

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 447

[HCFA-2071-F]

RIN 0938-AK12

Medicaid Program; Revision to Medicaid Upper Payment Limit Requirements for Hospital Services, Nursing Facility Services, Intermediate Care Facility Services for the Mentally Retarded, and Clinic Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule modifies the Medicaid upper payment limits for inpatient hospital services, outpatient hospital services, nursing facility services, intermediate care facility services for the mentally retarded, and clinic services. For each type of Medicaid inpatient service, existing regulations place an upper limit on overall aggregate payments to all facilities and a separate aggregate upper limit on payments made to State-operated facilities. This final rule establishes an aggregate upper limit that applies to payments made to government facilities that are not State government-owned or operated, and a separate aggregate upper limit on payments made to privately-owned and operated facilities. This rule also eliminates the overall aggregate upper limit that had applied to these services.

With respect to outpatient hospital and clinic services, this final rule establishes an aggregate upper limit on payments made to State government-owned or operated facilities, an aggregate upper limit on payments made to government facilities that are not State government-owned or operated, and an aggregate upper limit on payments made to privately-owned and operated facilities.

These separate upper limits are necessary to ensure State Medicaid payment systems promote economy and efficiency. We are allowing a higher upper limit for payment to non-State public hospitals to recognize the higher costs of inpatient and outpatient services in public hospitals. In addition, to ensure continued beneficiary access to care and the ability of States to adjust to the changes in the upper payment limits, the final rule includes a transition period for States with approved rate enhancement State plan amendments.

EFFECTIVE DATE: The provisions of this final rule are effective March 13, 2001.

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SUPPLEMENTARY INFORMATION:

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I. Statutory and Regulatory Framework

Title XIX of the Social Security Act (the Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to low-income families, elderly individuals, and persons with disabilities. Each State Medicaid program is administered by the State in accordance with an approved State plan. While the State has considerable flexibility in designing its State plan and operating its Medicaid program, it must comply with Federal

requirements specified in the Medicaid statute, regulations, and program guidance. Additionally, the plan must be approved by the Secretary, who has delegated this authority to HCFA.

Section 1903(a)(1)(A) of the Act provides for payments to States, through Federal financial participation (FFP), in expenditures for services covered under an approved State plan. Section 1902(a)(30)(A) of the Act requires a State plan to meet certain requirements in setting payment amounts for covered Medicaid care and services. One of these requirements is that payment for care and services under an approved State Medicaid plan be consistent with efficiency, economy, and quality of care. This provision provides authority for specific upper payment limits set forth in Federal regulations in 42 CFR part 447 relating to different types of Medicaid covered services. With respect to inpatient hospital services, nursing facility (NF) services, and intermediate care facility services for the mentally retarded (ICF/MR), upper payment limits are set forth in regulations at § 447.272, "Application of upper payment limits." This provision limits overall aggregate State payments and aggregate payments to State-operated providers. With respect to outpatient hospital services and clinic services, similar upper payment limits on aggregate State payments are set forth in regulations at § 447.321, "Outpatient hospital services and clinic services: Upper limits of payments."

Existing regulations stipulate that aggregate State payments for each type of services, that is, inpatient hospital and outpatient hospital services, NF services, ICF/MR services, and clinic services may not exceed a reasonable estimate of the amount the State would have paid under Medicare payment principles. Under §§ 447.257, "FFP: Conditions relating to institutional reimbursement," and 447.304, "Adherence to upper limits; FFP, paragraph (c)," FFP is not available for State expenditures that exceed the applicable upper payment limit.

The statute also permits States some flexibility to use local government funds for the non-Federal share of Medicaid expenditures. Under section 1902(a)(2) of the Act, States may fund up to 60 percent of the non-Federal share of Medicaid expenditures with local government funds. Section 1903(w)(6) of the Act specifically limits the Secretary's ability to place restrictions on a State's use of certain funds transferred to it from a local unit of government subject to the requirements in section 1902(a)(2) of the Act.

Before 1981, under section 1902(a)(13) of the Act, States were required to pay rates for hospital and long-term care services that were directly related to cost reimbursement. To obtain approval from HCFA, many States set rates using Medicare reasonable cost payment principles.

In 1980 and 1981, the Congress enacted legislation (section 962 of the Omnibus Reconciliation Act of 1980 (ORA 1980), Public Law 96-499, and section 2173 of the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981), Public Law 97-35, collectively known as the "Boren Amendment") that amended section 1902(a)(13) of the Act to give States flexibility to deviate from Medicare's reasonable cost payment principles in setting payment rates for hospital and long-term care services.

The Boren Amendment was primarily considered a floor on State spending because it required States to set rates that would meet the costs incurred by efficiently and economically operated facilities. However, the Boren Amendment also supported upper payment limits on overall rates. In legislative history, the Congress directed the Secretary to maintain ceiling requirements that limited State payments in the aggregate from exceeding Medicare payment levels. The Senate Finance Committee stated that "the Secretary would be expected to continue to apply current regulations that require that payments made under State plans do not exceed amounts that would be determined under Medicare principles of reimbursement" (S. Rep. No. 471, 96th Cong., 1st sess. (1979).

In 1986, the Congress implicitly affirmed the use of upper limits on payments for inpatient hospital services, NF services, and intermediate care facility (ICF) (now ICF/MR) services. Section 9433 of the Omnibus Budget Reconciliation Act of 1986, Public Law 99-509, precluded the Secretary from placing limits on State payments to hospitals that serve a disproportionate number of low-income patients with special needs (disproportionate share hospital (DSH) payments) but maintained the application of limits on regular inpatient payment rates.

The existing regulations on upper limits were last changed in a final rule published in the **Federal Register** on July 28, 1987 (52 FR 28141) that addressed the application of the upper payment limit to States that had multiple payment rates for the same class of services. The July 28, 1987 final rule also addressed the differential rate issue in the context of State-operated facilities. Several audits had revealed that the circumstances of State-operated

facilities created incentives for States to overpay these facilities. A high volume of uninsured patients had increased the costs of providing services in State government-owned or operated facilities. These costs, in turn, were passed on to the State. To offset those higher costs, States established payment methodologies that paid State government-owned or operated facilities at a higher rate than privately operated facilities. Higher Medicaid payments to State government-owned or operated facilities allowed States to obtain additional Federal Medicaid dollars to cover costs formerly met entirely by State dollars. To ensure payments to State-operated facilities would be consistent with efficiency and economy, the July 28, 1987 final rule applied the Medicare upper limit test to State-operated facilities separate from other facilities. However, it did not create a separate upper payment limit for other government facilities, which allowed their payments to count toward the same aggregate upper payment limit as private facilities.

Section 4711 of the Balanced Budget Act of 1997 (BBA), Public Law 105-33, amended section 1902(a)(13) of the Act to increase State flexibility in rate setting by replacing the substantive requirements of the Boren amendment with a new public process. The new public process requires the State agency to have in place, and use, a public process that determines the rates of payment under the plan for inpatient services furnished by hospitals, nursing facilities, and intermediate care facilities for the mentally retarded. As part of the new public process requirements, States must publish proposed and final rates, the methodologies underlying the establishment of the rates, and the justifications for the rates. The public process must give providers, beneficiaries and their representatives, and other concerned State residents an opportunity to review and comment on the proposed rates, methodologies, and justifications, before they become final. In addition, in the case of hospitals, the rates must take into account (in a manner consistent with section 1923 of the Act) the situation of hospitals that serve a disproportionate number of low-income patients with special needs. Under section 4711 of Public Law 105-33, States have flexibility to target rate increases to particular types of facilities so long as the rates are established in accordance with the new public process requirements.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) amends titles XVIII,

XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid Programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes. Section 705 of BIPA imposes additional requirements upon Medicaid UPL.

The BIPA addressed publication of this final rule at Section 705, "Deadline for Issuance of Final Regulation Relating to Medicaid Upper Payment Limits." In section 705(a), it requires that we publish these final regulations not later than December 31, 2000. It further requires that, while this final rule must be based on the proposed rule announced October 5, 2000, that this final regulation shall be published "* * * notwithstanding any requirement in the Administrative Procedures Act (APA) under chapter 5 of title 5, United States Code, or any other provision of law"* * * Section 705(b) of the BIPA provides for a longer transition period for States that had an approved State plan provision or methodology in effect on October 1, 1992. Section 701 of BIPA also changes a State's DSH allotments and provides for an increase in DSH allotment for extremely low DSH States based on the publication date of this rule.

We further note that waiver of the APA did not require that we review all comments received on the proposed rule and respond to them in the final rule. Under section 705(b), we considered replacing the transition periods in the proposed rule with that provided in this section of the law. Instead, we have decided to add a third transition period for those States with approved State plans or methodologies in effect on or before October 1, 1992.

II. Basis for the Proposed Changes

It had become apparent that the existing regulations created a financial incentive for States to overpay non-State government-owned or operated facilities because, through this practice, States, counties, and cities were able to effectively lower net State or local expenditures for covered services and gain extra Federal matching payments. This practice is not consistent with the Medicaid statute and has contributed to rapidly growing Medicaid spending.

The incentive for, and ability of, States to pay excessive rates to non-State government-owned or operated Medicaid providers can be explained as follows. As stated previously, the existing aggregate upper payment limit is applied to both private and non-State

government-owned or operated facilities. By developing a payment methodology that set rates for proprietary and nonprofit facilities at lower levels, States were able to set rates for county or city facilities at substantially higher levels and still comply with the existing aggregate upper payment limit. The Federal government matched these higher payment rates to public facilities. Because these facilities are public entities, funds to cover the State share were transferred from those facilities (or the local government units that operate them) to the State, thus generating increased Federal funding with no net increase in State expenditures. This is not consistent with the statutory requirements that Medicaid payments be economical and efficient.

On July 26, 2000, the Director of the Center for Medicaid and State Operations sent a letter to all State Medicaid Directors notifying them of the Administration's concern that "Medicaid payments meet the statutory definition of efficiency and economy" and that we would be issuing a proposed rule to address this problem. Additionally, States were informed that the Office of the Inspector General (OIG) and the General Accounting Office (GAO) had begun to monitor States with State plans that permitted these types of payments. Both the GAO and OIG have testified before Congress on the scope of these financing practices, their impact on State and Federal spending, and on the resultant uses of increased Federal funds. Preliminary results of OIG's work to date are described below.

As of December 22, 2000, the OIG had completed six substantial reviews in five States. Although the specifics of the enhanced payment programs and associated financing mechanisms differed somewhat in each State reviewed, the OIG found that payment programs share some common characteristics. These similarities are included below.

- In general, enhanced payments to city and county government owned providers were not based on the actual cost of providing services to Medicaid beneficiaries, or directly related to increasing the quality of care provided by the public facilities that received the enhanced payments.

- Enhanced payments to public nursing facilities were not being retained by the facilities to provide services to Medicaid beneficiaries. Instead, the majority of the enhanced payment was returned by the providers to the States through intergovernmental transfers (IGT). The States then used the funds for other purposes, some of which

were unrelated to the Medicaid program.

- Unlike the nursing facilities, public hospital providers retained the majority of the Medicaid enhanced payments. However, the portion of the funds that hospitals returned to the States through IGTs resulted in millions of dollars available to the States for other uses.

- While the public hospital providers served a large number of Medicaid beneficiaries and uninsured patients, the hospitals either (1) did not receive Medicaid disproportionate share hospital (DSH) payments from the States, or (2) returned the majority of the Medicaid DSH payments to the States through IGTs. It appears, for these providers, that States used enhanced payments in the place of DSH payments, although Medicaid DSH payments are designed to help hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients.

Similarly, the GAO testified before the Congress that existing arrangements violate the basic integrity of Medicaid as a joint Federal/State program. GAO asserted that, by taking advantage of a technicality, States had used these financing schemes, in effect, to replace State Medicaid dollars with Federal Medicaid dollars.

III. Summary of the Provisions of the October 10, 2000 Proposed Rule

On October 10, 2000, we published a proposed rule in the **Federal Register** (65 FR 60151) that set forth proposed changes in the Medicaid upper payment limits for hospital services, NF services, ICF/MR services, and clinic services. A detailed description of the specific provisions of the proposed rule can be found beginning at 65 FR 60152. In the October 10, 2000 proposed rule, we proposed to establish:

- An aggregate upper payment limit for inpatient hospital, NF, and ICR/MR services furnished by other government-owned or operated facilities.

- An aggregate upper payment limit for outpatient hospital and clinic services provided by State government-owned or operated facilities and a separate aggregate upper payment limit for outpatient hospital and clinic services provided by all other government-owned or operated facilities.

- Two transition periods for States with approved rate enhancement State plan amendments to comply with the proposed payment limits. (The length of the transition period would depend on the effective date of the State's plan amendment, which is discussed in section III.C. of this preamble.)

