

no longer meets the applicable conditions of participation specified under subpart I of part 483 of this chapter.

(b) *Agency procedures.* Before denying payments for new admissions, the Medicaid agency must comply with the following requirements:

(1) Provide the facility up to 60 days to correct the cited deficiencies and comply with conditions of participation for ICFs/MR.

(2) If at the end of the specified period the facility has not achieved compliance, give the facility notice of intent to deny payment for new admissions, and opportunity for an informal hearing.

(3) If the facility requests a hearing, provide an informal hearing that includes—

(i) The opportunity for the facility to present, before a State Medicaid official who was not involved in making the initial determination, evidence or documentation, in writing or in person, to refute the decision that the facility is out of compliance with the conditions of participation for ICFs/MR.

(ii) A written decision setting forth the factual and legal bases pertinent to a resolution of the dispute.

(4) If the decision of the informal hearing is to deny payments for new admissions, provide the facility and the public, at least 15 days before the effective date of the sanction, with a notice that includes the effective date and the reasons for the denial of payments.

[51 FR 24491, July 3, 1986, as amended at 59 FR 56236, Nov. 10, 1994]

§442.119 Duration of denial of payments and subsequent termination of an ICF/MR.

(a) *Period of denial.* The denial of payments for new admissions will continue for 11 months after the month it was imposed unless, before the end of that period, the Medicaid agency finds that—

(1) The facility has corrected the deficiencies or is making a good faith effort to achieve compliance with the conditions of participation for ICFs/MR; or

(2) The deficiencies are such that it is necessary to terminate the facility's provider agreement.

(b) *Subsequent termination.* The Medicaid agency must terminate a facility's provider agreement—

(1) Upon the agency's finding that the facility has been unable to achieve compliance with the conditions of participation for ICFs/MR during the period that payments for new admissions have been denied;

(2) Effective the day following the last day of the denial of payments period; and

(3) In accordance with the procedures for appeal of terminations set forth in subpart D of part 431 of this chapter.

[51 FR 24491, July 3, 1986, as amended at 59 FR 56236, Nov. 10, 1994]

Subparts D–F [Reserved]

PART 447—PAYMENTS FOR SERVICES

Subpart A—Payments: General Provisions

Sec.

- 447.1 Purpose.
- 447.10 Prohibition against reassignment of provider claims.
- 447.15 Acceptance of State payment as payment in full.
- 447.20 Provider restrictions: State plan requirements.
- 447.21 Reduction of payments to providers.
- 447.25 Direct payments to certain recipients for physicians' or dentists' services.
- 447.30 Withholding the Federal share of payments to Medicaid providers to recover Medicare overpayments.
- 447.31 Withholding Medicare payments to recover Medicaid overpayments.
- 447.40 Payments for reserving beds in institutions.
- 447.45 Timely claims payment.
- 447.46 Timely claims payment by MCOs.

COST SHARING

- 447.50 Cost sharing: Basis and purpose.

ENROLLMENT FEE, PREMIUM OR SIMILAR COST SHARING CHARGE

- 447.51 Requirements and options.
- 447.52 Minimum and maximum income-related charges.

DEDUCTIBLE, COINSURANCE, CO-PAYMENT OR SIMILAR COST-SHARING CHARGE

- 447.53 Applicability; specification; multiple charges.
- 447.54 Maximum allowable charges.
- 447.55 Standard co-payment.
- 447.56 Income-related charges.

§ 447.1

- 447.57 Restrictions on payments to providers.
- 447.58 Payments to prepaid capitation organizations.

FEDERAL FINANCIAL PARTICIPATION

- 447.59 FFP: Conditions relating to cost-sharing.
- 447.60 Cost-sharing requirements for services furnished by MCOs.
- 447.88 Options for claiming FFP payment for section 1920A presumptive eligibility medical assistance payments.

Subpart B—Payment Methods: General Provisions

- 447.200 Basis and purpose.
- 447.201 State plan requirements.
- 447.202 Audits.
- 447.203 Documentation of payment rates.
- 447.204 Encouragement of provider participation.
- 447.205 Public notice of changes in State-wide methods and standards for setting payment rates.

Subpart C—Payment For Inpatient Hospital and Long-Term Care Facility Services

- 447.250 Basis and purpose.

PAYMENT RATES

- 447.251 Definitions.
- 447.252 State plan requirements.
- 447.253 Other requirements.
- 447.255 Related information.
- 447.256 Procedures for CMS action on assurances and State plan amendments.

FEDERAL FINANCIAL PARTICIPATION

- 447.257 FFP: Conditions relating to institutional reimbursement.

UPPER LIMITS

- 447.271 Upper limits based on customary charges.
- 447.272 Inpatient services: Application of upper payment limits.

SWING-BED HOSPITALS

- 447.280 Hospital providers of NF services (swing-bed hospitals).

Subpart D [Reserved]

Subpart E—Payment Adjustments for Hospitals That Serve a Disproportionate Number of Low-Income Patients

- 447.296 Limitations on aggregate payments for disproportionate share hospitals for the period January 1, 1992 through September 30, 1992.

42 CFR Ch. IV (10–1–04 Edition)

- 447.297 Limitations on aggregate payments for disproportionate share hospitals beginning October 1, 1992.
- 447.298 State disproportionate share hospital allotments.
- 447.299 Reporting requirements.

Subpart F—Payment Methods for Other Institutional and Noninstitutional Services

- 447.300 Basis and purpose.
- 447.301 Definitions.
- 447.302 State plan requirements.
- 447.304 Adherence to upper limits; FFP.

OUTPATIENT HOSPITAL AND CLINIC SERVICES

- 447.321 Outpatient hospital and clinic services: Application of upper payment limits.

OTHER INPATIENT AND OUTPATIENT FACILITIES

- 447.325 Other inpatient and outpatient facility services: Upper limits of payment.

DRUGS

- 447.331 Drugs: Aggregate upper limits of payment.
- 447.332 Upper limits for multiple source drugs.
- 447.333 State plan requirements, findings and assurances.
- 447.334 Upper limits for drugs furnished as part of services.
- 447.342 [Reserved]

PREPAID CAPITATION PLANS

- 447.362 Upper limits of payment: Nonrisk contract.

RURAL HEALTH CLINIC SERVICES

- 447.371 Services furnished by rural health clinics.

Subpart I—Payment for Outpatient Prescription Drugs Under Drug Rebate Agreements

- 447.500–447.532 [Reserved]
- 447.534 Manufacturer reporting requirements.
- 447.536–447.550 [Reserved]

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

SOURCE: 43 FR 45253, Sept. 29, 1978, unless otherwise noted.

Subpart A—Payments: General Provisions

§ 447.1 Purpose.

This subpart prescribes State plan requirements, FFP limitations and procedures concerning payments made by

State Medicaid agencies for Medicaid services.

§ 447.10 Prohibition against reassignment of provider claims.

(a) *Basis and purpose.* This section implements section 1902(a)(32) of the Act which prohibits State payments for Medicaid services to anyone other than a provider or recipient, except in specified circumstances.

(b) *Definitions.* For purposes of this section:

Facility means an institution that furnishes health care services to inpatients.

Factor means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business representative as described in paragraph (f) of this section.

Organized health care delivery system means a public or private organization for delivering health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

(c) *State plan requirements.* A State plan must provide that the requirements of paragraphs (d) through (h) of this section are met.

(d) *Who may receive payment.* Payment may be made only—

(1) To the provider; or

(2) To the recipient if he is a noncash recipient eligible to receive the payment under § 447.25; or

(3) In accordance with paragraphs (e), (f), and (g) of this section.

(e) *Reassignments.* Payment may be made in accordance with a reassignment from the provider to a government agency or reassignment by a court order.

(f) *Business agents.* Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider, if the agent's compensation for this service is—

(1) Related to the cost of processing the billing;

(2) Not related on a percentage or other basis to the amount that is billed or collected; and

(3) Not dependent upon the collection of the payment.

(g) *Individual practitioners.* Payment may be made to—

(1) The employer of the practitioner, if the practitioner is required as a condition of employment to turn over his fees to the employer;

(2) The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or

(3) A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.

(h) *Prohibition of payment to factors.* Payment for any service furnished to a recipient by a provider may not be made to or through a factor, either directly or by power of attorney.

[43 FR 45253, Sept. 29, 1978, as amended at 46 FR 42672, Aug. 24, 1981; 61 FR 38398, July 24, 1996]

§ 447.15 Acceptance of State payment as payment in full.

A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan in accordance with § 431.55(g) or § 447.53. The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge.

[50 FR 23013, May 30, 1985]

§ 447.20 Provider restrictions: State plan requirements.

A State plan must provide for the following: