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.


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).
(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 State government operated and non-State government operated hospitals, nursing facilities and ICFs/MR “Medicaid State plan rate year 2008.

(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)(1) 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.

(D) For approved 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.


(iv) If a State meets the criteria in paragraph (e)(2)(ii) of this section and its State plan amendment expires before the end of the applicable transition period, the State may continue making payments that exceed the UPL described in paragraph (b) of this section in accordance with the applicable transition schedule described in paragraph (e)(2)(ii) of this section.

(v) A State with an approved State plan amendment payment provision that makes payments up to 150 percent of the UPL described in paragraph (b) of this section to providers described in paragraph (a)(2) of this section does not qualify for a transition period.

(f) Reporting requirements for payments during the transition periods. States that
are eligible for a transition period described in paragraph (e) of this section, and that make payments that exceed the upper payment limit under paragraph (b)(1) of this section, must report annually the following information to CMS:

(1) The total Medicaid payments made to each facility for services furnished during the entire State fiscal year.

(2) A reasonable estimate of the amount that would be paid for the services furnished by the facility under Medicare payment principles.


SWING-BED HOSPITALS

§ 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 55143, Nov. 24, 1992, unless otherwise noted.