IV. Analysis of and Responses to Public Comment

We received approximately 562 timely items of correspondence containing comments on the proposed rule from State Government officials, members of Congress, provider organizations, the Office of the Inspector General, county government officials, individual providers and private citizens. A discussion of the specific provisions of the proposed rule and summaries of the public comments received, and our responses to the comments are set forth below under the appropriate section heading:

Calculation of the UPL

Calculation/Technical Clarifications of UPL (§ 447.272(a) & (b), § 447.321(a) & (b))

We received many comments requesting clarification regarding the calculation of the proposed UPLs. In the proposed rule, we did not propose any changes to the methodology States may use to calculate the UPLs but proposed to redefine the groups of providers that would be subject to the UPLs.

Comment: One commenter noted that § 447.272(a) was introduced with the clause: "Except as provided in paragraphs (b)(2) and (c) of this section, * * *" The commenter added, however, that paragraph § 447.272(b), which included (b)(2), began with the language: "In addition to being subject to the requirements of paragraph (a) of this section, * * *" The commenter noted that these two clauses can be interpreted to be directly contradictory.

Response: In this final rule, we have eliminated the two clauses that were contradictory in our proposed rule. We revised paragraph (a) of §§ 447.272 and 447.321 to identify the different categories of facilities that furnish inpatient and outpatient services, respectively. Under the proposed rule, these categories included State government-owned or operated and other government-owned or operated. In this final rule, we renamed the "other government-owned or operated" category as "non-State government-owned or operated" and added a third category for privately-owned and operated facilities.

We revised paragraph (b) of sections §§ 447.272 and 447.321 to provide the general rule for aggregate payment that applies to each category of facilities described in paragraph (a).

Comment: One commenter recommended that we clarify our use of the terms "facilities" and "services" in §§ 447.272 and 447.321 to consistently use the phrase "services in a facility"

rather than the term "services" by itself. The commenter added that the word "those" should also be eliminated when it has no reference.

Response: We have revised §§ 447.272 and 447.321 to clarify the types of services furnished by each group of facilities that are included in the UPLs.

Comment: One commenter recommended that we provide clarification for the term "outpatient hospital" in § 447.321(a) because it is not commonly understood and suggested that we instead make a reference to hospital outpatient services.

Response: We removed the term "outpatient hospitals" from paragraphs (a) and (b) of § 447.321. In revised § 447.321(a), we use the phrase "outpatient services furnished by hospitals". In addition, at § 447.272(a), we use the language "inpatient services furnished by hospitals" rather than the term "inpatient hospitals".

Comment: One commenter recommended that in paragraph (b) of §§ 447.272 and 447.321 that HCFA find a more neutral word for "non-compliant" to describe State plan amendments.

Response: We have revised §§ 447.272 and 447.321 to eliminate the term "non-compliant."

Comment: One commenter suggested that we clarify in the regulation that, in determining the UPL, coinsurance and deductible payments paid or payable to hospitals by Medicare beneficiaries must be included in determining what would have been paid under Medicare. The commenter notes that § 447.321(b), which includes this concept, was eliminated without explanation.

Response: Under current UPL regulations at § 447.321, the coinsurance and deductible payments, which a Medicare beneficiary would be liable to pay, are included in the Medicare approved payment amount that can be used in UPL calculations. In this final rule, we will continue to allow States to use the Medicare approved payment amounts as a factor in their UPL computations.

Comment: One commenter recommended that States should be able to calculate the UPL based on date of service rather than date of payment or Federal claiming. The commenter stated that this is consistent with how hospital audits are performed. This eliminates other variances caused by billing patterns or timeliness of State payments.

Response: This final rule continues to permit States to compute the UPL based on date of service.

Comment: We received various comments seeking clarification of the criteria for hospitals to be considered a

public facility subject to the new proposed governmental UPL and transition rules. One commenter suggested that hospitals should be classified as public if they exhibit the same characteristics as safety-net hospitals. A commenter recommended that some hospitals should qualify as public even if they are not receiving local tax dollars. Some hospitals are located in counties that have formed a hospital district which permits the levying of special ad valorem taxes to support operation of the hospital.

Response: Within the context of this regulation, we consider a facility to be subject to the new governmental UPL if it can make an IGT payment to the State (either directly or indirectly through a governmental owner or operator, or other arrangement). We have created three aggregate groups based on whether the facility is privately-owned and operated, State government-owned or operated or non-State government-owned or operated. Facilities fall into the categories of non-State government-owned or operated and State government-owned or operated based upon their ability to make intergovernmental transfer payments back to the State and based upon the governance structure of the facility and who retains ultimate liability for the operations of the facility. However, all facilities that are prohibited from transferring funds back to the State will fall into the privately-owned and operated category.

Comment: Several commenters recommended that we continue the current UPL regulations. In addition, commenters suggested that we not establish a third aggregate UPL to apply to non-State government-owned or operated facilities. Another commenter stated that HCFA is already able to ensure economy and efficiency through the State plan approval process, so that no additional safeguards are necessary. A commenter pointed out that the current limits provide the public with assurances that States will not overspend the Medicaid budget.

Response: We disagree with the commenters. We do not believe that the current UPL regulations are sufficient to ensure that State Medicaid payments meet the statutory definition of efficiency and economy. Because the former UPL regulations permit States to pool provider payments, States could set rates to certain providers a multiple above the rate they would pay other providers for the same service. The OIG has completed substantial reviews of the financial mechanisms of five States with approved State plan amendments. As described in the preamble of the

proposed and final rule, some general findings showed that enhanced payments to providers were not based on the actual cost of providing services nor were they used to improve the quality of Medicaid services provided by the facilities receiving the enhanced payments. States used this mechanism to shift their share of Medicaid costs and inappropriately increase the Federal Government share. States were also able to recycle Federal funds received from these enhanced payments to generate additional Federal matching funds that may or may not have been used for Medicaid services for Medicaid eligible individuals. In addition, we believe the current UPL regulations are contributing to increases in Medicaid program costs that are out of proportion to the number of services provided and patients served. These findings demonstrate that additional safeguards are needed to ensure economy and efficiency of Medicaid payments.

Comment: One commenter stated that although the proposed rule on its face only adds a new aggregate limit, as it would be implemented, it would effectively modify the current aggregate limits by removing non-State governmental facilities from the calculations of the overall aggregate limit, and results in three different categories of calculation of the aggregate limits (private, State operated and other government operated).

Response: We agree that the practical effect of the proposed UPLs would be to create three classes of providers. In considering this consequence, in this final rule, we have restructured the proposed regulations at §§ 447.272 and 447.321 to separate the providers into three distinct groups that are based on facility ownership and operation. States may aggregate payments up to the UPL that is applicable to each group. Specifically, in paragraph (b) of §§ 447.272 and 447.321, we have eliminated the aggregate group for all providers by facility type and created three separate aggregate groups, which include State government-owned or operated, non-State government-owned or operated, and privately-owned and operated facilities.

Comment: One commenter recommended that we provide clarification on whether the 150 percent aggregate limit for non-State-owned or operated public hospitals is an exception to, and not included in, an aggregate limit for all hospitals of 100 percent of the Medicare payment principles.

Response: In proposed §§ 447.272(b) and 447.321(b), we eliminated the overall aggregate limit that had applied

to all classes of facilities and replaced it with three separate aggregate groups, based on facility ownership and operation, which are independent of each other. Non-State government-owned or operated of hospitals comprise one group, and we permit States to make aggregate payments to this group not to exceed 150 percent of a reasonable estimate of what Medicare would have paid for the same services. Because we have eliminated the overall aggregate group for all providers by facility type, payments to these facilities are not subject to an overall aggregate limit of 100 percent of what Medicare would have paid for services in all hospitals. The final rule clarifies that the limit for non-State-owned or operated public hospitals is an exception to the otherwise applicable limits, and these facilities would not be aggregated with other facilities of different types. We believe our new format presents the aggregate groups in a manner that makes it clear that the UPLs function independent of each other.

Comment: Commenters recommended that HCFA clarify the limits for inpatient and outpatient services for the same non-State government owned hospital. The two limits describe "payments to hospitals" not payments for inpatient hospital services and outpatient hospital services.

Response: The limits for inpatient and outpatient services are calculated separately for each service even though they may be provided by the same hospital. The current regulations governing inpatient and outpatient UPLs require that these UPLs be calculated separately and we have not changed these provisions in §§ 447.272 and 447.321. The limits apply to payments for services that in turn would be paid to the provider that furnished them to Medicaid eligible individuals.

Comment: Several commenters recommended that we expand the limits to include different Medicaid services. Some commenters suggested we aggregate inpatient and outpatient hospital services together and others recommended that we also include clinic services with hospital services. One commenter suggested that we include clinics in the calculations of a non-State-government-owned or operated hospital if the clinic refers patients to that hospital or the hospital refers patients to a clinic. Similarly, some commenters believed that we should apply UPLs on a facility-specific basis but also include both inpatient and outpatient services if offered by the facility. These commenters felt that the application of the limit on a service

basis could lead to unanticipated funding shifts based solely on the availability of Federal dollars.

Response: We are not accepting these recommendations. Including more than one Medicaid service under the same UPL would create incentives that may lead to abuses similar to those we are now trying to address since the number of providers across which payments may be aggregated would be increased. We considered facility-specific limitations as a possible remedy to the problem of excessive payments, but elected instead to refine our aggregate UPLs. We believe our approach provides an appropriate balance between the needs of States to have flexibility in rate setting and our objective to protect the integrity of the Medicaid program.

Comment: One commenter recommended extremely low DSH States be exempted from the outpatient UPL requirement for State hospitals.

Response: We are not accepting this comment, and have clarified in the final regulations that States must calculate an outpatient UPL separately for State-operated facilities. This will create a uniform procedure for calculating the UPL for inpatient and outpatient services. We believe the commenter's recommendation could result in perpetuating the very abuses this rule is designed to address. As noted in the preamble to the proposed rule, the UPLs were originally modified to include a separate limit for State operated facilities for NF's, ICF/MRs and hospitals for inpatient services so that these facilities were not paid at a higher rate than private facilities. Without creating a similar aggregate group for facilities that furnish outpatient services, States could continue to overpay State facilities while under paying the private facilities.

Comment: One commenter stated that fair and adequate payment for all providers is necessary.

Response: We agree. Under the UPLs, States will be able to set rates that fairly compensate Medicaid providers for Medicaid covered healthcare services.

Comment: One commenter recommended that the UPLs be coordinated such that if a State's payment to a particular group of facilities does not fully use the UPL amount, the "unused amount" should be made available to increase other UPLs that may be exceeded in another group. The commenter believes that this method should be allowed because the total limit on a State's claim for Federal financial participation would not be increased.

Response: Allowing States to distribute the any unused amounts under the UPL from one aggregate group to another aggregate group that may be over its UPL would perpetuate the practices that this action is designed to stem and would not be consistent with the statutory requirements that Medicaid payments promote economy and efficiency. States would still have an incentive to under-pay proprietary and nonprofit facilities and over-pay the State operated and non-State government operated facilities. Although the total limit of Federal financial participation would not be increased, States would still be able to obtain extra Federal funds with less of a State match by manipulating which facilities receive extra Medicaid payments.

Comment: Some commenters suggested that small providers, including sole community and critical access hospitals, be given special treatment and not be included in the UPL calculation.

Response: All providers, with the exception of Indian Health Services facilities are subject to the UPLs. We do not believe there is any justification for exempting any group of institutional providers from these regulations. Therefore, we are not removing facilities, such as sole community hospitals and critical access hospitals. These facilities have always been subject UPL regulations and will continue to be.

Comment: One commenter recommended that non-profit nursing homes be included with the county owned or operated nursing homes for determining the UPL for these facilities.

Response: Allowing non-profit nursing homes to be in the same aggregate group as county owned or operated nursing homes would still enable a State to set an excessively high payment rate for the county operated facilities, while paying the nonprofit facilities at a lower rate. This is not consistent with the statutory requirements that Medicaid payments promote economy and efficiency.

Comment: One commenter asked for clarification on whether residential treatment facilities (psychiatric services to those under 21, but not in a hospital) are subject to the UPLs since hospitals, NFs and ICF/MRs are. If residential treatment facilities are not included in these UPLs, the commenter asked us to specify the test for residential treatment centers. The commenter also asked if State and local government-owned residential treatment facilities would be subject to a separate upper limit test as a group.

Response: The UPL regulations at § 447.272 govern payments to inpatient “hospitals and long term care facilities,” which includes hospitals, nursing facilities, and intermediate care facilities for the mentally retarded. Residential treatment facilities are a separate type of institutional provider, which may furnish inpatient psychiatric services to individuals under age 21. Therefore, payments to these residential treatment facilities are governed by regulations at § 447.325, “Other inpatient and outpatient facility services: Upper Limits of Payment.” This regulation permits a State to pay the customary charge of the provider, but not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

Comment: One commenter recommended that HCFA provide clarification on the similarity of the terms “a reasonable estimate of “ and “amount that can reasonably be estimated.”

