

§ 441.750

end of the approval period. CMS approval of a renewal request is contingent upon State adherence to Federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

(B) If a State does not elect to establish targeting criteria through § 441.710(e)(2)(i), the limitations on length of approval does not apply.

(b) *Quality improvement strategy: Program performance and quality of care.* States must develop and implement an HCBS quality improvement strategy that includes a continuous improvement process and measures of program performance and experience of care. The strategy must be proportionate to the scope of services in the State plan HCBS benefit and the number of individuals to be served. The State will make this information available to CMS at a frequency determined by the Secretary or upon request.

(1) *Quality Improvement Strategy.* The quality improvement strategy must include all of the following:

(i) Incorporate a continuous quality improvement process that includes monitoring, remediation, and quality improvement, including recognizing and reporting critical incidents, as defined in § 441.302(a)(6)(i)(A), except that the references to section 1915(c) of the Act are instead references to section 1915(i) of the Act.

(ii) Be evidence-based, and include outcome measures for program performance, quality of care, and individual experience as determined by the Secretary.

(iii) Provide evidence of the establishment of sufficient infrastructure to implement the program effectively.

(iv) Measure individual outcomes associated with the receipt of HCBS, related to the implementation of goals included in the individual service plan.

(v) Implementation of the Home and Community-Based Services Quality Measure Set in accordance with § 441.312, except that the references to section 1915(c) of the Act are instead references to section 1915(i) of the Act.

(2) [Reserved]

[79 FR 3033, Jan. 16, 2014, as amended at 89 FR 40871, May 10, 2024]

42 CFR Ch. IV (10–1–25 Edition)

§ 441.750 Website transparency.

For States subject to the requirements of subpart M, the State must operate a website consistent with § 441.313, except that the references to section 1915(c) of the Act are instead references to section 1915(i) of the Act.

[89 FR 40871, May 10, 2024]

PART 442—STANDARDS FOR PAYMENT TO NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

Subpart A—General Provisions

Sec.

442.1 Basis and purpose.

442.2 Terms.

Subpart B—Provider Agreements

442.10 State plan requirement.

442.12 Provider agreement: General requirements.

442.13 Effective date of provider agreement.

442.14 Effect of change of ownership.

442.15 Duration of agreement for ICF/IIDs.

442.16 [Reserved]

442.30 Agreement as evidence of certification.

442.40 Availability of FFP during appeals for ICFs/IID.

442.42 FFP under a retroactive provider agreement following appeal.

442.43 Payment transparency reporting.

Subpart C—Certification of ICFs/IID

442.100 State plan requirements.

442.101 Obtaining certification.

442.105 [Reserved]

442.109 Certification period for ICF/IIDs: General provisions.

442.110 Certification period for ICF/IID with standard-level deficiencies.

442.117 Termination of certification for ICFs/IID whose deficiencies pose immediate jeopardy.

442.118 Denial of payments for new admissions to an ICF/IID.

442.119 Duration of denial of payments and subsequent termination of an ICF/IID.

Subparts D–F [Reserved]

AUTHORITY: 42 U.S.C. 1302.

SOURCE: 43 FR 45233, Sept. 29, 1978, unless otherwise noted.

Subpart A—General Provisions**§ 442.1 Basis and purpose.**

(a) This part states requirements for provider agreements for facility certification relating to the provision of services furnished by nursing facilities and intermediate care facilities for individuals with intellectual disabilities. This part is based on the following sections of the Act:

Section 1902(a)(4), administrative methods for proper and efficient operation of the State plan;

Section 1902(a)(27), provider agreements;

Section 1902(a)(28), nursing facility standards;

Section 1902(a)(33)(B), State survey agency functions; Section 1902(i), circumstances and procedures for denial of payment and termination of provider agreements in certain cases;

Section 1905(c), definition of nursing facility; Section 1905(d), definition of intermediate care facility for individuals with intellectual disabilities;

Section 1905 (f), definition of nursing facility services;

Section 1910, certification and approval of ICFs/IID and of RHCs;

Section 1913, hospital providers of nursing facility services;

Section 1919 (g) and (h), survey, certification and enforcement of nursing facilities; and Section 1922, correction and reduction plans for intermediate care facilities for individuals with intellectual disabilities.

