

**§ 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

imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(3) Reductions in provider payment may be limited to the extent that the following apply:

(i) The identified provider-preventable conditions would otherwise result in an increase in payment.

(ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

(4) FFP will not be available for any State expenditure for provider-preventable conditions.

(5) A State plan must ensure that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

(d) *Reporting.* State plans must require that providers identify provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.

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**§ 447.30 Withholding the Federal share of payments to Medicaid providers to recover Medicare overpayments.**

(a) *Basis and purpose.* This section implements section 1914 of the Act, which provides for withholding the Federal share of Medicaid payments to a provider if the provider has not arranged to repay Medicare overpayments or has failed to provide information to determine the amount of the overpayments. The intent of the statute and regulations is to facilitate the recovery of Medicare overpayments. The provision enables recovery of overpayments when institutions have reduced participation in Medicare or when physicians and suppliers have submitted few or no claims under Medicare, thus not receiving enough in Medicare reimbursement to permit offset of the overpayment.

(b) *When withholding occurs.* The Federal share of Medicaid payments may be withheld from any provider specified in paragraph (c) of this section to re-

cover Medicare overpayments that CMS has been unable to collect if the provider participates in Medicaid and—

(1) The provider has not made arrangements satisfactory to CMS to repay the Medicare overpayment; or

(2) CMS has been unable to collect information from the provider to determine the existence or amount of Medicare overpayment.

(c) The Federal share of Medicaid payments may be withheld with respect to the following providers:

(1) An institutional provider that has or previously had in effect a Medicare provider agreement under section 1866 of the Act; and

(2) A Medicaid provider who has previously accepted Medicare payment on the basis of an assignment under section 1842(b)(3)(B)(ii) of the Act; and during the 12 month period preceding the quarter in which the Federal share is to be withheld for a Medicare overpayment, submitted no claims under Medicare or submitted claims which total less than the amount of overpayment.

(d) *Order to reduce State payment.* (1) CMS may, at its discretion, issue an order to the Medicaid agency of any State that is using the provider's services, to reduce its payment to the provider by the amount specified in paragraph (f) of this section.

(2) The order to reduce payment to the provider will remain in effect until—

(i) The Medicaid agency determines that the overpayment has been completely recovered; or

(ii) CMS terminates the order.

(3) CMS may withhold FFP from any State that does not comply with the order specified in paragraph (d)(1) of this section to reduce payment to the provider and claims FFP for the expenditure on its quarterly expenditure report.

(e) *Notice of withholding.* (1) Before the Federal share of payments may be withheld under this section, CMS will notify the provider and the Medicaid agency of each State that CMS believes may use the overpaid provider's services under Medicaid.

(2) The notice will include the instruction to reduce State payments, as