Response: These phrases are used interchangeably to describe the States’ obligation to make a reasonable estimate under the UPL regulations and require no change in policy.

Comment: Several commenters were concerned about State flexibility in calculating the UPL. Some commenters recommended that States have the ability to determine how UPLs will be applied on a State by State basis to take into account variations in the payment practices among State Medicaid programs. Commenters recommended giving States the flexibility to apply Medicare payment principles to make a reasonable estimate of what Medicare would pay for similar Medicaid services. These commenters believe that States should have the flexibility to consider either Medicare principles of reasonable cost or prospective payment principles in calculating the UPLs or any reasonable methodology for comparing payment under Medicare or Medicaid.

Response: The new UPL regulations afford States some flexibility in calculating a reasonable estimate of what Medicare would have paid for Medicaid services. In formulating their own approach to computing the UPL, States have flexibility to use either Medicare principles of cost reimbursement or prospective payment systems as the foundation of their estimates. In this regulation, we are not changing the standards that we apply to the review of State estimates. While we generally provide guidance to States under the State plan review process, we intend to issue policy that will clarify

approaches we have determined to be reasonable, and we will provide additional guidance to States on how to compute the UPLs.

Comment: One commenter notes that the UPL could be calculated based on cost data, if available.

Response: The current regulations at §§ 447.272 and 447.321 allow States to use Medicare payment principles to determine what Medicare would have paid for Medicaid services. States are allowed to continue to use cost data to determine what Medicare would have paid for services.

Comment: Commenters suggested that the same elements of cost for Medicare and Medicaid should be included in both the actual payment and in the calculation of the UPL. States should have the flexibility to determine the content and method of those elements.

Response: The Medicare payment principles used to calculate the UPL are not subject to change through this regulation. We intend to publish subsequent implementing policy documents that will clarify the calculation of the UPL.

Comment: Commenters recommended that States should also have the flexibility to continue to reach a reasonable estimate based on the Medicare payment principles that reasonably relate to similar Medicaid services provided under comparable circumstances.

Response: The UPL requires States to make a reasonable estimate based on Medicare payment principles. There are many factors and elements that States may consider to support their estimates. Using Medicare payment principles for services similar to Medicaid service is a permissible approach.

Comment: One commenter recommended that payment shortfalls to hospitals and nursing facilities should be a factor in setting the UPL.

Response: “Shortfall” generally refers to the difference between the cost of a service and the payment for the services. Shortfalls should not be a factor in setting or calculating the UPL because this limit is based on a reasonable estimate of what Medicare would have paid for the same services, and therefore, is unaffected by actual payments for services. However, because the UPL would allow States to set rates that fully cover the cost of Medicaid services, payments to cover Medicaid shortfalls would be allowable under the UPLs.

Comment: One commenter recommended that the UPL should be revised when payments are on average, below reasonable economic and efficient standards. These added

payments should then be utilized to underwrite programs that serve low-income individuals.

Response: Section 1902(a)(30)(A) of the Act requires that payments for care and services under an approved State Medicaid plan be consistent with efficiency, economy, and quality of care. The new UPLs permit States to set facility-specific Medicaid rates that are based on costs determined reasonable under Medicare payment principles. Therefore, payments should not be below economic and efficiency standards.

Comment: Several commenters recommended that HCFA clarify the definition of “other government owned or operated” facilities. Commenters recommended that the other government-owned or operated group should include hospitals that contract with local governments or have a high level of medical assistance or indigent care but are not owned or operated by the local government. One commenter recommended the following qualifying factors for other government owned or operated facilities: Local government may own assets, control a majority of the hospital’s board or must sign off on any major changes in services, including expansions into another county.

Another commenter recommended that States should have maximum flexibility in determining the applicability of 150 percent to other government owned or operated hospitals because hospitals may have a relationship with their local government that may fall outside of the current definition of owned or operated. Another commenter questioned if a State can own a facility and have a local government operate it and still receive the enhanced FFP. The commenter continued to question whether a local government can own and have a private contractor operate a facility and still receive the enhanced FFP.

Response: We restructured § 447.272(a) and 447.321(a) and included at paragraph (a)(2) of these sections, the category, “non-State government owned or operated facilities” formerly “other government-owned or operated facilities”. We specify that this category is limited to “all government facilities that are neither owned nor operated by the State.” Specifically, for purposes of this regulation, non-State government owned or operated facilities are government facilities, as defined by their ability to make direct or indirect intergovernmental transfer payments to the State, and for which the State does not assume primary ownership or legal liability for the operations of the facilities. Examples of the kinds of

facilities that fall into this category are county or city owned and operated facilities, quasi-independent hospital districts, and hospitals that are owned by local governments but operated by private companies through contractual arrangements with those local governments as long as the hospital retains the ability to make an IGT to the State.

Comment: We received numerous comments on the language used to determine the State-operated facilities. Some commenters recommend that the rule be revised to read "State owned and operated." One commenter wanted this language if the 150 percent limit was not extended to the State operated hospitals. One commenter further explains that if a hospital is State owned and county operated, the State could inflate the other government group by including the hospital in that group, yet not allow the hospital to receive more than 100 percent for the current State-owned or operated group. However, another commenter supported our rationale for keeping the categories of State and non-State owned hospitals separate and distinct. Some commenters recommended that we change the language to State owned, but not State operated because university hospitals that are State owned, but privately operated, may be put into a more restricted group.

Response: We restructured the regulations at §§ 447.272(a) and 447.321(a) and added language to clarify that "State government-owned or operated facilities" are all facilities that are either owned or operated by the State. In making this revision, we intend to capture within this group, facilities that are owned by the State, but managed or operated by a local government or private company. We further intend to distinguish between State-owned or operated facilities and those owned or operated by non-State governments. The categories of State government operated and non-State government operated are mutually exclusive, and consequently facilities cannot be considered as part of more than one group when considering the calculation of the UPLs. In addition, as we stated earlier, facilities that qualify for both the State-government and non-State government categories must be put into the State government category.

The 150 Percent Upper Payment Limit for Non-State-Operated Public Hospitals—§§ 447.272(b)(2) and 447.321(b)(2)

In §§ 447.272(b)(2) and 447.321(b)(2) of the proposed rule, we set forth provisions for a UPL of 150 percent of

the reasonable estimate of what would have been paid under Medicare payment principles for inpatient and for outpatient hospital services provided in non-State government hospitals. We explained that we were doing this so that the new limits being applied to these providers assured that they would remain in operation and continue to provide services to the Medicaid population. We solicited specific comment on whether the 150 percent limit is appropriate. We received a significant number of comments in response to this proposal.

Support for 150 Percent UPL for Public Hospitals

Comment: One commenter supports the separation of the other government providers from the overall aggregate cap and the 150 percent limit for these facilities. Other commenters indicated that the 150 percent UPL in proposed paragraph (b)(2) of §§ 447.272 and 447.321 (now paragraph (c)(1) of §§ 447.272 and 447.321) generally reflected a reasonable balance and response to the problem identified.

Response: We appreciate the commenters' support for our provisions relating to the 150 percent UPL. Therefore, we will retain the 150 percent provision in paragraph (c)(1) of §§ 447.272 and 447.321.

Comment: Some commenters support the 150 percent limit, but only if it does not cause a decrease in the aggregate limit for private facilities.

Response: It was our intent in the proposed rule that these categories and UPL limits be separate. In this final rule, we have clarified that the 150 percent UPL for non-State government-operated hospitals is separate from the private hospital category and limit. We have restructured paragraph (a) of §§ 447.272 and 447.321 to identify the different categories of facilities that furnish inpatient and outpatient services, respectively. Under the proposed rule, these categories included State government-owned or -operated and non-State government-owned or -operated facilities. In §§ 447.272(a)(3) and 447.321(a)(3) of this final rule, we added a third category for privately-owned and operated facilities.

Support for a Lower UPL Than 150 Percent for Public Hospitals

Comment: Some commenters indicated that the 150 percent limit is not needed and that the limit should remain 100 percent for all groups. These commenters noted that hospitals would receive adequate reimbursement if they (1) retained 100 percent of the State and Federal shares of Medicaid payments up

to this UPL and (2) received and retained 100 percent of the State and Federal shares of allowable DSH payments. Other commenters noted that there was no evidence that hospitals or patients benefited from the increased Federal funds that would be obtained from increasing the non-State government-owned or operated limit to 150 percent.

Response: While we agree that there is no clear standard as to what UPL would suffice to assure that hospitals and patients benefit, we believe the 150 percent standard is reasonable. Given the special mission of these public hospitals and their important role in serving the Medicaid population, we think that the 150 percent UPL is justified.

We also agree that hospitals should retain the entire amount of the State and federal payments they receive to cover the cost of providing services to Medicaid and indigent patients. While we have instituted reporting requirements as part of this final rule, it is not our intent to regulate intergovernmental transfers. Likewise, we have not changed the rules related to DSH funds. However, we have made every reasonable effort to assure that we pay these facilities only what is necessary to meet the demand for service for Medicaid individuals. We intend to monitor payments to these providers closely and may propose further refinements as we gain experience with the new UPLs. Should we find that the payments made under the higher limit are not being retained by hospitals to support Medicaid services, we would be open to making further revisions in subsequent rulemaking.

Comment: One commenter noted that DSH funds should be used to fund non-State government-owned or operated hospitals rather than increase their UPL to 150 percent.

Response: One of the primary functions of DSH payments is to help hospitals cover the costs of providing care to indigent patients. In establishing the 150 percent UPL for non-State-owned or operated public hospitals, we were careful to list those reasons that we believe entitled these facilities to receive higher payments than would otherwise be allowed. Although we realize there is an ancillary benefit that may cover the costs of providing uncompensated care in these facilities, that was not the reason for our decision to set a higher UPL for these providers. We were more concerned with assuring the continued existence and stability of these core providers who serve the Medicaid population.

Under current law, States have broad discretion to allocate DSH funds among eligible providers and may redirect DSH funds to these facilities. However, some States that have replaced DSH funds that could have gone to public hospitals with UPL funds may not choose or be able to do so under existing DSH allotments. We have not proposed to change the rules related to DSH funds in this rule. We have made every reasonable effort to assure that we pay only those funds that are necessary to these facilities to meet the demand for service for Medicaid individuals.

Support for a Higher UPL for Public Hospitals

Comment: A number of commenters recommended that the final regulation increase the 150 percent UPL to 175, 200, 250 percent or higher for non-State government-owned or operated facilities. While many of the commenters simply stated that the 150 percent limit is arbitrary and did not provide additional rationale for changing the limit, others did cite various reasons in support of increasing the UPL percentage. The reasons cited included the significant reductions in funding these providers will face as a result of the new limits, the amount of uncompensated care provided by these facilities, and the fact that the 150 percent limit does not adequately account for the amount of funds that these institutions will have to transfer back to State treasuries.

Response: We are not persuaded that a UPL above 150 percent has been justified. We were aware in publishing the proposed rule that proper payment data were difficult to obtain and that those who could provide such data were reluctant to do so because it would disclose the transfer of the excessive payment amounts received by providers back to the State. Given that, our discussion with a wide range of groups led us to believe that the only group of providers that would suffer harm that would hinder their ability to serve the Medicaid population were non-State government-owned or -operated hospitals, even when they retain the full payment. Even then, it was not absolutely clear what level of funding would be needed to both meet these needs and, at the same time, curtail the practice of transferring enhanced payments back to State treasuries. Given limited data, we proposed a UPL for these facilities of 150 percent of a reasonable estimate of Medicare payment principles.

In establishing this 150 percent UPL for non-State-owned or -operated public hospitals, we were careful to list those

reasons that we believe entitled these facilities to receive higher payments than would otherwise be allowed. Since public entities may be allowed to transfer payment back to States, we still have concerns as to whether these higher payments would, in fact, be retained by these hospitals to allow them to provide needed services to the Medicaid population. We are instituting reporting requirements in paragraph (d) of §§ 447.272 and 447.321 that will allow us to monitor and track the distribution of these funds.

Comment: Other commenters noted that a limit of 175 percent of the UPL would be consistent with the hospital specific cap of 175 percent of the hospitals uncompensated costs for the disproportionate share hospitals (DSH) limit allowed by the Congress for the State of California and that the Administration has expressed support for applying this DSH limit to other States.

Response: The Administration has separately expressed its support for legislation raising the hospital specific cap to 175 percent of uncompensated costs for public hospitals. The Administration took this position to provide more flexibility in the States administration of DSH payments, but the 175 percent hospital specific cap for uncompensated costs for DSH was not our basis for establishing the 150 percent UPL described in the proposed rule. While uncompensated care costs did not form the basis for establishing the 150 percent limit, we recognize that these UPL payments will offset both the Medicaid payment shortfall and the uninsured costs included in DSH payments. DSH and UPL continue to be separate payment policies. Therefore, in this final rule, we see no basis for applying the same percentages that the Administration supports for a different part of the Medicaid program.

Comment: One commenter noted that the UPL should be set at 175 percent and should not be lowered until a detailed analysis of the consequence of the higher threshold on the availability and access to health care services.

Response: We do not agree. We were aware in publishing the proposed rule that proper payment data were difficult to obtain and that those who could provide such data were reluctant to do so because it would disclose the transfer of the excessive payment amounts received by providers back to the State. It was not clear what level of funding would be needed to both meet these needs and, at the same time, curtail the practice of transferring enhanced payments back to State treasuries. Given limited data, we proposed a UPL for

these facilities of 150 percent of a reasonable estimate of Medicare payment principles. We are instituting reporting requirements in paragraph (d) of §§ 447.272 and 447.321 that will allow us to monitor and track the distribution of these funds.

Non-Support: Discriminatory

Comment: Many commenters indicated that application of the 150 percent limit only to non-State government-owned or -operated hospitals is discriminatory. They note that HCFA has no basis for distinguishing between private, State, and non-State government-operated hospitals or between non-State government-owned or -operated hospitals and other non-State government-owned or operated providers such as nursing facilities and clinics or other providers that serve the same safety-net provider role or serve the same patient populations as public hospitals, such as FQHCs and RHCs. Many commenters recommended that the eligibility criteria for the 150 percent limit should be broadened to include facilities that serve the same role or the same populations as public hospitals. Some of these commenters recommended specific criteria such as a Medicaid utilization rate that is equal to that of non-State government-operated hospitals in each State or the 11.75 percent Medicaid utilization rate that is used by the 340B drug discount program of the Public Health Service Act.

Response: We do not agree. Our discussions with a wide range of groups led us to believe that the only group of providers that both retained this money and would suffer harm that would hinder their ability to serve the Medicaid population were non-State government-operated hospitals. In establishing this 150 percent UPL for non-State-operated public hospitals, we were careful to list those reasons that we believe entitled these facilities to receive higher payments than would otherwise be allowed.

Non-State government-operated hospitals serve a unique role that we do not believe would continue to be adequately funded if it were not reflected in Medicaid rates. State-operated hospitals generally have a larger tax base from which to fund uncompensated care and services. Moreover, State operated hospitals that provide inpatient hospital services have been operating under a 100 percent UPL for these services since 1987.

We do not support the inclusion of public clinics, FQHCs or RHCs in the 150 percent category. Since these facilities are or can be paid at full cost,

we see no benefit to further inflating these payments. We believe their inclusion would only compound the problem of drawing down an inflated Federal payment in order to then transfer this overpayment back to the State. Moreover, Medicaid payments to FQHCs and RHCs are established in statute.

While we agree that some private providers may also fulfill a safety-net health care need similar in circumstance to those we described for the non-State government operated hospitals, we do not believe that, as a general class, these private hospitals currently receive Medicaid payments that are at the 100 percent UPL level and see no basis for further raising that level to 150 percent.

We appreciate the role that other non-State government operated facilities such as nursing facilities serve in the provision of health care. However, we do not believe that the circumstances described for NFs justify receiving the 150 percent UPL. Generally, indigent NF patients are Medicaid eligible or become Medicaid eligible and therefore the NF qualifies for Medicaid payment. In addition, NFs do not as a rule provide the kinds of high cost Medicaid support services that non-State government-owned or -operated hospitals provide. Thus, the financial factors affecting non-State government-owned or -operated hospitals do not equally affect NFs.

We do not see the benefit of applying definitions of safety-net hospitals that are used for other purposes. We believe that while there may have been other reasonable alternatives to applying the 150 percent UPL to non-State government-operated hospitals, given the structure of the current regulations, the problem is most directly addressed by the application of the 150 percent UPL to these hospitals.

Comment: Some commenters indicated that it is unfair to narrow the 150 percent UPL to exclude NFs based on the prior performance of other State programs in returning this money to the State to serve other purposes.

Response: As previously indicated, our criteria for excluding NFs from the 150 percent UPL is based on reasons other than the performance of other State programs.

Comment: Some commenters indicated that we should ensure that all hospitals are appropriately compensated to higher payment limits for non-Medicaid, indigent care, regardless of their type.

Response: We appreciate the commenters' concerns. However, as indicated previously, the financial burden of providing uncompensated care did not form the basis for our

decision to set a higher UPL for non-State government-operated hospitals. Our discussion with a wide range of groups led us to believe that the only group of providers that both retained this money and would suffer harm that would hinder their ability to serve the Medicaid population were non-State government-operated hospitals. Therefore, we believe that the DSH programs under Medicare and Medicaid, which are intended to help defray the costs of uncompensated care, are better suited to serve this purpose than a higher UPL for Medicaid payments.

Comment: Commenters noted that the proposed rule was drafted so that access to the 150 percent UPL for hospital payments appeared to be tied to the phase out of existing excessive payment State plan amendment for hospitals. They assumed this to be in error noting that 150 percent of the aggregate UPL would be available for non-State government-owned or -operated hospital services on the effective date of the rule.

Response: The 150 percent UPL is not contingent upon the transition period. Given the proper supporting State plan methodologies, States will be able to pay these facilities up to the 150 percent UPL as of the effective date of this final rule.

Comment: Commenters asked for confirmation that the 150 percent UPL would be available to all States upon submission of a State plan amendment (SPA) after the effective date of the final rule.

Response: Federal financial participation will be available for all approved SPAs up to the 150 percent UPL for non-State government-owned or -operated hospital services with the effective date of this final rule.

Comment: Some commenters noted that payment under the 150 percent UPL limit may exceed the provider's customary charges, as provided in § 447.271 and that this was an additional limitation. The commenter proposed that we modify or abolish § 447.271 so that charges do not limit payments under the 150 percent UPL.

Response: Since this final rule would allow charges consistent with payment at the 150 percent UPL standard, we would interpret § 447.271(b) regarding agency payment at a rate greater than its costs to be consistent with these final rules. Therefore, we do not believe that a change to this section of the regulations is necessary.

Comment: One commenter noted that contrary to the statement on pages 60156 and 60157 of the proposed rule that suggested the 150 percent UPL for

non-State government-owned or operated facilities would prevent new proposals, in fact it would require a new SPA if the current State plan did not provide for payment up to that level.

Response: To the extent that a State did not have a State plan authority to make payments at this level, a SPA would be needed to claim FFP at this level. However, the State could also continue payment at their current State plan approved rates that were otherwise in conformance with this final rule with no change in its State plan.

Comment: One commenter indicated that States can not continue to fund private safety-net providers such as children's hospitals.

Response: This final regulation does not make any changes that affect payments to children's hospitals or to non-public safety-net providers. States can continue to pay these providers rates necessary to cover the costs of care up to the aggregate limit for privately owned and operated providers. This regulation does assure that the Federal Government and the States each contribute their proper share of funding to these payments.

Comment: One commenter stated that the preamble of the proposed rule does not distinguish between inpatient and outpatient hospital services when noting the role of safety-net hospitals.

Response: Public safety-net hospitals provide both inpatient and outpatient services to large numbers of Medicaid, uninsured and other low-income populations. Additionally, these hospitals provide high cost community support services in both inpatient and outpatient settings. Because these higher cost services, as well as the uncompensated care burden these hospitals bear, are not confined to either inpatient or outpatient services, we believe it is appropriate for the higher rate (of 150 percent of what Medicare would have paid) to be applied to payments in both settings.

Managed Care

The upper payment limits we proposed relate to fee-for-service Medicaid payments. However, we did receive many comments requesting clarification on how they might affect managed care arrangements.

Comment: A number of commenters suggested that HCFA clarify the policy on how the proposed UPL will affect budget neutrality for section 1115 demonstration programs. One commenter recommended we further clarify the preamble language to the proposed rule that indicates that section 1115 expenditure ceilings would be adjusted to account for the effect of the

regulation. Others noted that the final rule should specify that the amount of any increased payments made for hospital services under the rule would be added to section 1115 expenditure ceilings. Another commenter stated that HCFA should reward States that voluntarily reduce their UPL program expenditures below the regulatory limits before the deadline by crediting the Federal savings toward the expenditure ceilings for section 1115 demonstration projects.

Response: As we indicated in the preamble to the proposed rule, we will make adjustments to the budget ceilings for section 1115 demonstration programs. These adjustments will be made in accordance with the terms and conditions governing each program. In general, these terms and conditions provide for adjustments whenever a change in law or regulation would affect State spending in the absence of the demonstration. To the extent that any State with a section 1115 demonstration will experience a change in its spending under this final rule, we will adjust that State's budget ceiling accordingly. According to the terms and conditions governing most demonstrations, the change in the budget ceiling is effective upon the effective date of the new law or regulations. In order to determine whether they will be affected, States should examine their institutional payment provisions to determine how their spending will change under the final rule. If section 1115 States choose to comply with the new UPL before the end of the transition period, the funds that would have otherwise been paid to institutions during the transition period remain as savings under the waiver, and can be used in accordance with the terms and conditions of the waiver. Finally, because each section 1115 program has terms and conditions specifying how adjustments will be made, we do not agree with the commenters that these procedures need to be specified in regulation.

Comment: Several commenters asked us to clarify whether the transition period specified in §§ 447.272(b)(2) and 447.321(b)(1) of the proposed rule applies to States whose UPLs are set via a waiver program instead of a State plan amendment.

Response: As indicated in our previous response, our general policy is to make adjustments whenever a change in law or regulations would affect State spending in the absence of the waiver. To determine when a waiver program would be affected, we would necessarily follow the same rules that apply to provider payments made under an approved State plan. Since those rules

provide for a transition period subject to certain conditions, we would apply those same conditions to waiver programs to determine when they would be affected. For example, if excessive payments are currently being made and had been made before October 1, 1999 under a waiver program, then the earliest point the new UPLs would affect State spending would be the beginning of State FY 2002.

Comment: One commenter urged us to allow flexibility in how the UPLs for various types of providers will be calculated under waiver programs. In cases where a waiver changes the distribution of Medicaid payments among different types of facilities, this commenter recommended that the State be allowed to measure compliance with the new UPL according to how the payments would have been made in the absence of the waiver program.

Response: We agree that there may be instances when States have used waiver programs to make system changes that result in shifting payments among different types of facilities, for example, from inpatient settings to ambulatory care settings. However, we do not agree that waiver programs should be exempted from compliance with these UPLs. When States shift patterns of care from inpatient settings to ambulatory care settings, the payment follows the service provision. The UPL for each set of institutions is calculated according to the services provided within those institutions. We believe that the Medicare cost principles allow States sufficient flexibility to pay each set of providers appropriately without a change in the regulation.

Comment: Two commenters suggested that HCFA count managed care payments and services in the UPL. One of these commenters stated that implementation of the regulation should take into consideration the extent to which public hospitals participate in managed care. This commenter noted that public hospitals with a relatively high managed care line of business will receive little relief from this rule if managed care payments are excluded from the higher UPL, since the special rule would then apply to only a small portion of their caseload.

Response: The UPL for institutional payments specified in this rule applies to fee-for-service payments. Managed care payments are subject to separate limits contained in § 447.361. In considering the question of whether a single limit should apply to both fee for service and managed care payments, as the commenter suggests, we had to consider two separate issues. The first

issue is whether having two limits inappropriately places providers at a disadvantage. As the commenter correctly points out, some providers have a great deal of managed care business and little or no fee for service business. However, we believe that providers have the ability and the incentive to negotiate appropriate rates with managed care organizations. The limit in § 447.361 provides adequate flexibility for managed care organizations to pay appropriate rates. In addition, in the case of DSH, States will be required as of January 1, 2001 to consider managed care payment shortfalls when making disproportionate share payments. So, to the extent there may be shortfalls, the DSH payments should provide relief.

The second issue we considered is whether having two separate limits may create situations where States may, either inadvertently or by design, make excessive payments to providers, both directly and through managed care organizations. We believe that as long as States cannot make separate or supplemental payments directly to providers for services that are included in managed care contracts, except as provided for in statute for disproportionate share hospitals and federally qualified health centers, this situation cannot occur. The prohibition against making direct payments to providers for services for which a State is already paying a managed care organization is contained in § 434.57.

Comment: Two commenters noted that the notice of proposed rulemaking appears to affect the ability of a State to claim all funds anticipated under Section 1115 Medicaid Demonstration Waiver. These commenters urged that the State be allowed to claim all funds, despite the new UPL regulation.

Response: As noted above, we will make adjustments to the budget ceilings for Section 1115 demonstration programs in cases where State spending will be affected by the new UPLs. We do expect that in some cases, the new limits will prevent States from claiming all funding anticipated under their Section 1115 demonstration program. We encourage all Section 1115 States to review their payment methodologies to determine whether they will be affected. We will make every effort to work with States to ensure that services are not jeopardized as the appropriate adjustments are made.

Comment: A number of commenters encouraged us to exclude payments made under Section 1115 or Section 1915(b) programs from the UPL calculation. One of these commenters noted that the UPL is not necessary as

a cost control measure, because waiver programs already have requirements (budget neutrality for Section 1115 programs and cost effectiveness for section 1915(b) programs designed to limit Federal exposure.

Response: In many cases, waiver programs primarily involve managed care payments. As stated above, these managed care payments are not included in the UPL calculations. However, we realize that in some cases, waiver programs involve other types of payments to institutional providers, and these payments will be affected by this regulation. This regulation is intended to have the same effect whether the payments in question are contained in a State plan amendment or in a waiver. We do not agree with the commenter that payments made under waiver programs, other than managed care payments, should be excluded from the UPL calculation.

Comment: One commenter noted that some States operate under waivers in which they receive lower disproportionate share hospital (DSH) payments in exchange for receiving higher non-DSH Medicaid payments. In these cases, the commenter recommended that the State be allowed to count the payments in question as DSH payments, thus exempting them from the UPL.

Response: Although we are aware that some States have re-directed part of their DSH program to support Medicaid eligibility expansions, we do not believe it is necessary to exempt portions of institutional payments from the UPL to reflect this. To the extent the eligibility expansions increase institutions' medical utilization, the increased utilization should create a higher UPL according to the methodology contained within this rule. Since many eligibility expansions are done in the context of managed care, and managed care payments are exempt from the UPL, we do not believe that States will be disadvantaged in any way by this regulation.

Reporting Requirements

As a condition for establishing a policy of higher UPLs for non-State government-owned or operated hospitals, we announced in the preamble of the proposed rule, our intention to require payments to these hospitals be separately identified and reported to HCFA. The purpose of this requirement was to ensure the higher payments are appropriate and are being fully retained by hospitals. We believe the separate identification of these payments will be a necessary administrative tool to ensure the proper

administration of the Medicaid program. We specifically solicited comments on the most suitable methods of reporting and accounting for these payments.

Comment: We received comments suggesting that we expand on the reporting requirements. One commenter recommended that HCFA require the reporting of both intergovernmental transfer revenues (including certified public expenditures if they are used) and supplemental payments. This commenter believes this information is necessary to understand the extent to which funds are actually going to the health care providers or are being retained by health care providers. Other commenters noted that a requirement to report payments alone does not ensure local public hospitals retain Medicaid payments. All or portions of the payments could still be transferred back to the State treasury. Since all the new UPLs still permit pooling, albeit to a smaller degree, the commenters noted that within each class of providers, payments can still be transferred back to the State or diverted directly to non-Medicaid purposes. To remedy the deficiencies they mention, the commenters recommend that the final rule stipulate that payments to public providers, whether State or locally owned or operated, will be considered to breach the applicable UPLs unless they are retained by the public hospitals, or nursing homes to which they are paid and are used by those facilities to meet the costs of delivering services to Medicaid (and uninsured) patients. To implement this approach, one commenter recommended a certification process by which the State Medicaid director or the head of the single State agency certifies that the payments represent an expenditure for the cost of services furnished to Medicaid patients, which could be verified through audits.

Response: We appreciate the input we received on the development of a reporting requirement. Our intent is to develop and enforce a reporting requirement that is not overly administratively burdensome on States or providers, yet sufficient to help us assess what payments are made to facilities in comparison to their UPL and, to the extent possible, ensure Medicaid payments are retained by providers to offset the costs they incur in furnishing covered services to Medicaid patients. After giving consideration to the above comments, we have decided not to require reporting of these data at this time. However, we reserve the right to require reporting of IGT data in the future. However, we do agree that a reporting

process to identify facility specific payment as well as that facility's individual UPL would be appropriate. Therefore, we are adding new §§ 447.272(f) and 447.321(f) "Reporting requirements" to reflect the addition of a reporting process for Medicaid payments to non-State public providers and providers within the group of providers that exceed the UPL during the transition period on a facility specific basis. We believe this will help improve Federal oversight in this area. We will continue to give further consideration to additional reporting requirements suggestions in further policy guidance and may consult with States, providers, and other interested parties in developing them.

Comment: Several commenters expressed opposition to any additional reporting requirements. While some commenters appreciated the intent behind this requirement, they believed it is neither practical nor appropriate for the Federal government to play such an involved role in determining how the State general revenues are appropriated and spent. These commenters believe that the current reporting requirements are sufficient. Other commenters indicated that this requirement was unnecessary and would be a costly burden on States and providers and asserted States should receive 90 percent enhanced Federal matching for compliance costs.

Response: We disagree with the commenters that current reporting requirements are adequate. The Medicaid program is not a general revenue sharing program, but rather an individual entitlement program under which States make direct payments to health care providers or contracts with prepaid entities. Our interest is not in tracking general revenues, but Medicaid payments paid to Medicaid providers on behalf of Medicaid eligible individuals for Medicaid eligible services. Not only do we feel it is appropriate for us to collect information on provider payments, but we believe that it is necessary to ensure Federal matching dollars are appropriately expended. Further, we do not believe reporting the payments in the manner suggested would be overly burdensome as it will be generated either from claims payment data or UPL calculation data the State would have already performed as the basis of these payments. On the issue of the enhanced 90 percent Federal matching rate, the final rule makes no change to policy in that area. However, we do not believe that this reporting will generally require those activities that qualify for this enhanced match.

Comment: We received several comments relating to the nature and substance of the reporting requirements. One commenter suggested the reporting requirement should be with respect to Medicaid expenditures at the State level. This commenter thought it would be reasonable for States to report expenditures based on the provider categories in the regulation. Another commenter recommended the reporting of enhanced payments to public hospitals on an annual basis similar to the reporting requirements for DSH payments.

Response: We agree. Our intent is to develop and enforce a reporting requirement that is not administratively burdensome on States or providers, yet sufficient to help ensure Medicaid payments are retained by providers to offset the costs they incur in furnishing covered services to Medicaid patients. We believe that information at a provider specific level is needed to ensure the integrity of Medicaid payments. With respect to the timing, we think an annual basis is sufficient.

Comment: Several commenters suggested that HCFA establish some type of monitoring program. Certain commenters wanted to ensure Federal funding is being used for Medicaid purposes and that funds are directed to the maintenance of the nation's safety-net hospitals, including children's hospitals. One commenter recommended setting up a task force to monitor the health care needs of populations in those States that have not used IGT funding to determine if Medicaid and other funding sources are adequate for States to meet the health care needs of their citizens.

Response: We are always interested in developing more efficient and effective ways to administer the Medicaid program. As we indicated in our previous response, we intend to give consideration to any additional steps that may be necessary to ensure the Medicaid program fulfills its statutory purposes and solicit input from States, providers, and Medicaid patients. While we do not intend to go beyond a certification requirement at this time, we may issue additional policy guidance under our general authority to ensure the proper administration of the Medicaid program.

Comment: One commenter stated HCFA must issue proposed rules without any specific reporting requirements and that reporting requirements ultimately adopted must have appropriate additional notice and comment rulemaking as required under the Administrative Procedures Act. The commenter stated that HCFA should

issue a separate proposed rule for the reporting requirement.

Response: We believe the commenter is referring to the Paperwork Reduction Act. We will publish a separate notice in the **Federal Register** and provide a 30-day comment period. Further details regarding this process are found in section VI of the preamble, "Collection of information—reporting requirements".

Comment: Several commenters felt that the transition period should be more stringent unless the excess payments permitted during the period are linked to the provision of health care service.

Response: We agree that payments above the new UPLs that are permissible during the transition period should be subject to a reporting requirement. We, therefore, will extend the reporting requirements to States as a condition of receiving the transition period.

Indian Health Service

We proposed in § 447.272(b)(2) that Indian Health Service (IHS) and tribal hospitals funded under the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638) would not be subject to the UPLs. We received comments regarding the impact of this regulation on these entities. A number of these commenters recommend that these IHS and tribal hospitals be considered public for the purpose of applying the 150 percent UPL. A few commenters indicated concern regarding how the shift in funding will affect rates paid to these facilities. In response to these comments, we have revised the regulation to clarify that these facilities will not be subject to these aggregated UPLs. Instead, these facilities are subject to payment limits in § 447.325.

Comment: One commenter recommended that non-State owned public nursing facilities located in close proximity to Indian reservations should be included in the 150 percent category.

Response: We do not believe that the circumstances described for NFs justify receiving the 150 percent UPL. Generally, indigent NF patients are Medicaid eligible or become Medicaid eligible and therefore the NF qualifies for Medicaid payment. Thus, the financial factors affecting non-State government-operated hospitals do not equally affect NFs.

Comment: One commenter indicated that it is not clear what, if any, UPL would apply to Pub. L. 93-638 tribal hospitals. Another suggested that we expand the exclusion at § 447.272(b)(2) to include all facilities owned or operated by American Indian tribes.

Response: We generally agree with this comment. We have restructured paragraph (c) of §§ 447.272 and 447.321 to exclude IHS and tribal facilities that are funded under Pub. L. 93-638 from the UPLs. Instead, these facilities will be subject to the payment limits at § 447.325.

Comment: One commenter indicated that Pub. L. 93-638 tribal hospitals should be included as public hospitals.

Response: We disagree with this comment. The Federal Government maintains a government to government relationship with the tribes. Accordingly, we do not believe these hospitals should be included in either the State government or non-State government pools. Including them as public facilities within the UPLs may enable States to set lower payments for the IHS and tribal facilities, and set payments for government operated providers at higher levels and still comply with the aggregate UPLs. Therefore, to avoid these types of incentives, we have excluded IHS facilities from the UPLs.

Comment: One commenter indicated that tribal hospitals serve all residents of their region and, in most regions, are the sole health care providers. The commenter stated that not only are tribal hospitals funded at an amount too low to fulfill their mandate, but the OMB-negotiated rates are less than rates paid to other public hospitals. This commenter also indicated that authorization to make additional payments to Pub. L. 93-638 hospitals as public facilities is in the best interest of improving access to health care for the rural Medicaid population.

Response: We recognize that tribal facilities, especially hospitals, may serve as sole providers in rural communities throughout the country. We do not agree that the inpatient per diem and outpatient per visit rates are necessarily insufficient. These rates are calculated at the full cost of providing Medicaid services under Medicare payment principles. While other public hospitals may be paid more than IHS hospitals in some instances, this issue may be appropriately addressed in public procedures for State ratesetting required by section 1902(a)(13) of the Act.

Also, as noted earlier, it would not be beneficial to the tribal facility to be identified as a public provider (government-operated). Including tribal facilities as a public provider may cause a reduction in payments to the tribal providers so States can shift these amounts to their own government facilities within the aggregate UPL.

Disproportionate Share Hospitals

Section 1902(a)(13)(A) of the Act requires that, in the case of hospitals, payment rates take into account (in a manner consistent with the disproportionate share hospital requirements in section 1923 of the Act), the situation of hospitals which serve a disproportionate number of low-income patients with special needs. We have received comments regarding the disproportionate share hospital (DSH) program and its relationship to the application of the revised UPLs.

Comment: Several commenters recommended that the regulation be delayed, coordinated with, or made contingent upon, the enactment of legislation that will increase the Statewide DSH caps and increase the facility-specific DSH caps. Some commenters suggested that the regulation be made contingent upon enactment of legislation that will increase the facility-specific DSH caps, as long as the legislation requires that DSH payments be used for hospitals and IGTs. Another commenter recommended that the implementation of the regulation be delayed until Congress has the opportunity for careful consideration of modification of the DSH legislation.

Response: The BIPA requires that we publish this final rule by December 31, 2000. This same law provides for increases to the State DSH allotments (including for extremely low DSH States) and an increase in the hospital-specific DSH limits for public hospitals for a 2-year period. The effective date of the increase in DSH allotments coincides with the date that this final regulation is published in the **Federal Register**. The increase in hospital-specific DSH limits for public hospitals for a 2-year period that begins with the State fiscal year beginning after September 30, 2002.

Comment: One commenter suggested that all payments to DSHs be exempt from the UPL regulations.

Response: We disagree with this comment. While Medicaid DSH payments to these hospitals have been and remain exempt from UPLs, Medicaid services payments to these same hospitals have always been subject to the UPLs. Medicaid services payments are made only on behalf of Medicaid eligible individuals, and are subject to the efficiency and economy requirements in section 1902(a)(30) of the Act. Since the upper limits permit States to set reasonable rates for Medicaid services, we do believe it is necessary to exempt payments made to

a DSH facility on behalf of a Medicaid eligible individual.

Comment: Two commenters indicated that the rule should be modified to reflect the special needs of low-DSH allotment States.