(b) Section 431.610 of this subchapter contains requirements for designating the State licensing agency to survey these facilities and for certain survey agency responsibilities.

[43 FR 45233, Sept. 29, 1978, as amended at 47 FR 31533, July 20, 1982; 59 FR 56235, Nov. 10, 1994]

§ 442.2 Terms.

In this part—

Facility refers to a nursing facility, and an intermediate care facility for Individuals with Intellectual Disabilities or persons with related conditions (ICF/IID).

Facility, and any specific type of facility referred to, may include a distinct part of a facility as specified in § 440.40 or § 440.150 of this subchapter.

Immediate jeopardy means a situation in which immediate corrective action is necessary because the provider's noncompliance with one or more re-

quirements of participation or conditions of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to an individual receiving care in a facility.

New admission means the admission of a Medicaid beneficiary who has never been in the facility or, if previously admitted, had been discharged or had voluntarily left the facility. The term does not include the following:

(a) Individuals who were in the facility before the effective date of denial of payment for new admissions, even if they become eligible for Medicaid after that date.

(b) If the approved State plan includes payments for reserved beds, individuals who, after a temporary absence from the facility, are readmitted to beds reserved for them in accordance with § 447.40(a) of this chapter.

[43 FR 45233, Sept. 29, 1978, as amended at 51 FR 24491, July 3, 1986; 53 FR 1993, Jan. 25, 1988; 54 FR 5358, Feb. 2, 1989; 56 FR 48865, Sept. 26, 1991; 59 FR 56235, Nov. 10, 1994]

Subpart B—Provider Agreements**§ 442.10 State plan requirement.**

A State plan must provide that requirements of this subpart are met.

§ 442.12 Provider agreement: General requirements.

(a) *Certification and recertification.* Except as provided in paragraph (b) of this section, a Medicaid agency may not execute a provider agreement with a facility for nursing facility services nor make Medicaid payments to a facility for those services unless the Secretary or the State survey agency has certified the facility under this part to provide those services. (See § 442.101 for certification by the Secretary or by the State survey agency).

(b) *Exception.* The certification requirement of paragraph (a) of this section does not apply with respect to religious nonmedical institutions as defined in § 440.170(b) of this chapter.

(c) *Conformance with certification condition.* An agreement must be in accordance with the certification provisions set by the Secretary or the survey agency under subpart C of this part for ICFs/IID or subpart E of part 488 of this chapter for NFs.

§ 442.13

(d) *Denial for good cause.* (1) If the Medicaid agency has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement, with a certified facility.

(2) A provider agreement is not a valid agreement for purposes of this part even though certified by the State survey agency, if the facility fails to meet the civil rights requirements set forth in 45 CFR parts 80, 84, and 90.

[45 FR 22936, Apr. 4, 1980, as amended at 56 FR 48865, Sept. 26, 1991; 59 FR 56235, Nov. 10, 1994; 64 FR 67052, Nov. 30, 1999]

§ 442.13 Effective date of provider agreement.

The effective date of a provider agreement with an NF or ICF/IID is determined in accordance with the rules set forth in § 431.108.

[62 FR 43936, Aug. 18, 1997]

§ 442.14 Effect of change of ownership.

(a) *Assignment of agreement.* When there is a change of ownership, the Medicaid agency must automatically assign the agreement to the new owner.

(b) *Conditions that apply to assigned agreements.* An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Any expiration date for ICFs/IID.

(3) Compliance with applicable health and safety requirements.

(4) Compliance with the ownership and financial interest disclosure requirements of §§ 455.104 and 455.105 of this chapter.

(5) Compliance with civil rights requirements set forth in 45 CFR parts 80, 84, and 90.

(6) Compliance with any additional requirements imposed by the Medicaid agency.

[45 FR 22936, Apr. 4, 1980, as amended at 53 FR 20495, June 3, 1988; 59 FR 56235, Nov. 10, 1994]

42 CFR Ch. IV (10–1–25 Edition)

§ 442.15 Duration of agreement for ICF/IIDs.

(a) The agreement for an ICF/IID remains in effect until the Secretary determines that the facility no longer meets the applicable requirements. The State Survey Agency must conduct a survey of the facility to determine compliance with the requirements at a survey interval of no greater than 15 months.

(b) FFP is available for services furnished by a facility for up to 30 days after its agreement expires or terminates under the conditions specified in § 441.11 of this subchapter.

[77 FR 29031, May 16, 2012]

§ 442.16 [Reserved]

§ 442.30 Agreement as evidence of certification.

(a) Under §§ 440.40(a) and 440.150 of this chapter, FFP is available in expenditures for NF and ICF/IID services only if the facility has been certified as meeting the requirements for Medicaid participation, as evidenced by a provider agreement executed under this part. An agreement is not valid evidence that a facility has met those requirements if CMS determines that—

(1) The survey agency failed to apply the applicable requirements under subpart B of part 483 of this chapter for NFs or subpart I of part 483 of this chapter, which set forth the conditions of participation for ICFs/IID.

(2) The survey agency failed to follow the rules and procedures for certification set forth in subpart C of this part, subpart E of part 488, and § 431.610 of this subchapter;

(3) The survey agency failed to perform any of the functions specified in § 431.610(g) of this subchapter relating to evaluating and acting on information about the facility and inspecting the facility;

(4) The agency failed to use the Federal standards, and the forms, methods and procedures prescribed by CMS as required under § 431.610(f)(1) or § 488.318(b) of this chapter, for determining the qualifications of providers; or

(5) The survey agency failed to adhere to the following principles in determining compliance:

(i) The survey process is the means to assess compliance with Federal health, safety and quality standards;

(ii) The survey process uses resident outcomes as the primary means to establish the compliance status of facilities. Specifically, surveyors will directly observe the actual provision of care and services to residents, and the effects of that care, to assess whether the care provided meets the needs of individual residents;

(iii) Surveyors are professionals who use their judgment, in concert with Federal forms and procedures, to determine compliance;

(iv) Federal procedures are used by all surveyors to ensure uniform and consistent application and interpretation of Federal requirements;

(v) Federal forms are used by all surveyors to ensure proper recording of findings and to document the basis for the findings.

(6) The survey agency failed to assess in a systematic manner a facility's actual provision of care and services to residents and effects of that care on residents.

(7) Required elements of the NF survey process fails to include all of the following:

(i) An entrance conference;

(ii) A resident-centered tour of facility;

(iii) An in-depth review of a sample of residents including observation, interview and record review;

(iv) Observation of the preparation and administration of drugs for a sample of residents;

(v) Evaluation of a facility's meals, dining areas and eating assistance procedures;

(vi) Formulation of a deficiency statement based on the incorporation of all appropriate findings onto the survey report form;

(vii) An exit conference; and

(viii) Follow-up surveys as appropriate.

(8) The agreement's terms and conditions do not meet the requirements of this subpart.

(b) The Administrator will make the determination under paragraph (a) of this section through onsite surveys, other Federal reviews, State certification records, or reports he may re-

quire from the Medicaid or survey agency.

(c) If the Administrator disallows a State's claim for FFP because of a determination under paragraph (a) of this section, the State is entitled upon request to reconsideration of the disallowance under 45 CFR part 16.

[43 FR 45233, Sept. 29, 1978, as amended at 51 FR 21558, June 13, 1986; 53 FR 20495, June 3, 1988; 53 FR 23101, June 17, 1988; 56 FR 48865, Sept. 26, 1991; 59 FR 56235, Nov. 10, 1994]

§ 442.40 Availability of FFP during appeals for ICFs/IID.

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

Effective date of expiration means the date of expiration originally specified in the provider agreement, or the later date specified if the agreement is extended under § 442.16; and

Effective date of termination means a date earlier than the expiration date, set by the Medicaid agency when continuing participation until the expiration date is not justified, because the facility no longer meets the requirements for participation.

(b) *Scope, applicability, and effective date*—(1) *Scope.* This section sets forth the extent of FFP in State Medicaid payments to an ICF/IID after its provider agreement has been terminated or has expired and not been renewed.

