

(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) Except as provided in paragraph (b) of this section, 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) The agency may pay a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider's charges were equal to or greater than its costs.

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

(1) State government-owned or operated facilities (that is, all facilities that are either owned or operated by the State).

(2) Non-State government-owned or operated facilities (that is, all government facilities that are neither owned nor operated by the State).

(3) Privately-owned and operated facilities.

(b) *General rules.* (1) 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) Except as provided in paragraph (c) of this section, aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) of this section may not exceed the upper payment limit described in paragraph (b)(1) of this section.

(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 (Public Law 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.

(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)(1) of this section by one of the following dates:

(1) *For non-State government-owned or operated hospitals*—March 19, 2002.

(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.

(6) For the portion of State FY 2009 before October 1, 2008: State FY 2009 UPL + .10X.

(7) Beginning October 1, 2008: UPL described in paragraph (b) of this section.

(D) For State 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.

(iii) When State FY 2003 begins after September 30, 2002, the reduction schedule in paragraphs (e)(2)(ii)(C)(1) through (e)(2)(ii)(C)(7) will begin on State FY 2003.

(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)(1) 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.

[66 FR 3175, Jan. 12, 2001, as amended at 66 FR 46399, Sept. 5, 2001; 67 FR 2610, Jan. 18, 2002]

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.

§ 447.296 Limitations on aggregate payments for disproportionate share hospitals for the period January 1, 1992 through September 30, 1992.

(a) The provisions of this section apply to the 50 States and the District of Columbia, but not to any State whose entire Medicaid program is oper-

ated under a waiver granted under section 1115 of the Act.

(b) For the period January 1, 1992 through September 30, 1992, FFP is available for aggregate payments to hospitals that serve a disproportionate number of low-income patients with special needs only if the payments are made in accordance with sections 1902(a)(13)(A) and 1923 of the Act, and with one of the following:

(1) An approved State plan in effect as of September 30, 1991.

(2) A State plan amendment submitted to CMS by September 30, 1991.

(3) A State plan amendment, or modification thereof, submitted to CMS between October 1, 1991 and November 26, 1991, if the amendment, or modification thereof, was intended to limit the State's definition of disproportionate share hospitals to those hospitals with Medicaid inpatient utilization rates or low-income utilization rates (as defined in section 1923 (b) of the Act) at or above the statewide arithmetic mean.

(4) A methodology for disproportionate share hospital payments that was established and in effect as of September 30, 1991, or in accordance with a State law enacted or State regulation adopted as of September 30, 1991.

(5) A State plan amendment submitted to CMS by September 30, 1992 that increases aggregate disproportionate share hospitals payments in order to meet the minimum payment adjustments required by section 1923(c)(1) of the Act. The minimum payment adjustment is the amount required by the Medicare methodology described in section 1923(c)(1) of the Act for those hospitals that satisfy the minimum Federal definition of a disproportionate share hospital in section 1923(b) of the Act.

(6) A State plan amendment submitted to CMS by September 30, 1992 that provides for a redistribution of disproportionate share hospital payments within the State without raising total payments compared to the previously approved State plan. CMS will approve the amendment only if the State submits written documentation that demonstrates to CMS that the aggregate payments that will be made after the redistribution are no greater