Response: The UPLs established in this regulation are caps placed on the amount of Medicaid payments States can make to groups of providers for services obtained by Medicaid eligible individuals. The limits do not impact the availability of Federal funds States may use for the payment of Medicaid DSH expenditures.

The BIPA provides extremely low DSH States with increases to their DSH allotments.

Comment: One commenter noted that DSH funding should be increased by statutory revisions instead of by the 150 percent UPL since DSH expenditures are for uncompensated care.

Response: As noted, recently passed legislation increased individual public hospital-specific (uncompensated care cost) limits under the DSH program. However, we realize some States and public hospitals have come to rely on the funds generated through the enhanced program payments. While we agree with this comment to a degree, we believe the 150 percent UPL provides an appropriate balance between our objective to reduce excessive payments and to allow States flexibility to target payments to under-funded hospitals.

Comment: One commenter indicated that we should amend the proposed rule to include an exception to allow "proportionate share" payments of FFP up to the DSH cap if funds are dedicated or restricted to medical services coverage for low-income uninsured individuals in those States where the total of all disproportionate share payments does not exceed the State's DSH limit.

Response: A link between the DSH payments and services would require a statutory change that would mandate that DSH payments be paid for specific services. The disproportionate share hospital program was created by Congress to allow States to make provider-specific payments to Medicaid providers that treat a disproportionately high number of Medicaid and low-income patients. DSH payments are not linked to specific patient claims or services. Therefore, we do not have authority to link DSH payments to specific services without a statutory change.

Comment: One commenter indicated that the preamble of the proposed rule fails to explain why the DSH program, which provides funds for hospitals that serve low income patients with special

needs, is inadequate to this task, thus justifying the 150 percent limit to make room for an additional funding stream.

Response: Our intent in establishing these new limits is to reduce excessive payments that some States make to certain government operated health care facilities. In light of financial pressures facing government-operated hospitals, we believe a higher limit is appropriate to ensure Medicaid eligible individuals will continue to have adequate access to the health care services they provide.

Transition Periods for States That Have Approved Rate Enhancement State Plan Amendments §§ 447.272(b)(2)(i), (ii) and 447.321(b)(1)(i), (ii)

We recognize that immediate implementation of these new upper payment limits could disrupt State budget arrangements for States that have relied on funding obtained from approved rate enhancement State plan amendments (SPAs). Therefore, in the October 10, 2000 proposed rule, we included a transition policy for States with approved rate enhancement methodologies that would be affected by the proposed upper payment limits (65 FR 60151).

We had proposed two transition periods, which States may qualify for based on the effective date of the State plan amendment that provided for excessive payments. For approved amendments with an effective date on or after October 1, 1999, we proposed a transition period that would end on September 30, 2002. At the end of this period, Medicaid payments to governmental providers would have to stay within the new UPLs. We proposed a longer transition period for States with approved amendments that were effective prior to October 1, 1999. For these States, we proposed a 3-year phase down to the new UPLs beginning in the first full State fiscal year (FY) that begins calendar year 2002. During the 3-year phase down, States would be required to determine the amount of payment in excess of the proposed UPLs and gradually reduce this amount in 25 percent increments. We solicited comments on the material elements of these transition periods, including the starting point for the phase-out, the percentage reduction each year, and the appropriate transition period.

Congress passed the BIPA, which requires that we publish this final rule by December 31, 2000. Section 705(b) of BIPA provides for a transition period for States with a State Medicaid payment provision or methodology that meets both of the following criteria:

1. It was approved, deemed to have been approved, or was in effect on or

before October 1, 1992 (including any subsequent amendments or successor provisions or methodologies and whether or not a State plan amendment was made to carry out such provision or methodology after such date) or under which claims for Federal financial participation were filed and paid on or before such date.

2. It provides for payments that are in excess of the upper payment limit test established under this final rule (or which would be noncompliant with this final rule if the actual dollar payment levels made under the payment provision or methodology in the State fiscal year that begins during 1999 were continued).

Comment: Many commenters expressed support for any transition period to re-adjust State budget plans impacted by the new UPLs. Other commenters indicated that the two tiered approach in §§ 447.272(a) and 447.321(a) seemed reasonable and should allow ample time for non-compliant States to bring their plans into compliance.

Response: We appreciate the commenters' support. We agree that the amount of time permitted under the transition period is sufficient for States to come into compliance with the UPLs.

Comment: Several commenters opposed providing a longer transition period to States that have amendments in effect prior to October 1, 1999. These commenters felt that the 2-year or shorter period was sufficient time for all States to bring their spending into compliance with the proposed regulations. Two commenters argued that avoiding disruption of States budget arrangements is not the purpose of Federal Medicaid matching payments nor the Secretary's duty under Federal Medicaid law. The 5-year transition simply rewards States that drew down more Federal funds than those States that followed statutory rules. These commenters were also critical of the 5-year transition period because it would be granted to every qualifying State regardless of financial circumstances. In support of this position, the commenters cited information indicating the financial health of most States is good and combined State balances totaled \$21.2 billion in FY 2000.

Response: While we agree with these comments in principle, we believe it is appropriate to phase-in the new UPLs over the timeframes described in the proposed rule. As addressed elsewhere in the preamble, States, providers, and beneficiaries expressed concern over how the application of the upper limits would impact Medicaid access and quality of care. We believe that the time

permitted in the proposed rule is reasonable and balances the need to protect the fiscal integrity of the Medicaid program with State budget issues.

Comment: We received many comments that recommended a longer transition period ranging from 6 to 10 years instead of our proposal for the 2 and 5 year transition period specified in the proposed rule. Some of the comments were State specific and others suggested that the 8-year transition period in HR 2614 (later enacted as BIPA), legislation pending in the House should form the basis for an extended transition period. Others suggested the length of the transition period should be proportional to the length of time the payment arrangement had been in effect or extended if economic conditions worsen.

Response: We believe that the time permitted by our transition periods is sufficient and balances the need to protect the integrity of the Medicaid program and addresses State budget issues. Our paramount interest in issuing these regulations is to preserve the integrity of the Medicaid program. Under section 1903(a) of the Social Security Act, States are required to fund their share (in accordance with a statutory formula) of Medicaid covered health care services furnished to eligible individuals. In recognition that States may have diverted Federal matching funds for other purposes, whether health-related or not, we provided a transition period which would allow all States who qualify for a transition period to have at least one legislative session before SPAs would have to comply with the new upper limits. We also note that in passing section 705 of BIPA, Congress provided a longer transition period for States only with excessive payment methodologies in effect or approved on or before October 1, 1992. We believe that if Congress wanted all States to have an 8-year transition period as provided for in BIPA, they would have done so.

Comment: Many commenters expressed opposition to having different transition periods based on the effective date of an SPA. In addition, commenters recommended that all affected States have the 5-year transition period. One commenter suggested that our basis of "reasonable reliance" on the funds is flawed. This commenter indicated that the length of time that these revenues have been available to a State is not an indication of the importance of these dollars. This commenter also did not believe a distinction could be made between affirmatively approved amendments and deemed approved

amendments. Other commenters criticized the distinction because in their view the only difference is the timing of when States choose to submit amendments under current regulations.

Response: We do not agree. We note that all amendments with an effective date of October 1, 1999 or later were "deemed approved" rather than affirmatively approved. The decision to let these SPAs lapse into approval was intended to avoid any appearance of ratification of these SPAs, and in response to an increase in the number and dollar magnitude of new plan submissions. This decision was consistent with our goal to address the loophole in existing UPL regulations. Depending on State response times to requests for additional information, the time between initial submission and eventual "approval" could take as long as 9 months. We made it clear to States whose SPAs were deemed approved after October 1, 1999, that we intended to change the regulation, and therefore, put them on notice that they could not permanently rely on the additional Federal dollars generated through these mechanisms. However, States with SPAs approved prior to October 1, 1999 were not aware of our intention to change the regulations related to UPL. The reliance concept is applicable because these funds have been built into State and provider budgets for longer periods of time. We note also that in enacting a third transition period for States with excessive payment methodologies in place on or before October 1, 1992, the Congress has ratified our approach to establish transition periods based on a "reliance concept."

Comment: Some commenters expressed concern that the 2-year phase-in period is too rapid and does not provide adequate time for State legislatures and Medicaid programs to prepare for the immediate and long range budgetary consequences they will confront as a result of the rule. One commenter felt that logistical barriers should compel us to reexamine the reasonableness of the timeframes it has presented for States to come into compliance with the rule. The commenter pointed out that 23 States have biennial budgets that have already been established, 13 States have legislatures that meet for short periods of time, and some States do not have full time legislatures who could timely respond within the proposed transition periods.

Response: We did not find these comments to be persuasive. States with biennial budgets would be able to amend their budgets in the interim

legislative session. We also note that all amendments with an effective date of October 1, 1999 or later were "deemed approved" rather than affirmatively approved. The decision to let these SPAs lapse into approval was intentional and in response to an increase in the number and dollar magnitude of new plan submissions. This decision was consistent with our goal to address the loophole in existing UPL regulations. As indicated in the proposed rule, during the review of these amendments, we informed States of our intent to curtail excessive payments and advised the States not to rely on the continuation of this funding. Therefore, these States should have made contingency financing plans for important programs funded with these enhanced payments, knowing that we intended to curtail them as soon as possible. We again note that the Congress recently considered our transition periods in passing section 705 of BIPA. By requiring us to add a third transition period for States with methodologies approved or effective before October 1, 1992, Congress has affirmed our transition periods for other States.

Comment: One commenter suggested it would be more appropriate to change the scope of the 2-year transition period to make it applicable to State plan amendments effective on or after October, 1999, and submitted before the effective date of the final regulation. The commenter indicated that the date of State plan approval by HCFA is not within the control of States and suggests the possibility of two States submitting equally acceptable amendments on the same date and having them approved by HCFA on different dates.

Response: We do not agree with this comment. Once the final regulations are issued, we will rely on them to review State plan amendments and will disapprove amendments that do not comply with them. We also note that we have followed a uniform practice that treats all States equally in reviewing these amendments. Thus, we do not believe there is a possibility of different approval dates for two States with equally acceptable amendments submitted on the same date.

Comment: Several commenters requested that this transition policy be revised to clarify that approved amendments with an effective date prior to October 1, 1999, but later amended or renewed after October 1, 1999, qualify for the extended transition period.

Response: We agree that the transition policy as stated in the proposed rule is unclear with respect to States that annually renew or amend their rate

methodologies that direct excessive payments to public non-State government providers. If a State had an approved amendment in effect prior to October 1, 1999 and amended or renewed that authority after October 1, 1999, the State would appear to qualify for two transition periods. In these cases where a State meets the requirements to qualify for more than one transition period, our policy is to give that State flexibility to decide which transition period to select. Because we have clarified this in the preamble, we do not believe we need to amend the regulation text.

Technical Clarifications on Transition and Base Year Issues

Comment: Several commenters felt the base year amount should be adjusted to reflect annual changes in the Nursing Facility Market Basket Inflation Index and to recognize Balanced Budget Act (BBA) "give back" dollars currently under consideration by the Congress.

Response: We disagree. These types of adjustments would not impact the base year, but instead would be taken into account when making the UPL calculation in the year it occurs. For instance, if the excessive payment to be phased down is \$100 million, that number stays constant, and a different percentage (that is, 75, 50, 25) is applied to it each year. Over this period of time, the cost of services furnished by providers may increase, or the amount Medicare may pay may increase for the reasons cited by the commenter. The effect of these increases would be to raise the UPL for services in the year they are furnished.

Comment: A commenter recommended that each State should be able to properly reflect any increases that occur in Medicare Skilled Nursing Facility Prospective Payment System rates during the course of the State FY 2000 in its UPL base period calculations. The commenter further recommended that States should be given additional time to utilize patient assessments and other data from FY 2000 to more precisely re-estimate their FY 2000 UPL for nursing facility services, even if these data are not available until after State FY 2000.

Response: In computing UPLs, we require State estimates to be reasonable. With respect to the changing nature of Medicare payment systems, in previous refinements to UPL regulations, we issued guidance to States indicating that they must use Medicare payment principles in effect during the same period the services were furnished. We have also advised that States must take into account program differences, such

as non-covered services or acuity levels that might overstate the estimate. These policies permit States flexibility to make refinements to Medicare payment systems that were in effect during State FY 2000.

Comment: The same commenter was also concerned that each State's UPL estimate for State FY 2000, which determines the "excess" payments that will be phased-out, may not reflect any further change to the SNF PPS methodology that occur after State FY 2000. The commenter asked how a State using SNF PPS to compute its estimate will be able to receive a credit for increases in Medicare rates and a commensurate reduction in the excessive payments. The commenter suggests that an equitable approach would permit the State to factor any change in Medicare rates into the calculation of excess payments on an ongoing basis.

Response: Our current policy permits and, in some cases, requires States to factor Medicare payment changes into their UPL estimates on an ongoing basis. However, these types of changes would not impact the base period "excessive payment" computation. Instead, they would affect the UPL calculations in the year services were furnished. If the effect of Medicare payment changes were to increase the UPL for services furnished in State FY 2003, then once the UPL amount was determined for that year, 75 percent of the base period excessive payment would be added to that amount.

Comment: A commenter noted that the proposed rule differentiates between State and non-State government facilities and felt that to be consistent, the calculation of the base period and subsequent transition period payments should also exclude State owned and operated facilities.

Response: The base calculation is derived by comparing actual Medicaid payments paid to all providers to the maximum amount allowed under the applicable new UPL for services furnished during State FY 2000.

Comment: One commenter asked for clarification of "State fiscal year" with respect to the base period. The commenter believes the proposed rule is ambiguous because the phase-out period is described to begin in the State FY that begins in calendar year (CY) 2002. The commenter requested that we confirm that the "State fiscal year 2000" is the State FY year that begins in CY 2000. Another commenter urged that base year excessive payment computation be based on the State FY between 2000 and 2003 in which the highest amount of payment was made.

Response: We did not intend any ambiguity nor do we believe the proposed rule is ambiguous with respect to the base period. In the discussion of the base period calculation, the proposed rule clearly indicates the services and payments for such services in State FY year 2000 shall be used to compute the excessive payment. In this instance, we are referring to the State FY that ends in calendar year 2000 since this year would commonly be understood and referred to as State FY 2000. We are maintaining State FY 2000 as the base period for the purpose of computing the phase down amount. This year was selected because it represents the last complete State FY prior to this rule change.

Comment: Several commenters indicated that the text of § 447.272(b)(2)(iii) as proposed, limits payments to the lower of the base State FY 2000 payments or the limit based on the reduction schedule. Commenters stated that this restriction could result in a lower transition payment than that which would be available in the absence of the transition provisions. This requirement also appears in § 447.321(b)(1)(iii) and (b)(2)(iii). Commenters recommended that the reference to "base State FY 2000 payments" be deleted from each regulation.

Response: While we have included generous transition periods, we do not think it is appropriate to permit States to make payments that would further increase the amount of payment that is in excess of the new UPLs. We have revised the text of the transition provisions in §§ 447.272(e) and 447.321(e) to make this clarification. We have also extended this policy to all transition periods.

Comment: Many commenters suggested alternative starting points for this transition period. Several commenters recommended that the start point of the 3-year "phase down" period begin with the start of Federal FY 2003 rather than in the State FY that begins in CY 2002. These commenters pointed out that this change would ensure all States that qualify for this transition period receive the same amount of time to come into full compliance with the new UPLs. They also noted that this change would extend the same "hold harmless" protection afforded States in the shorter transition period.

Response: Because the additional time permitted under the longer transition period is based on State fiscal years, we realize that some long transition States may have to begin to comply with the 25 percent reduction schedule before the expiration of the shorter transition

period. However, we would not expect this result to create any hardships since the longer transition period will permit, at a minimum, 30 extra months to make payments at higher levels that would have been permitted under the shorter transition period. We note that the use of State fiscal years is consistent with the Congressional implementation of facility specific disproportionate share hospital payment limits, except that we have provided States with considerably more time to come into full compliance.

General Comments

Comment: Several commenters asked that we clarify that payments for clinic services will receive the same transition period as public hospital services.

Response: The same transition periods apply equally to each of the five Medicaid services that are subject to the new UPLs. Should Medicaid payments for nursing facility or clinic services exceed the maximum permitted under the new UPLs, the State would be afforded the applicable "transition periods" set forth in §§ 447.272(e) or 447.321(e).

Comment: One commenter indicated that a transition protection should be available in any transition year in which a State would otherwise exceed the applicable limit. While the proposed rule extends the transition periods to States with rate enhancements that would be impacted by the new UPLs, the commenter believed that the proposed rule was ambiguous with respect to when the rate enhancement arrangement is to be determined non-compliant for the purpose of receiving the benefit of a transition period. The commenter asserts that the preamble to the proposed rule suggests that the relevant period for determining non-compliance is State FY 1999–2000. Assuming this is the case, the commenter believes that freezing the determination of non-compliance to a particular year inappropriately denies transition assistance to States that have not taken full advantage of UPL flexibility. The transition rules were apparently designed to phase-down those States that would substantially exceed the new UPL. The commenter feels that the transition provisions fail to provide protection to States that may exceed the new UPL during the transition because of factors beyond their control, even though they were compliant during the base year. Because payment levels in such a State can vary due to a number of factors, such as increase in Medicaid enrollment, the commenter recommends that the determination of eligibility for a

transition rule should be made on a current period basis.

Response: A transition period is available to States that have approved methodologies that result in provider payments that exceed the new UPLs at the time of this rule change. If the payments result from an approved State plan methodology that was effective on or after October 1, 1999, the State would be eligible for the abbreviated transition period. If the payments result from an approved State plan methodology that was in effect prior to October 1, 1999, the State would qualify for one of the extended transition periods, depending on when the State plan methodology was effective or approved. The commenter is correct in that State FY 2000 is the relevant period for determining the excessive payment amount that will be factored into a longer transition period.

Comment: In phasing out a payment methodology during a particular transition period, a commenter asked if we will require new State plan amendments to effect reductions in payment, or will we consider compliance with the regulation, such as applying the percentage in the regulation to the last approved State plan amendment sufficient without a new State plan amendment.

Response: Given the diverse nature of UPL State plan amendments, it is difficult to describe a single action that would be appropriate in all cases. States are required under 42 CFR 430.12(c) to reflect changes in Federal law, regulations, policy interpretations or court decisions. We anticipate States, in many cases, will need to change their payment methodologies in order to reduce payments to levels that comply with the new UPLs and ceilings during the transition period. Under § 447.257 and § 447.304, we provide disallowance authority to the extent that States do not submit conforming State plan amendments. We encourage affected States to contact their HCFA Regional Office for guidance specific to their situation.

Comment: The proposed UPL rule suggests that the transition period for States are applicable only to the new category: other government-owned or operated hospitals. The preamble, however, describes these transition periods as applicable to the entire State program. The commenter recommends clarification of the transition periods' applicability consistent with the preamble.

Response: The transition provisions apply to approved amendments and/or waivers that result in rate enhancements that exceed the new UPLs in a particular

State. In addition, in the case of outpatient hospital services and clinic services, a new UPL applies to State government-owned or operated and non-State-government owned or operated facilities. Although States make payments to all provider types such as inpatient hospital, nursing facilities, and clinics, the transition provision would only apply to those payment arrangements that result in payments that exceed the new UPLs. Under a State's Medicaid program, for example, should State payments only to State NFs exceed the new UPLs, the State would be eligible only for the transition period relating to NF services, and not the other service categories that are subject to new UPLs.

Comment: We received numerous comments recommending that we grandfather existing UPL enhanced payment proposals. These comments suggested various bases for selection, for example, on approval as of a specific point in time, length of time a program had been operating, or other qualifying factors such as compliance with a maintenance of effort provision or extremely low DSH spending.

Response: Our intent in issuing these new UPLs is to ensure States set provider payments rates that are consistent with efficiency and economy and made in accordance with section 1903(a) of the Social Security Act. We believe this is necessary to preserve the integrity of the Medicaid program. Any type of grandfather solution would effectively result in the permanent continuation of the payment arrangements that necessitated the issuance of these new payment limits and therefore would not be an effective policy in preserving the integrity of the Medicaid program. We also believe that a grandfather policy would be arbitrary and capricious and would not withstand legal challenge. Such targeted relief to specific States or groups of States would need to be addressed legislatively.

Comment: Some commenters suggested that the final regulation include a list of States affected by the regulation and which transition the State qualifies for.

Response: On an individual basis, we plan to work with those States affected by the new UPLs.

Comment: A few commenters requested clarification of how amendments submitted after the effective date of the regulation would be treated.

Response: An amendment that would result in payments that exceed an applicable UPL would be disapproved.

Comment: A commenter indicated that States wishing to convert to the

new UPL should be permitted to do so at any time during the transition period. This would allow States to submit new UPL transactions based upon the final rule.

Response: States that would otherwise qualify for a transition period are free to adjust payments to comply with the new UPLs at any time prior to the expiration of the transition period.

Comment: Many commenters urged us to approve pending applications in their State, or in all States before finalizing the rule.

Response: We have given all States ample notice of our position that these programs are abusive and of our intent to publish this regulation to curtail such programs. To affirmatively approve pending applications would be counterproductive to our purpose of preserving the fiscal integrity of the Medicaid program.

Intergovernmental Transfers

Although the UPLs we proposed do not regulate IGTs, we received many comments related to States' flexibility to use them.

States Ability To Use IGTs

Comment: Several commenters stated that the IGT program is legal and they also pointed out that the abuses cited in the proposed rule were approved by HCFA. They indicated that there is a long history of using such financing mechanisms to offset the increased cost of Federal initiatives and unfunded mandates. They believe we are focusing too narrowly and should be looking at overall Medicaid funding needs.

Response: This regulation does not eliminate the use of IGTs. States and the Federal government share the responsibility of financing the Medicaid program. IGTs are a financing mechanism States can use to help fund their share of allowable program expenditures. Under the Medicaid statute, up to 60 percent of State funding may come from local public resources. States, counties, and cities have developed their own unique arrangements for sharing in Medicaid costs. IGTs have their own statutory basis and those provisions are not being interpreted or modified by this regulation.

We agree with the commenter that the current UPL related funding schemes fit within the structure of our current regulations. As noted earlier in this document, the old regulation was designed to allow flexibility for States to pay providers differently to account for higher costs of some facilities. However, that flexibility has been used in recent years to establish funding arrangements

that are excessive and abusive and do not assure that federal Medicaid funding is spent for Medicaid covered services provided to Medicaid eligible individuals. Such funding arrangements represent a direct and immediate threat to the integrity of the Medicaid program and therefore need to be changed.

Comment: Several commenters recommended that we avoid changing the way the Medicaid UPLs are calculated. Another commenter noted that current regulations are adequate to control abuse through the State plan approval process.

Response: Due to excessive payment arrangements resulting from the pooling and aggregation of public and private payment rates in the current UPL regulations, we believe it is necessary to change the current UPL regulations. The UPLs will still be calculated using Medicare payment principles, which is not a change from current regulations. We disagree that current regulations are adequate to control abuses through the State plan approval process because the current rules permit States to pool and aggregate UPLs across like provider types and do not provide sufficient authority to ensure Medicaid payments are consistent with efficiency and economy.

Comment: Several commenters suggested that States should not be allowed to arbitrarily increase their State match rates through the use of IGTs. One commenter stated that the problem of "recycling" enhanced funding needs to be addressed since it's being "marketed" to additional States and will therefore increase the scope of the problem. The commenter believes that these IGT funds may make it appear that Medicaid expenditures are increasing when the dollars are not related to program costs.

Response: We are not proposing to modify our current requirements relating to IGTs at this time. This regulation addresses excessive payments that result by pooling and aggregation of public and private payment rates. We believe it is necessary to change these pooling arrangements to ensure Medicaid payments to providers are consistent with efficiency and economy.

Uses of IGT Funds

Comment: Commenters recommended that we specify, in this rule, that Federal funds received as a share of Medicaid expenditures financed through IGTs must be used for Medicaid purposes. Specifically, one commenter suggested that UPL funds generated in nursing facilities should be required to pay for services provided by nursing facilities.

Response: We agree that Federal Medicaid matching funds should be used to pay for Medicaid services provided to Medicaid eligible individuals and believe the UPLs will help ensure this result. We do not believe that simply specifying or requiring that Federal funds received as a share of Medicaid expenditures financed through IGTs be used for Medicaid purposes will solve the problem. The Office of the Inspector General's (OIG's) draft audits have shown that once States obtain excess Federal funds through IGTs, they may transfer a portion of those dollars from providers to their General State fund and we lose the ability to track how Medicaid dollars are spent. Therefore, we would have no means of monitoring or enforcing such a provision.

Comment: Many commenters indicated that their individual States are appropriately using funds obtained through IGTs. The commenters believe that these States should not be punished for problems in other States. The commenters also believe that the regulation should distinguish between "good" and "bad" uses rather than eliminating the program.

Response: This regulation does not modify or change Medicaid IGT requirements. States can continue to use IGTs to finance Medicaid payments. States, counties, and cities have developed their own unique arrangements for sharing in Medicaid costs and this regulation should not disturb such arrangements.

Comment: One commenter indicated that overall States are meeting their responsibilities and cannot offset cuts in IGT funds. Many commenters pointed out that States and providers need this money. The commenters indicated that the State Medicaid rates are already inadequate and will probably be reduced if there is a cut in IGT funds. Several commenters are concerned that eliminating the IGT program will cause a serious disruption to State and county "safety-net" providers and other enhanced services that could not otherwise be funded.

