(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: