the Federal government, in accordance with part 433, subpart F of this chapter.

(g) *Compliance dates.* Initial compliance dates have been separately established for institutional and non-institutional Medicaid providers operated by units of government. Following initial compliance dates, ongoing compliance will be consistent for all providers operated by units of government. A State must comply with the Medicaid cost limit described in paragraph (c) of this section in accordance with the timeframes and requirements in paragraphs (g)(1) through (g)(3) of this section.

(1) *Initial Compliance for Institutional Govermentally-Operated Health Care Providers.* For each State, compliance with the Medicaid cost limit described in paragraph (c) of this section applicable to institutional governmentally-operated health care providers begins with the Medicaid State plan rate year 2008. A State's review of Medicaid payments made to institutional governmentally-operated health care providers to ensure compliance with the Medicaid cost limit during Medicaid State plan rate year 2008 must be completed no later than the last day of federal fiscal year 2010 (September 30, 2010). The State must submit to CMS a summary report of the findings of this review by the last day of calendar year of 2010 (December 31, 2010). For any cost reports that are not finalized, the State should use the ''as filed'' cost report and indicate such in the summary report to CMS. The State should then submit a corrected summary report to CMS within 30 days of the finalization of the cost report.

(2) *Initial Compliance for Non-Institutional Governmentally-Operated Health Care Providers.* For each State, compliance with the cost limit described in paragraph (c) of this section applicable to non-institutional governmentally-operated health care providers begins with the Medicaid State plan rate year 2009. A State's review of Medicaid payments made to non-institutional governmentally-operated health care providers to ensure compliance with the Medicaid cost limit during Medicaid State plan rate year 2009 must be completed no later than the last day of federal fiscal year 2011 (September 30, 2011). The State must submit to CMS a summary report of the findings of this review by the last day of calendar year of 2011 (December 31, 2011).

(3) *Ongoing Compliance for Institutional and Non-Institutional Governmentally-Operated Health Care Providers.* Each subsequent State review of Medicaid payments made to governmentally-operated health care providers, after the Medicaid State plan rate years identified in paragraphs (g)(1) and (g)(2) of this section, must be performed annually and completed by the last day of the federal fiscal year ending two years from the Medicaid State plan rate year under review. Each State must submit a summary report to CMS demonstrating the results of the State's review of Medicaid payments to ensure compliance with the Medicaid cost limit applicable to governmentally-operated health care providers by the last day of the calendar year ending two years from the Medicaid State Plan rate year under review.

(i) For any cost reports that are not finalized at the time the State performs the review of Medicaid payments to institutional governmentally-operated health care providers, the State should use the ''as filed'' cost report and indicate such in the summary report to CMS. The State should then submit a corrected summary report to CMS within 30 days of the finalization of the cost report.

[72 FR 29833, May 29, 2007]

### § 447.207 Retention of payments.

(a) Payment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved State plan (or the approved provisions of a waiver or demonstration if applicable). The Secretary will determine compliance with this provision by examining any associated transactions that are related to the provider's total computable payment to ensure that the State's claimed expenditure, which serves as the basis for Federal Financial Participation, is equal to the State's net expenditure, and that the full amount of the non-Federal share of the payment has been satisfied.

(b) *Exceptions.* Provisions of paragraph (a) of this section specifically do not pertain to:

(1) Use of Medicaid revenues to fund payments that are normal operating expenses of conducting business, such as payments related to taxes (including permissible health-care related taxes), fees, or business relationships with governments unrelated to Medicaid in which there is no connection to Medicaid payment.

(2) Payments authorized by Sections 701(d) and 705 of the Benefits Improvement Act of 2000 (BIPA).

[72 FR 29834, May 29, 2007]

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

SOURCE: 46 FR 47971, Sept. 30, 1981, unless otherwise noted.

### §447.250 Basis and purpose.

(a) This subpart implements section 1902(a)(13)(A) of the Act, which requires that the State plan provide for payment for hospital and long-term care facility services through the use of rates that the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulations, and quality and safety standards.

(b) Section 447.253(a)(2) implements section 1902(a)(30) of the Act, which requires that payments be consistent with efficiency, economy, and quality of care;

(c) Sections 447.253 (c) and (d) implement sections 1902(a)(13)(B) and 1902(a)(13)(C) of the Act, which require a State Medicaid agency to make certain assurances to the Secretary regarding increases in payments resulting solely from changes in ownerships of hospitals, NFs, and ICFs/MR.

(d) Section 447.271 implements section 1903(i)(3) of the Act, which requires that payments for inpatient hospital services not exceed the hospital's customary charges.

(e) Section 447.280 implements section 1913(b) of the Act, which concerns reimbursement for long-term care services furnished by swing-bed hospitals.

[48 FR 56057, Dec. 19, 1983, as amended at 57 FR 43921, Sept. 23, 1992]

PAYMENT RATES

### §447.251 Definitions.

For the purposes of this subpart—

*Long-term care facility services* means intermediate care facility services for the mentally retarded (ICF/MR) and nursing facility (NF) services.

*Provider* means an institution that furnishes inpatient hospital services or an institution that furnishes long-term care facility services.

[46 FR 47971, Sept. 30, 1981, as amended at 54 FR 5359, Feb. 2, 1989; 56 FR 48867, Sept. 26, 1991]

### §447.252 State plan requirements.

(a) The plan must provide that the requirements of this subpart are met.

(b) The plan must specify comprehensively the methods and standards used by the agency to set payment rates in a manner consistent with §430.10 of this chapter.

(c) If the agency chooses to apply the cost limits established under Medicare (see §413.30 of this chapter) on an individual provider basis, the plan must specify this requirement.

(Approved by the Office of Management and Budget under control number 0938–0193)

[48 FR 56058, Dec. 19, 1983, as amended at 51 FR 34833, Sept. 30, 1986]

### §447.253 Other requirements.

(a) *State assurances.* In order to receive CMS approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to CMS that the requirements set forth in paragraphs (b) through (i) of this section are being met, must submit the related information required by §447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) *Findings.* Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings: