan must specify data elements that will support the state's analysis of whether beneficiaries have sufficient access to care. The plan and monitoring analysis will consider:

(i) The extent to which beneficiary needs are fully met;

(ii) The availability of care through enrolled providers to beneficiaries in each geographic area, by provider type and site of service;

(iii) Changes in beneficiary utilization of covered services in each geographic area.

(iv) The characteristics of the beneficiary population (including considerations for care, service and payment variations for pediatric and adult populations and for individuals with disabilities); and

(v) Actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service.

(2) *Access monitoring review plan beneficiary and provider input.* The access monitoring review plan must include an analysis of data and the state's conclusion of the sufficiency of access to care that will consider relevant provider and beneficiary information, including information obtained through public rate-setting processes, the medical care advisory committees established under §431.12 of this chapter, the processes described in paragraph (b)(7) of this section, and other mechanisms (such as letters from providers and beneficiaries to State or Federal officials), which describe access to care concerns or suggestions for improvement in access to care.

(3) *Access monitoring review plan comparative payment rate review.* For each of the services reviewed, by the provider types and sites of service (e.g., primary care physicians in office settings) described within the access monitoring analysis, the access monitoring review plan must include an analysis of the percentage comparison of Medicaid payment rates to other public (including, as practical, Medicaid managed care rates) and private health insurer