(2) *Applicability.* (i) This section and § 442.42 apply only when the Medicaid agency, of its own volition, terminates or does not renew a provider agreement, and only when the survey agency certifies that there is no jeopardy to beneficiary health and safety. When the survey agency certifies that there is jeopardy to beneficiary health and safety, or when it fails to certify that there is no jeopardy, FFP ends on the effective date of termination or expiration.

(ii) When the State acts under instructions from CMS, FFP ends on the date specified by CMS (CMS instructs the State to terminate the Medicaid provider agreement when CMS in validating a State survey agency certification, determines that an ICF/IID does not meet the requirements for participation.)

§ 442.42

42 CFR Ch. IV (10–1–25 Edition)

(3) *Effective date.* This section and § 442.42 apply to terminations or expirations that are effective on or after September 28, 1987. For terminations or nonrenewals that were effective before that date, FFP may continue for up to 120 days from September 28, 1987, or 12 months from the effective date of termination or nonrenewal, whichever is earlier.

(c) *Basic rules.* (1) Except as provided in paragraphs (d) and (e) of this section, FFP in payments to an ICF/IID ends on the effective date of termination of the facility's provider agreement, or if the agreement is not terminated, on the effective date of expiration.

(2) If State law, or a Federal or State court order or injunction, requires the agency to extend the provider agreement or continue payments to a facility after the dates specified in paragraph (d) of this section, FFP is not available in those payments.

(d) *Exception: Continuation of FFP after termination or expiration of provider agreement—*(1) *Conditions for continuation.* FFP is available after the effective date of termination or expiration only if—

(i) The evidentiary hearing required under § 431.153 of this chapter is provided by the State agency after the effective date of termination or expiration (or, if begun before termination or expiration, is not completed until after that date); and

(ii) Termination or nonrenewal action is based on a survey agency certification that there is no jeopardy to beneficiaries' health and safety.

(2) *Extent of continuation.* FFP is available only through the earlier of the following:

(i) The date of issuance of an administrative hearing decision that upholds the agency's termination or nonrenewal action.

(ii) The 120th day after the effective date of termination of the facility's provider agreement or, if the agreement is not terminated, the 120th day after the effective date of expiration. (If a hearing decision that upholds the facility is issued after the end of the 120-day period, when FFP has already been discontinued, the rules of § 442.42 on retroactive agreements apply).

(e) *Applicability of § 441.11.* If FFP is continued during appeal under paragraph (d) of this section, the 30-day period provided by § 441.11 of this chapter would not begin to run until issuance of a hearing decision that upholds the agency's termination or nonrenewal action.

[52 FR 32551, Aug. 28, 1987, as amended at 56 FR 48865, Sept. 26, 1991; 59 FR 56236, Nov. 10, 1994]

§ 442.42 FFP under a retroactive provider agreement following appeal.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, if an NF or ICF/IID prevails on appeal from termination or, in the case of an ICF/IID, nonrenewal of a provider agreement, and the State issues a retroactive agreement, FFP is available beginning with the retroactive effective date, which must be determined in accordance with § 442.13.

(b) *Exception.* This rule does not apply if CMS determines, under § 442.30, that the agreement is not valid evidence that the facility meets the requirements for participation. This exclusion applies even if the State issues the new agreement as the result of an administrative hearing decision favorable to the facility or under a Federal or State court order.

[52 FR 32551, Aug. 28, 1987, as amended at 59 FR 56236, Nov. 10, 1994]

§ 442.43 Payment transparency reporting.

(a) *Definitions.* (1) *Compensation* means, with respect to direct care workers and support staff delivering services authorized under this part:

(i) Salary, wages, and other remuneration as defined by the Fair Labor Standards Act and implementing regulations (29 U.S.C. 201 *et seq.*, 29 CFR parts 531 and 778);

(ii) Benefits (such as health and dental benefits, life and disability insurance, paid leave, retirement, and tuition reimbursement); and

(iii) The employer share of payroll taxes.

(2) *Direct care worker* means one of the following individuals who provides services to Medicaid-eligible individuals receiving services under this part, who may be employed by or contracted

or subcontracted with a Medicaid provider or State or local government agency:

- (i) A registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist;
- (ii) A certified nurse aide who provides services under the supervision of a registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist;
- (iii) A licensed physical therapist, occupational therapist, speech-language pathologist, or respiratory therapist;
- (iv) A certified physical therapy assistant, occupational therapy assistant, speech-language therapy assistant, or respiratory therapy assistant or technician;
- (v) A social worker;
- (vi) A direct support professional;
- (vii) A personal care aide;
- (viii) A medication assistant, aide, or technician;
- (ix) A feeding assistant;
- (x) Activities staff; or
- (xi) Any other individual who is paid to provide clinical services, behavioral supports, active treatment (as defined at § 483.440 of this chapter) or address activities of daily living (such as those described in § 483.24(b) of this chapter) for Medicaid-eligible individuals receiving Medicaid services under this part, including nurses and other staff providing clinical supervision.

(3) *Support staff* means an individual who is not a direct care worker and who maintains the physical environment of the care facility or supports other services for residents. Support staff may be employed by or contracted or subcontracted with a Medicaid provider or State or local government agency. They include any of the following individuals:

- (i) A housekeeper;
- (ii) A janitor or environmental services worker;
- (iii) A groundskeeper;
- (iv) A food service or dietary worker;
- (v) A driver responsible for transporting residents;
- (vi) A security guard; or
- (vii) Any other individual who is not a direct care worker and who maintains the physical environment of the care facility or supports other services for Medicaid-eligible individuals re-

ceiving Medicaid services under this part.

(4) *Excluded costs* means costs reasonably associated with delivering Medicaid-covered nursing facility or ICF/IID services that are not included in the calculation of the percentage of Medicaid payments to providers that is spent on compensation for direct care workers and support staff. Such costs are limited to:

- (i) Costs of required trainings for direct care workers and support staff (such as costs for qualified trainers and training materials);
- (ii) Travel costs for direct care workers and support staff (such as mileage reimbursement or public transportation subsidies); and
- (iii) Costs of personal protective equipment for facility staff.

(b) *Reporting requirements.* The State must report to CMS annually, by facility, the percentage of Medicaid payments (not including excluded costs) for services specified in paragraph (b)(1) of this section, that is spent on compensation for direct care workers and on compensation for support staff, at the time and in the form and manner specified by CMS. For the purposes of this part, Medicaid payment for fee-for-service (FFS) includes base and supplemental payments as defined in section 1903(bb)(2) of the Social Security Act, and for payments from a managed care organization (MCO) or prepaid inpatient health plan (PIHP) (as these entities are defined in § 438.2 of this chapter) includes the MCO's or PIHP's contractually negotiated rate, State directed payments as defined in § 438.2 of this chapter, pass-through payments as defined in § 438.6(a) of this chapter for nursing facilities, and any other payments from the MCO or PIHP.

(1) *Services.* Except as provided in paragraphs (b)(2) and (3) of this section, reporting must be based on all Medicaid payments (including but not limited to FFS base and supplemental payments, and payments from an MCO or PIHP, as applicable) made to nursing facility and ICF/IID providers for Medicaid-covered services, with the exception of services provided in swing bed hospitals as defined in § 440.40(a)(1)(ii)(B) of this chapter.

§ 442.100

(2) *Exclusion of specified payments.* The State must exclude from its reporting to CMS payments claimed by the State for Federal financial participation under this part for which Medicaid is not the primary payer.

(3) *Exclusion of data from the Indian Health Service and Tribal health programs.* States must exclude data from the Indian Health Service and Tribal health programs subject to the requirements at 25 U.S.C. 1641 from the reporting required in paragraph (b) of this section.

(c) *Report contents and methodology—*
(1) *Contents.* Reporting must provide information necessary to identify, at the facility level, the percent of Medicaid payments spent on compensation to:

(i) Direct care workers at each nursing facility;

(ii) Support staff at each nursing facility;

(iii) Direct care workers at each ICF/IID; and

(iv) Support staff at each ICF/IID.

(2) *Methodology.* The State must provide information according to the methodology, form, and manner of reporting stipulated by CMS.

(d) *Availability and accessibility requirements.* The State must operate a website consistent with § 435.905(b) of this chapter that provides the results of the reporting requirements specified in paragraphs (b) and (c) of this section. In the case of a State that implements a managed care delivery system under the authority of sections 1915(a), 1915(b), 1932(a), and/or 1115(a) of the Act and that includes nursing facility and/or ICF/IID services in their MCO or PIHP contracts, the State may meet this requirement by linking to individual MCO's or PIHP's websites. The State must:

(1) Include clear and easy to understand labels on documents and links;

(2) Verify no less than quarterly, the accurate function of the website and the current accuracy of the information and links; and

(3) Include prominent language on the website explaining that assistance in accessing the required information on the website is available at no cost and include information on the availability of oral interpretation in all languages and written translation avail-

42 CFR Ch. IV (10–1–25 Edition)

able in each non-English language, how to request auxiliary aids and services, and a toll-free and TTY/TDY telephone number.

(e) *Information reported by States.* CMS must report on its website the results of the reporting requirements specified in paragraphs (b) and (c) of this section that the State reports to CMS.

(f) *Applicability date.* States must comply with the requirements in this section beginning 4 years after June 21, 2024; and in the case of the State that implements a managed care delivery system under the authority of section 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and includes nursing facility services or ICF/IID services, the first rating period for contracts with the MCO or PIHP beginning on or after 4 years after June 21, 2024.

[89 FR 40995, May 9, 2024]

Subpart C—Certification of ICFs/ IID

§ 442.100 State plan requirements.

A State plan must provide that the requirements of this subpart and part 483 are met.

[53 FR 20495, June 3, 1988]

§ 442.101 Obtaining certification.

(a) This section states the requirements for obtaining notice of an ICF/IID's certification before a Medicaid agency executes a provider agreement under § 442.12.

(b) The agency must obtain notice of certification from the Secretary for an ICF/IID located on an Indian reservation.

(c) The agency must obtain notice of certification from the survey agency for all other ICFs/IID.

(d) The notice must indicate that one of the following provisions pertains to the ICF/IID:

(1) An ICF/IID meets the conditions of participation set forth in subpart I of part 483 of this chapter.

(2) The ICF/IID has been granted a waiver or variance by CMS or the survey agency under subpart I of part 483 of this chapter.

(3) An ICF/IID has been certified with standard-level deficiencies and

(i) All conditions of participation are found met; and

(ii) The facility submits an acceptable plan of correction covering the remaining deficiencies.

(e) The failure to meet one or more of the applicable conditions of participation is cause for termination or non-renewal of the ICF/IID provider agreement.

[56 FR 48866, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992; 59 FR 56236, Nov. 10, 1994; 79 FR 27153, May 12, 2014]

§ 442.105 [Reserved]

§ 442.109 Certification period for ICF/IIDs: General provisions.

(a) A survey agency may certify a facility that fully meets applicable requirements. The State Survey Agency must conduct a survey of each ICF/IID not later than 15 months after the last day of the previous survey.

(b) The statewide average interval between surveys must be 12 months or less, computed in accordance with paragraph (c) of this section.

(c) The statewide average interval is computed at the end of each Federal fiscal year by comparing the last day of the most recent survey for each participating facility to the last day of each facility's previous survey.

[77 FR 29031, May 16, 2012]

§ 442.110 Certification period for ICF/IID with standard-level deficiencies.

Facilities with standard-level deficiencies may be certified under § 442.101 with a condition that the certification will continue if either of the following applies:

(a) The survey agency finds that all deficiencies have been satisfactorily corrected.

(b) The survey agency finds that the facility has made substantial progress in correcting the deficiencies and has a new plan of correction that is acceptable.

[79 FR 27153, May 12, 2014]

§ 442.117 Termination of certification for ICFs/IID whose deficiencies pose immediate jeopardy.

(a) A survey agency must terminate a facility's certification if it determines that—

(1) The facility no longer meets conditions of participation for ICFs/IID as specified in subpart I of part 483 of this chapter.

(2) The facility's deficiencies pose immediate jeopardy to residents' health and safety.

(b) Subsequent to a certification of a facility's noncompliance, the Medicaid agency must, in terminating the provider agreement, follow the appeals process specified in part 431, subpart D of this chapter.

[51 FR 24491, July 3, 1986, as amended at 59 FR 56236, Nov. 10, 1994]

§ 442.118 Denial of payments for new admissions to an ICF/IID.

(a) *Basis for denial of payments.* The Medicaid agency may deny payment for new admissions to an ICF/IID that no longer meets the applicable conditions of participation specified under subpart I of part 483 of this chapter.

(b) *Agency procedures.* Before denying payments for new admissions, the Medicaid agency must comply with the following requirements:

(1) Provide the facility up to 60 days to correct the cited deficiencies and comply with conditions of participation for ICFs/IID.

(2) If at the end of the specified period the facility has not achieved compliance, give the facility notice of intent to deny payment for new admissions, and opportunity for an informal hearing.

(3) If the facility requests a hearing, provide an informal hearing that includes—

(i) The opportunity for the facility to present, before a State Medicaid official who was not involved in making the initial determination, evidence or documentation, in writing or in person, to refute the decision that the facility is out of compliance with the conditions of participation for ICFs/IID.

(ii) A written decision setting forth the factual and legal bases pertinent to a resolution of the dispute.

§ 442.119

(4) If the decision of the informal hearing is to deny payments for new admissions, provide the facility and the public, at least 15 days before the effective date of the sanction, with a notice that includes the effective date and the reasons for the denial of payments.

[51 FR 24491, July 3, 1986, as amended at 59 FR 56236, Nov. 10, 1994]

§ 442.119 Duration of denial of payments and subsequent termination of an ICF/IID.

(a) *Period of denial.* The denial of payments for new admissions will continue for 11 months after the month it was imposed unless, before the end of that period, the Medicaid agency finds that—

(1) The facility has corrected the deficiencies or is making a good faith effort to achieve compliance with the conditions of participation for ICFs/IID; or

(2) The deficiencies are such that it is necessary to terminate the facility's provider agreement.

(b) *Subsequent termination.* The Medicaid agency must terminate a facility's provider agreement—

(1) Upon the agency's finding that the facility has been unable to achieve compliance with the conditions of participation for ICFs/IID during the period that payments for new admissions have been denied;

(2) Effective the day following the last day of the denial of payments period; and

(3) In accordance with the procedures for appeal of terminations set forth in subpart D of part 431 of this chapter.

[51 FR 24491, July 3, 1986, as amended at 59 FR 56236, Nov. 10, 1994]

Subparts D–F [Reserved]

PART 447—PAYMENTS FOR SERVICES

Subpart A—Payments: General Provisions

Sec.

447.1 Purpose.

447.10 Prohibition against reassignment of provider claims.

447.15 Acceptance of State payment as payment in full.

42 CFR Ch. IV (10–1–25 Edition)

447.20 Provider restrictions: State plan requirements.

447.21 Reduction of payments to providers.

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

447.26 Prohibition on payment for provider-preventable conditions.

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

447.31 Withholding Medicare payments to recover Medicaid overpayments.

447.40 Payments for reserving beds in institutions.

447.45 Timely claims payment.

447.46 Timely claims payment by MCOs.

MEDICAID PREMIUMS AND COST SHARING

447.50 Premiums and cost sharing: Basis and purpose.

447.51 Definitions.

447.52 Cost sharing.

447.53 Cost sharing for drugs.

447.54 Cost sharing for services furnished in a hospital emergency department.

447.55 Premiums.

447.56 Limitations on premiums and cost sharing.

447.57 Beneficiary and public notice requirements.

447.88 Options for claiming FFP payment for section 1920A presumptive eligibility medical assistance payments.

447.90 FFP: Conditions related to pending investigations of credible allegations of fraud against the Medicaid program.

Subpart B—Payment Methods: General Provisions

447.200 Basis and purpose.

447.201 State plan requirements.

447.202 Audits.

447.203 Documentation of access to care and service payment rates.

447.204 Medicaid provider participation and public process to inform access to care.

447.205 Public notice of changes in State-wide methods and standards for setting payment rates.

Subpart C—Payment For Inpatient Hospital and Long-Term Care Facility Services

447.250 Basis and purpose.

PAYMENT RATES

447.251 Definitions.

447.252 State plan requirements.

447.253 Other requirements.

447.255 Related information.

447.256 Procedures for CMS action on assurances and State plan amendments.