

Centers for Medicare & Medicaid Services, HHS

§ 447.10

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 Determination of AMP.
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 Upper limits for multiple source drugs.
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.

(b) *Definitions.* For purposes of this section:

Facility means an institution that furnishes health care services to inpatients.

Factor means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business representative as described in paragraph (f) of this section.

Organized health care delivery system means a public or private organization for delivering health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

(c) *State plan requirements.* A State plan must provide that the requirements of paragraphs (d) through (h) of this section are met.

(d) *Who may receive payment.* Payment may be made only—

(1) To the provider; or

(2) To the recipient if he is a noncash recipient eligible to receive the payment under § 447.25; or

§ 447.15

(3) In accordance with paragraphs (e), (f), and (g) of this section.

(e) *Reassignments.* Payment may be made in accordance with a reassignment from the provider to a government agency or reassignment by a court order.

(f) *Business agents.* Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider, if the agent's compensation for this service is—

(1) Related to the cost of processing the billing;

(2) Not related on a percentage or other basis to the amount that is billed or collected; and

(3) Not dependent upon the collection of the payment.

(g) *Individual practitioners.* Payment may be made to—

(1) The employer of the practitioner, if the practitioner is required as a condition of employment to turn over his fees to the employer;

(2) The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or

(3) A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.

(h) *Prohibition of payment to factors.* Payment for any service furnished to a recipient by a provider may not be made to or through a factor, either directly or by power of attorney.

[43 FR 45253, Sept. 29, 1978, as amended at 46 FR 42672, Aug. 24, 1981; 61 FR 38398, July 24, 1996]

§ 447.15 Acceptance of State payment as payment in full.

A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost sharing

42 CFR Ch. IV (10–1–07 Edition)

amount imposed by the plan in accordance with § 431.55(g) or § 447.53. The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge.

[50 FR 23013, May 30, 1985]

§ 447.20 Provider restrictions: State plan requirements.

A State plan must provide for the following:

(a) In the case of an individual who is eligible for medical assistance under the plan for service(s) for which a third party or parties is liable for payment, if the total amount of the established liability of the third party or parties for the service is—

(1) Equal to or greater than the amount payable under the State plan (which includes, when applicable, cost-sharing payments provided for in §§ 447.53 through 447.56), the provider furnishing the service to the individual may not seek to collect from the individual (or any financially responsible relative or representative of that individual) any payment amount for that service; or

(2) Less than the amount payable under the State plan (including cost sharing payments set forth in §§ 447.53 through 447.56), the provider furnishing the service to that individual may collect from the individual (or any financially responsible relative or representative of the individual) an amount which is the lesser of—

(i) Any cost-sharing payment amount imposed upon the individual under §§ 447.53 through 447.56; or

(ii) An amount which represents the difference between the amount payable under the State plan (which includes, where applicable, cost-sharing payments provided for in §§ 447.53 through 447.56) and the total of the established third party liability for the services.

(b) A provider may not refuse to furnish services covered under the plan to an individual who is eligible for medical assistance under the plan on account of a third party's potential liability for the service(s).

[55 FR 1433, Jan. 16, 1990]