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.

[48 FR 56057, Dec. 19, 1983, as amended at 52 FR 28147, July 28, 1987; 54 FR 5359, Feb. 2, 1989; 57 FR 43921, Sept. 23, 1992]

§447.255 Related information.

The Medicaid agency must submit, with the assurances described in §447.253(a), the following information:

(a) The amount of the estimated average proposed payment rate for each type of provider (hospital, ICF/MR, or nursing facility), and the amount by which that estimated average rate increased or decreased relative to the average payment rate in effect for each type or provider for the immediately preceding rate period;

(b) An estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on—

(1) The availability of services on a Statewide and geographic area basis;

(2) The type of care furnished;

(3) The extent of provider participation; and

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

[48 FR 56058, Dec. 19, 1983, as amended at 54 FR 5359, Feb. 2, 1989; 56 FR 48867, Sept. 26, 1991; 57 FR 43924, Sept. 23, 1992; 57 FR 46431, Oct. 8, 1992]

§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 approvable amendment is submitted in accordance with § 430.20 of this chapter and 447.253.

[48 FR 56058, Dec. 19, 1983, as amended at 52 FR 28147, July 28, 1987]

FEDERAL FINANCIAL PARTICIPATION

§ 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.

[52 FR 28147, July 28, 1987]

UPPER LIMITS

§ 447.271 Upper limits based on customary charges.

(a) 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) [Reserved]

[72 FR 29834, May 29, 2007]

§ 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, nursing facilities, and ICFs/MR within one of the following categories:

(1) State government operated facilities (that is, all facilities that are operated by the State) as defined at § 433.50(a) of this chapter.

(2) Non-State government operated facilities (that is, all governmentally operated facilities that are not operated by the State) as defined at § 433.50(a) of this chapter.

(3) Privately operated facilities, that is, all facilities that are not operated by a unit of government as defined at § 433.50(a) of this chapter.

(b) *General rules.* (1) For privately operated facilities, 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) For State government operated facilities and for non-State government operated facilities, upper payment limit refers to the individual health care provider's Medicaid cost as defined at § 447.206.

(3) Except as provided in paragraph (c) of this section, aggregate Medicaid payments to the group of privately operated facilities described in paragraph (a) of this section may not exceed the upper payment limit described in paragraph (b)(1) of this section.

(4) Except as provided in paragraph (c) of this section, Medicaid payments to State government operated facilities and non-State government operated facilities must not exceed the individual health care provider's Medicaid cost as documented in accordance with § 447.206.

(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.

(3) The limitation in paragraph (b) of this section does not apply to payments authorized by Sections 701(d) and 705 of the Benefits Improvement Protection Act of 2000 (BIPA).