

§ 447.25 Direct payments to certain beneficiaries for physicians' or dentists' services.

(a) *Basis and purpose.* This section implements section 1905(a) of the Act by prescribing requirements applicable to States making direct payments to certain beneficiaries for physicians' or dentists' services.

(b) *State plan requirements.* Except for groups specified in paragraph (c) of this section, a State may make direct payments to beneficiaries for physicians' or dentists' services. If it does so, the State plan must—

(1) Provide for direct payments; and

(2) Specify the conditions under which payments are made.

(c) *Federal financial participation.* No FFP is available in expenditures for direct payment for physicians' or dentists' services to any beneficiary—

(1) Who is receiving assistance under the State's approved plan under title I, IV-A, X, XIV or XVI (AABD) of the Act; or

(2) To whom supplemental security benefits are being paid under title XVI of the Act; or

(3) Who is receiving or eligible for a State supplementary payment or would be eligible if he were not in a medical institution, and who is eligible for Medicaid as a categorically needy beneficiary.

(d) *Federal requirements.* (1) Direct payments to beneficiaries under this section are an alternative to payments directly to providers and are subject to the same conditions; for example, the State's reasonable charge schedules are applicable.

(2) Direct payments must be supported by providers' bills for services.

§ 447.26 Prohibition on payment for provider-preventable conditions.

(a) *Basis and purpose.* The purpose of this section is to protect Medicaid beneficiaries and the Medicaid program by prohibiting payments by States for services related to provider-preventable conditions.

(1) Section 2702 of the Affordable Care Act requires that the Secretary exercise authority to prohibit Federal payment for certain provider preventable conditions (PPCs) and health care-acquired conditions (HCACs).

(2) Section 1902(a)(19) of the Act requires that States provide care and services consistent with the best interests of the beneficiaries.

(3) Section 1902(a)(30) of the Act requires that State payment methods must be consistent with efficiency, economy, and quality of care.

(b) *Definitions.* As used in this section—

Health care-acquired condition means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other provider-preventable condition means a condition occurring in any health care setting that meets the following criteria:

(i) Is identified in the State plan.

(ii) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

(iii) Has a negative consequence for the beneficiary.

(iv) Is auditable.

(v) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Provider-preventable condition means a condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition" as defined in this section.

(c) *General rules.*

(1) A State plan must provide that no medical assistance will be paid for "provider-preventable conditions" as defined in this section; and as applicable for individuals dually eligible for both the Medicare and Medicaid programs.

(2) No reduction in payment for a provider preventable condition will be