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.


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.
447.26 Prohibition on payment for provider-preventable conditions.
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.

42 CFR Ch. IV (10–1–11 Edition)

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 and nominal charges.
447.55 Standard co-payment.
447.56 Income-related charges.
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.

ALTERNATIVE PREMIUMS AND COST SHARING UNDER SECTION 1916A

447.62 Alternative premiums and cost sharing: Basis, purpose and scope.
447.64 Alternative premiums, enrollment fees, or similar fees: State plan requirements.
447.66 General alternative premium protections.
447.68 Alternative copayments, coinsurance, deductibles, or similar cost sharing charges: State plan requirements.
447.70 General alternative cost sharing protections.
447.71 Alternative premium and cost sharing exemptions and protections for individuals with family incomes at or below 100 percent of the FPL.
447.72 Alternative premium and cost sharing exemptions and protections for individuals with family incomes above 100 percent but at or below 150 percent of the FPL.
447.74 Alternative premium and cost sharing protections for individuals with family incomes above 150 percent of the FPL.
447.76 Public schedule.
447.78 Aggregate limits on alternative premiums and cost sharing.
447.80 Enforceability of alternative premiums and cost sharing.
447.82 Restrictions on payments to providers.
447.88 Options for claiming FFP payment for section 1920A presumptive eligibility medical assistance payments.
447.90 FFP: Conditions related to pending investigations of credible allegations of fraud against the Medicaid program.
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.
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.
447.302 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.
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.

Subparts G–H (Reserved)

Subpart I—Payment for Drugs

447.500 Basis and purpose.
447.502 Definitions.
447.504 (Reserved)
447.505 Determination of best price.
447.506 Authorized generic drugs.
447.508 Exclusion from best price of certain sales at a nominal price.
447.510 Requirements for manufacturers.
447.512 Drugs: Aggregate upper limits of payment.
447.514 (Reserved)
447.516 Upper limits for drugs furnished as part of services.
447.518 State plan requirements, findings and assurances.
447.520 FFP: Conditions relating to physician-administered drugs.

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.