change in its methods and standards for setting payment rates for services.

(b) **When notice is not required.** Notice is not required if—

1. The change is being made to conform to Medicare methods or levels of reimbursement;
2. The change is required by court order; or
3. The change is based on changes in wholesalers’ or manufacturers’ prices of drugs or materials, if the agency’s reimbursement system is based on material cost plus a professional fee.

(c) **Content of notice.** The notice must—

1. Describe the proposed change in methods and standards;
2. Give an estimate of any expected increase or decrease in annual aggregate expenditures;
3. Explain why the agency is changing its methods and standards;
4. Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review;
5. Give an address where written comments may be sent and reviewed by the public; and
6. If there are public hearings, give the location, date and time for hearings or tell how this information may be obtained.

(d) **Publication of notice.** The notice must—

1. Be published before the proposed effective date of the change; and
2. Appear as a public announcement in one of the following publications:
   (i) A State register similar to the FEDERAL REGISTER.
   (ii) The newspaper of widest circulation in each city with a population of 50,000 or more.
   (iii) The newspaper of widest circulation in the State, if there is no city with a population of 50,000 or more.

§ 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.

§ 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.

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

Source: 46 FR 47971, Sept. 30, 1981, unless otherwise noted.
§ 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)

§ 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:

(1) Payment rates. (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(ii) With respect to the lower costs (if any) of the facility for nursing care under a waiver of the requirement in §483.30(c) of this Chapter to provide licensed nurses on a 24-hour basis.

(iii) With respect to inpatient hospital services—

(A) Except for preadmission screening for individuals with mental illness and mental retardation under §483.20(f) of this Chapter, the methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in §483.30(c) of this Chapter to provide licensed nurses on a 24-hour basis;

(B) The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in §483.30(c) of this Chapter to provide licensed nurses on a 24-hour basis;

(C) The State establishes procedures under which the data and methodology used in establishing payment rates are made available to the public.

(2) Upper payment limits. The agency’s proposed payment rate will not exceed the upper payment limits as specified in §447.272.

(c) Changes in ownership of hospitals. In determining payment when there has been a sale or transfer of the assets of a hospital, the State’s methods and standards must provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than the payments would increase under Medicare under §§413.130, 413.134, 413.153, and 413.157 of this chapter, insofar as these sections affect payments for depreciation, interest on capital indebtedness, return on equity capital (if
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applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

(d) Changes in ownership of NFs and ICFs/MR. In determining payment when there has been a sale or transfer of assets of an NF or ICF/MR, the State’s methods and standards must provide the following depending upon the date of the transfer.

(1) For transfers on or after July 18, 1984 but before October 1, 1985, the State’s methods and standards must provide that payment rates can reasonably be expected not to increase in the aggregate, solely as the result of a change in ownership, more than payments would increase under Medicare under §§ 413.130, 413.134, 413.153 and 413.157 of this chapter, insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity capital (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

(2) For transfers on or after October 1, 1985, the State’s methods and standards must provide that the valuation of capital assets for purposes of determining payment rates for NFs and ICFs/MR is not to increase (as measured from the date of acquisition by the seller to the date of the change of ownership) solely as a result of a change of ownership, by more than the lesser of—

(i) One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership, or, if necessary, as extrapolated retrospectively by the Secretary) in the Dodge construction index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year; or

(ii) One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year.

(e) Provider appeals. The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

(f) Uniform cost reporting. The Medicaid agency must provide for the filing of uniform cost reports by each participating provider.

(g) Audit requirements. The Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers.

(h) Public notice. The Medicaid agency must provide that it has complied with the public notice requirements in § 447.205 of this part when it is proposing significant changes to its methods or standards for setting payment rates for inpatient hospital or LTC facility services.

(i) Rates paid. The Medicaid agency must pay for inpatient hospital and long term care services using rates determined in accordance with methods and standards specified in an approved State plan.

(4) The degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

§ 447.256 Procedures for CMS action on assurances and State plan amendments.

(a) Criteria for approval. (1) CMS approval action on State plans and State plan amendments, is taken in accordance with subpart B of part 430 of this chapter and sections 1116, 1902(b) and 1915(f) of the Act.

(2) In the case of State plan and plan amendment changes in payment methods and standards, CMS bases its approval on the acceptability of the Medicaid agency’s assurances that the requirements of §447.253 have been met, and the State’s compliance with the other requirements of this subpart.

(b) Time limit. CMS will send a notice to the agency of its determination as to whether the assurances regarding a State plan amendment are acceptable within 90 days of the date CMS receives the assurances described in §447.253, and the related information described in §447.255 of this subpart. If CMS does not send a notice to the agency of its determination within this time limit and the provisions in paragraph (a) of this section are met, the assurances and/or the State plan amendment will be deemed accepted and approved.

(c) Effective date. A State plan amendment that is approved will become effective not earlier than the first day of the calendar quarter in which an approvalable amendment is submitted in accordance with §§430.20 of this chapter and 447.253.

§ 447.257 FFP: Conditions relating to institutional reimbursement.

FFP is not available for a State’s expenditures for hospital inpatient or long-term care facility services that are in excess of the amounts allowable under this subpart.

§ 447.271 Upper limits based on customary charges.

(a) Except as provided in paragraph (b) of this section, the agency may not pay a provider more for inpatient hospital services under Medicaid than the provider’s customary charges to the general public for the services.

(b) The agency may pay a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider charges were equal to or greater than its costs.

§ 447.272 Inpatient services: Application of upper payment limits.

(a) Scope. This section applies to rates set by the agency to pay for inpatient services furnished by hospitals, NFs, and ICFs/MR within one of the following categories:

(1) State government-owned or operated facilities (that is, all facilities that are either owned or operated by the State).

(2) Non-State government-owned or operated facilities (that is, all government facilities that are neither owned nor operated by the State).

(3) Privately-owned and operated facilities.

(b) General rules. (1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.

(2) Except as provided for in paragraph (c) of this section, aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) of this section may not exceed the upper payment limit described in paragraph (b)(1) of this section.

(c) Exceptions.—(1) Indian Health Services and tribal facilities. The limitation in paragraph (b) of this section does not apply to Indian Health Services facilities and tribal facilities that are
funded through the Indian Self-Determination and Education Assistance Act (Pub. L. 93–638).

(2) Disproportionate share hospitals. The limitation in paragraph (b) of this section does not apply to payment adjustments made under section 1923 of the Act that are made under a State plan to hospitals found to serve a disproportionate number of low-income patients with special needs as provided in section 1902(a)(13)(A)(iv) of the Act. Disproportionate share hospital (DSH) payments are subject to the following limits:

(i) The aggregate DSH limit using the Federal share of the DSH limit under section 1923(f) of the Act.

(ii) The hospital-specific DSH limit in section 1923(g) of the Act.

(iii) The aggregate DSH limit for institutions for mental disease (IMDs) under section 1923(h) of the Act.

(d) Compliance dates. Except as permitted under paragraph (e) of this section, a State must comply with the upper payment limit described in paragraph (b) of this section by one of the following dates:

(1) For non-State government owned or operated hospitals.—March 19, 2002.

(2) For all other facilities—March 13, 2001.

(e) Transition periods—(1) Definitions. For purposes of this paragraph, the following definitions apply:

(i) Transition period refers to the period of time beginning March 13, 2001 through the end of one of the schedules permitted under paragraph (e)(2)(ii) of this section.

(ii) UPL stands for the upper payment limit described in paragraph (b) of this section for the referenced year.

(iii) X stands for the payments to a specific group of providers described in paragraphs (a)(2) and (a)(3) of this section in State FY 2000 that exceeded the amount that would have been under the upper payment limit described in paragraph (b) of this section if that limit had been applied to that year.

(2) General rules. (i) The amount that a State’s payment exceeded the upper payment limit described in paragraph (b) of this section must not increase.

(ii) A State with an approved State plan amendment payment provision effective on one of the following dates and that makes payments that exceed the upper payment limit described in paragraph (b) of this section to providers described in paragraphs (a)(2) and (a)(3) of this section may follow the respective transition schedule:

(A) For State plan provisions that are effective after September 30, 1999 and were approved before January 22, 2001, payments may exceed the upper payment limit in paragraph (b) of this section until September 30, 2002.

(B) For approved plan provisions that are effective after October 1, 1992 and before October 1, 1999, payments during the transition period may not exceed the following—

(1) For State FY 2003: State FY 2003 UPL + .75X.

(2) For State FY 2004: State FY 2004 UPL + .50X.

(3) For State FY 2005: State FY 2005 UPL + .25X.

(4) For State FY 2006: State FY 2006 UPL.

(C) For approved plan provisions that are effective on or before October 1, 1992, payments during the transition period may not exceed the following:

(1) For State FY 2004: State FY 2004 UPL + .85X.

(2) For State FY 2005: State FY 2005 UPL + .70X.

(3) For State FY 2006: State FY 2006 UPL + .55X.

(4) For State FY 2007: State FY 2007 UPL + .40X.

(5) For State FY 2008: State FY 2008 UPL + .25X.

(6) For the portion of State FY 2009 before October 1, 2008: State FY 2009 UPL + .10X.

(7) Beginning October 1, 2008: UPL described in paragraph (b) of this section.

(D) For State plan provisions that were effective after September 30, 1999, submitted to CMS before March 13, 2001, and approved by CMS after January 21, 2001, payments may exceed the limit in paragraph (b) of this section until the later of November 5, 2001, or 1 year from the approved effective date of the State plan provision.

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

(a) General rule. If the State plan provides for NF services furnished by a swing-bed hospital, as specified in §§440.40(a) and 440.150(f) of this chapter, the methods and standards used to determine payment rates for routine NF services must—

(1) Provide for payment at the average rate per patient day paid to NFs, as applicable, for routine services furnished during the previous calendar year; or

(2) Meet the State plan and payment requirements described in this subpart, as applicable.

(b) Application of the rule. The payment methodology used by a State to set payment rates for routine NF services must apply to all swing-bed hospitals in the State.

[59 FR 56237, Nov. 10, 1994]

Subpart D [Reserved]

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

SOURCE: 57 FR 56143, Nov. 24, 1992, unless otherwise noted.


(a) The provisions of this section apply to the 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act.

(b) For the period January 1, 1992 through September 30, 1992, FFP is available for aggregate payments to hospitals that serve a disproportionate number of low-income patients with special needs only if the payments are made in accordance with sections 1902(a)(13)(A) and 1923 of the Act, and with one of the following:

(1) An approved State plan in effect as of September 30, 1991.


(3) A State plan amendment, or modification thereof, submitted to CMS between October 1, 1991 and November 26, 1991, if the amendment, or modification thereof, was intended to limit the State’s definition of disproportionate share hospitals to those hospitals with Medicaid inpatient utilization rates or low-income utilization rates (as defined in section 1923 (b) of the Act) at or above the statewide arithmetic mean.

(4) A methodology for disproportionate share hospital payments that was established and in effect as of September 30, 1991, or in accordance with a