(b) The agency must record, in State manuals or other official files, the following information for increases in payment rates for individual practitioner services:

(1) An estimate of the percentile of the range of customary charges to which the revised payment structure equates and a description of the methods used to make the estimate.

(2) An estimate of the composite average percentage increase of the revised payment rates over the preceding rates.

§ 447.204 Encouragement of provider participation.

The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

§ 447.205 Public notice of changes in Statewide methods and standards for setting payment rates.

(a) *When notice is required.* Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.

(b) *When notice is not required.* Notice is not required if—

(1) The change is being made to conform to Medicare methods or levels of reimbursement;

(2) The change is required by court order; or

(3) The change is based on changes in wholesalers' or manufacturers' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.

(c) *Content of notice.* The notice must—

(1) Describe the proposed change in methods and standards;

(2) Give an estimate of any expected increase or decrease in annual aggregate expenditures;

(3) Explain why the agency is changing its methods and standards;

(4) Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review;

(5) Give an address where written comments may be sent and reviewed by the public; and

(6) If there are public hearings, give the location, date and time for hearings or tell how this information may be obtained.

(d) *Publication of notice.* The notice must—

(1) Be published before the proposed effective date of the change; and

(2) Appear as a public announcement in one of the following publications:

(i) A State register similar to the FEDERAL REGISTER.

(ii) The newspaper of widest circulation in each city with a population of 50,000 or more.

(iii) The newspaper of widest circulation in the State, if there is no city with a population of 50,000 or more.

[46 FR 58680, Dec. 3, 1981; 47 FR 8567, Mar. 1, 1982, as amended at 48 FR 56057, Dec. 19, 1983]

§ 447.206 Cost limit for providers operated by units of government.

(a) *Scope.* This section applies to payments made to health care providers that are operated by units of government as defined in § 433.50(a)(1) of this chapter.

(b) *Exceptions.* The limitation in paragraph (c) of this section does not apply to:

(1) Indian Health Services facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (Pub. L. 93–638);

(2) Managed Care Organizations (MCOs), Prepaid Inpatient

Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) which are organized and operating in accordance with the provisions of 42 CFR 438;

(3) Federally Qualified Health Centers (FQHCs) and Rural

Health Clinics (RHCs) reimbursed in accordance with Section 1902(bb) of the Act; and

(4) *Disproportionate share hospital payments.* The limitation in paragraph (c) 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.

(a) *General rules.* (1) All health care providers that are operated by units of government are limited to reimbursement not in excess of the individual health care provider's cost of providing covered Medicaid services to eligible Medicaid recipients.

(2) Reasonable methods of identifying and allocating costs to Medicaid will be determined by the Secretary in accordance with sections 1902, 1903, and 1905 of the Act, as well as 45 CFR 92.22 and Medicare cost principles when applicable.

(3) Institutional governmentally-operated health care providers (i.e., hospitals, nursing facilities, and ICFs/MR) are required to provide the State with data extracted from primary source documents as well as copies of the source documents. These source documents would include the health care provider's Medicare cost report (or Medicaid cost report for intermediate nursing facility care and ICFs/MR consistent with Medicare cost reporting principles, and audited financial statements that will be used in conjunction with information provided by the States' Medicaid Management Information System (MMIS).

(4) Medicaid costs for non-institutional governmentally-operated health care providers must be supported by auditable documentation in a form approved by the Secretary that is consistent with §433.51(b)(1) through (b)(4) of this chapter.

(d) *Use of certified public expenditures.* This paragraph applies when States use a cost reimbursement methodology funded by certified public expenditures.

(1) In accordance with paragraph (c) of this section, each provider must submit annually a cost report to the Medicaid agency that reflects the individual provider's cost of serving Medicaid recipients during the year.

(2) States may utilize most recently filed cost reports to develop interim rates and may trend those interim rates by an applicable health care-related index. Interim reconciliations must be performed by reconciling the interim Medicaid payment rates to the filed cost report for the spending year in which interim payment rates were made.

(3) Final reconciliation must be performed annually by reconciling any interim payments to the finalized cost report for the spending year in which any interim payment rates were made.

(4) Non-institutional governmentally-operated health care providers must utilize a cost report, approved by the Secretary, beginning in their Medicaid State plan rate year 2009. Interim rates set by States for purposes of Medicaid payments funded by certified public expenditures in Medicaid State plan rate year 2009 must be calculated based on cost data from at least one quarter of their Medicaid State plan rate year 2008 documented in accordance with the cost report approved by the Secretary. Existing certified public expenditure methodologies can be used to make Medicaid payments during Medicaid State plan rate year 2008.

(e) *Payments not funded by certified public expenditures.* This paragraph applies to payments made to providers operated by units of government that are not funded by certified public expenditures. In accordance with paragraph (c) of this section, each provider must submit annually a cost report to the Medicaid agency that reflects the individual provider's cost of serving Medicaid recipients during the year. The Medicaid agency must review the cost report to determine that costs on the report were properly allocated to Medicaid and verify that Medicaid payments to the provider during the year did not exceed the provider's cost.

(f) *Overpayments.* If, under paragraph (d) or (e) of this section, it is determined that a governmentally-operated health care provider received an overpayment, amounts related to the overpayment will be properly credited to

the Federal government, in accordance with part 433, subpart F of this chapter.

(g) *Compliance dates.* Initial compliance dates have been separately established for institutional and non-institutional Medicaid providers operated by units of government. Following initial compliance dates, ongoing compliance will be consistent for all providers operated by units of government. A State must comply with the Medicaid cost limit described in paragraph (c) of this section in accordance with the timeframes and requirements in paragraphs (g)(1) through (g)(3) of this section.

(1) *Initial Compliance for Institutional Govermentally-Operated Health Care Providers.* For each State, compliance with the Medicaid cost limit described in paragraph (c) of this section applicable to institutional governmentally-operated health care providers begins with the Medicaid State plan rate year 2008. A State's review of Medicaid payments made to institutional governmentally-operated health care providers to ensure compliance with the Medicaid cost limit during Medicaid State plan rate year 2008 must be completed no later than the last day of federal fiscal year 2010 (September 30, 2010). The State must submit to CMS a summary report of the findings of this review by the last day of calendar year of 2010 (December 31, 2010). For any cost reports that are not finalized, the State should use the ''as filed'' cost report and indicate such in the summary report to CMS. The State should then submit a corrected summary report to CMS within 30 days of the finalization of the cost report.

(2) *Initial Compliance for Non-Institutional Governmentally-Operated Health Care Providers.* For each State, compliance with the cost limit described in paragraph (c) of this section applicable to non-institutional governmentally-operated health care providers begins with the Medicaid State plan rate year 2009. A State's review of Medicaid payments made to non-institutional governmentally-operated health care providers to ensure compliance with the Medicaid cost limit during Medicaid State plan rate year 2009 must be completed no later than the last day of federal fiscal year 2011 (September 30, 2011). The State must submit to CMS a summary report of the findings of this review by the last day of calendar year of 2011 (December 31, 2011).

(3) *Ongoing Compliance for Institutional and Non-Institutional Governmentally-Operated Health Care Providers.* Each subsequent State review of Medicaid payments made to governmentally-operated health care providers, after the Medicaid State plan rate years identified in paragraphs (g)(1) and (g)(2) of this section, must be performed annually and completed by the last day of the federal fiscal year ending two years from the Medicaid State plan rate year under review. Each State must submit a summary report to CMS demonstrating the results of the State's review of Medicaid payments to ensure compliance with the Medicaid cost limit applicable to governmentally-operated health care providers by the last day of the calendar year ending two years from the Medicaid State Plan rate year under review.

(i) For any cost reports that are not finalized at the time the State performs the review of Medicaid payments to institutional governmentally-operated health care providers, the State should use the ''as filed'' cost report and indicate such in the summary report to CMS. The State should then submit a corrected summary report to CMS within 30 days of the finalization of the cost report.

[72 FR 29833, May 29, 2007]

§ 447.207 Retention of payments.

(a) Payment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved State plan (or the approved provisions of a waiver or demonstration if applicable). The Secretary will determine compliance with this provision by examining any associated transactions that are related to the provider's total computable payment to ensure that the State's claimed expenditure, which serves as the basis for Federal Financial Participation, is equal to the State's net expenditure, and that the full amount of the non-Federal share of the payment has been satisfied.