Response: This regulation does not attempt to change States' ability to use IGTs. States, counties, and cities have developed their own unique arrangements for sharing in Medicaid costs and these arrangements are protected by statute. Furthermore, this rule will not reduce or limit the amount of Federal funding available to States to pay for Medicaid services to Medicaid eligible individuals. We believe that States were given ample notice of our intent to publish this rule in our letter to State Medicaid Directors on July 26,

2000. In addition, the transition periods in the final rule will provide States with sufficient time to modify their budgetary planning as necessary.

States have the flexibility to set payment rates in accordance with their public process. States will retain the flexibility to pay 100 percent of the costs of serving Medicaid patients, and the Federal government will pay its share of those costs in accordance with each State's Federal medical assistance percentage. In recognition of the unique and important role public safety-net hospitals play in caring for low income, vulnerable populations, we have provided States with flexibility to set higher Medicaid payment rates for these providers. However, we do not intend for these higher Medicaid payments to ultimately replace State dollars for Medicaid or other enhanced services.

Comment: One commenter reasoned that IGT funds should go to children's hospitals even if they are not publicly owned or operated.

Response: Under current rules, States have the discretion to determine how they will use public funds that have been transferred to them from or certified by units of government within the State. In addition, there are no rules that prevent States from paying children's hospitals in accordance with the new UPL regulations for private hospitals. With this group of providers, States still have the flexibility to pay some hospitals more than others to account for differences in cost or caseload.

Comment: One commenter is concerned that reduced funding to county non-acute hospitals will cause patients to be transferred to acute care hospitals, resulting in higher hospital stays and higher costs.

Response: We believe all county hospitals will be able to benefit from higher Medicaid service rates permitted under the UPL for county hospitals.

Comment: One commenter recommended that county facilities have a "hold harmless provision" to prevent care decreases. Another commenter recommended children's hospitals have a hold harmless provision.

Response: We do not have the authority to require States to hold any facility harmless in the implementation of the new Medicaid UPLs. If a State is making excessive payments to certain facilities, we anticipate the State will have to adjust payments to those facilities to comply with the new UPLs.

Quality of Care and Access

Comment: Numerous commenters expressed concern regarding the impact

that this rule will have on the quality of patient care in a variety of programs and settings due to the potential loss of funding available as a result of the implementation of this rule. Many of these commenters noted that quality health care depends on adequate funding. Commenters expressed concern about the impact of reduced quality of care on the following: nursing facilities, hospitals, federally qualified health centers (FQHCs) county non-profit nursing facilities, public nursing facilities, county facilities, safety-net providers, children's hospitals, local health departments, physicians, the State Children's Health Insurance Program (SCHIP), eligibility expansions, Medicaid and SCHIP outreach, the uninsured population, and rural areas. States appear to be using excess Federal funds obtained through current flexibility in the Medicaid upper payment limits to support a variety of health care services.

Response: We strongly support the provision of quality health care to every Medicaid eligible individual. We also recognize that quality health care depends on adequate funding. We do not believe this final rule will interfere with the provision of quality health care services to Medicaid eligible individuals as it permits States to set payment rates that will sufficiently reimburse providers for Medicaid services.

Comment: Several commenters recommended that we adopt special provisions to protect certain providers and populations including children's hospitals, nursing facilities, Medicaid eligible individuals, children and families, pregnant women, seniors, and people with disabilities. Adopting a special provision would be consistent with section 1902(a)(30) of the Act, which requires Medicaid payments to be consistent with quality of care and sufficient to provide adequate access to care.

Response: In this rule, we are modifying the application of the Medicaid upper payment limits. Although we recognize that the groups mentioned by the commenters have special health care needs, we feel that under the new UPLs, States will clearly be able to set rates that fairly compensate all Medicaid service providers for services furnished to Medicaid eligible individuals. The purpose of our rule is to protect the fiscal integrity of the Medicaid program. We intend to achieve this purpose by curtailing excessive rates that some States have established to pay certain providers.

Comment: Commenters pointed out that cutting the IGT funds will reduce

access to care for the elderly and disabled, particularly individuals with heavy care needs, and the uninsured.

Response: First we note that this rule does not place restrictions on IGTs which have their own statutory authority. This regulation deals with pooling and aggregating Medicaid payments under the current UPL categories. Section 1902(a)(30) of the Act requires States to set payments that are consistent with efficiency, economy, and quality of care. Under this authority, States can establish payment methodologies that take into account differences in costs that providers may incur based on the acuity level of their Medicaid patient population. The UPLs we have established do not interfere with reasonable rates that reflect the volume and costs of Medicaid services furnished by a provider. We also note that under section 1902(a)(30) of the Act, payments must be sufficient to enlist enough providers so that services are available to the Medicaid population to the same extent services are available to the general population.

Comment: Several commenters indicated that they believed the rule will result in less FFP for States and, although many States have flush budgets, they may restrict funds for nursing services and other Medicaid benefits, reduce the number of Medicaid eligible individuals, and cause redirection of State funds. Another commenter indicated that the IGT rule's affect on nursing homes will cause a lack of nursing home placement for patients.

Response: As we stated in the regulatory impact statement of the proposed regulation, the rule will not reduce the overall aggregate amount that a State can pay for Medicaid services. Each State makes its own budgetary and rate setting decisions. Under section 1902(a)(30)(A) of the Act, States are required to provide payment that is sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that the care and services are available to the general population in the geographic area. While States have considerable flexibility in rate setting, should they impose rate reductions as a result of this final rule, they still must assure that Medicaid services are available at least to the degree these services are available to other populations in the same geographic area.

Comment: Commenters are concerned that the new Medicaid UPLs will create financial insecurity for numerous providers and will put the following providers at risk of closing their doors or declaring bankruptcy: sole-

community hospitals, county facilities caring for patients who receive specialized services, private safety-net hospitals, inner-city and rural safety-net hospitals providing services to low-income and uninsured people, nursing homes, large county nursing facilities, and skilled for-profit and non-profit nursing homes. In addition, a few commenters expressed concern that the proposed rule will put certain State's Medicaid programs in jeopardy.

Response: We recognize the precarious situation of providers who face low payment rates and are responsible for providing care and services to Medicaid eligible and uninsured individuals. We want to emphasize that this regulation permits States to set reasonable rates for Medicaid services.

Comment: Several commenters expressed the concern that the regulation will jeopardize the ability of States to develop, maintain, and expand home and community-based services, including home and community-based waiver programs, for the elderly, persons with disabilities, or persons with developmental disabilities. Similarly, several other commenters indicated that funds derived from the UPL loophole are used for other laudable causes, such as reduction in the use of restraint and seclusion, taking nursing home beds out of service, providing and enhancing safety-net services to low income populations, and behavioral management training. The commenters stated that these causes would also be jeopardized.

Response: We recognize the concerns of these commenters, but note that this regulation does not directly affect Federal financial participation for these services. States can continue to develop home and community-based waiver programs and provide home and community-based services under their Medicaid programs and the federal government will match State expenditures for these services. While some States may have used the UPL loophole to support home and community-based services or other laudable causes, as described by the commenters, these arrangements are inappropriate as they effectively result in Federal funds being used in place of required State funding.

We also believe States have many important incentives to continue to develop, maintain, and expand home and community-based services. First, home and community-based services, including home and community-based service waivers serve as a cost-effective alternative to institutional care. Second, the provision of home and community-

based services under the Medicaid program is an important tool for enabling States to fulfill their responsibilities in serving persons with disabilities "in the most integrated setting appropriate" as required by the Americans with Disabilities Act. Lastly, the provision of home and community-based services is crucial if States are to be responsive to the needs and preference of the elderly and persons with disabilities who seek alternatives to institutional care.

Comment: One commenter noted that the proposed rule could result in a reduction of services to Medicaid recipients with disabilities unless we add a State fiscal maintenance of effort (MOE) provision to protect recipients who receive home and community-based services. This commenter recommended that we require that each State spend no less in each future year (adjusted for health care inflation) on home and community-based services provided either under a home and community-based services waiver or under the Medicaid State plan.

Response: We do not have sufficient authority to impose an MOE requirement because HCBW services are an optional program under the Medicaid Statute. We believe States will maintain these programs because of the incentives previously mentioned.

Miscellaneous

We also received a number of comments not directly related to the provisions of the proposed rule, which we summarize here.

Comment: One commenter recommended that we maintain our traditional flexibility in interpreting the UPL regulation and allow State flexibility.

Response: We agree that States should maintain the ability to establish payment rates for their providers. However, with respect to the State's payment rates, section 1902(a)(30) of the Act requires that these rates be consistent with efficiency, economy and quality of care. HCFA has found that the increase in title XIX Federal funding for enhanced payments to nursing homes and hospitals is not consistent with the statutory definition of efficiency and economy. Therefore, we are taking this action to ensure that State Medicaid payments meet the statutory definition of efficiency and economy by issuing this UPL regulation to address the enhanced program payments.

Comment: Several commenters indicated that we do not have the legal authority to set UPLs.

Response: The legal basis for setting the UPL is section 1902(a)(30) of the Act

which provides that the State's payment rates be consistent with efficiency, economy and quality of care. This provision provides us the legal authority, on behalf of the Secretary, to set the UPLs on Medicaid payments as set forth in the Federal regulations at 42 CFR part 447.

Comment: The State of Georgia does not have an UPL SPA pending and wants to be removed from the list.

Response: We disagree. The State has a pending amendment to its State plan which will make payments previously made to DSHs, to hospitals within the State's UPL. To date, the State has not demonstrated that these enhanced payments are tied to the cost of Medicaid services.

Comment: One commenter suggested that we consider approaches to closing the loophole that will not damage safety-net providers.

Response: We do not believe that "closing the loophole" or capping the enhanced payments States are making to providers will damage safety-net providers. We have accounted for potential affects of this regulation on public hospitals by setting the UPL cap at 150 percent of what Medicare principles would have paid. We have also granted transition periods to States to allow them to continue the enhanced programs for a prescribed amount of time.

Comment: One commenter indicated that as a major rule, this final rule can not take effect until 60 days after publication.

Response: This rule will be effective 60 days from the date of publication.

Comment: One commenter suggested that we consider allowing all States to apply UPL funds to health services that would result in net savings to Medicaid (for example, training community-care aides). Another commenter indicated the UPL funds should only be permitted to reduce institutional bias and should be based on removing people from nursing homes. One commenter recommended that Medicaid funds should go to nursing homes so there will be adequate operating capital.

Response: The Medicaid statute currently contains several authorities States can use to legitimately redirect Medicaid funding in the manner suggested by the commenters. Under section 1115 of the Act, States can operate programs that expand eligibility and/or include services not otherwise covered by Medicaid, if these programs do not result in increased Federal spending. Under section 1915(c) of the Act, States can establish home and community-based programs as an alternative to institutional care. The

main distinction between these programs and similar programs that may be funded under the former UPLs, is that States would be required to fund their share of the costs as required by the Medicaid statute. To operate similar programs under the UPLs, States would have to represent expenditures for the medically necessary provision on institutional care for the purpose of claiming Federal matching funds, and then have those institutions transfer Federal funds to support non-institutional services. The representation is misleading since by definition the funds would not be used by the institution to provide medically necessary care and services to its inpatients, but rather to support some type of alternative program. We believe these types of funding arrangements completely undermine the integrity of the Medicaid program. It is our intent that under the new UPLs, Medicaid payments claimed as a nursing home expenditure, or as an expenditure for some other type of institutional service, will in fact be paid to and retained by those facilities to offset the costs they incurred in furnishing Medicaid services to eligible individuals.

Comment: One commenter indicated that safeguarding the financial integrity of Medicaid is of paramount concern. Another commenter indicated that [Medicaid] program integrity is important.

Response: We agree with this comment and will continue to work with States and provider groups to ensure the integrity of the Medicaid program, while preserving the State's current flexibility to set payment rates in accordance with section 1902(a)(13)(A) of the Act.

Comment: One commenter suggested that we create a separate alternative which specifically focuses on the State's use of an IGT policy rather than an upper payment limit.

Response: Our primary concern is reducing excessive payments and we believe the establishment of upper payment limits is the most direct approach to achieve this objective. As indicated in the proposed rule, we gave consideration to developing an IGT policy. However, had we proposed an IGT policy, our intent would have been to have it supplement our proposed UPL modifications. Because we realize that States, counties, and cities have developed their own unique arrangements for sharing in Medicaid costs, we decided not to pursue this policy at the time we proposed the new UPLs. We remain concerned with the manner in which IGTs are used in particular instances and agree that a

policy specific to them may be necessary to ensure that Federal funds are used to match bona fide expenditures.

Comment: Several commenters recommended that we require State maintenance of efforts and reject State plan amendments that would lower payments to nursing homes. Another commenter indicated that we cannot approve State plan amendments that would lower or provide inadequate updating.

Response: The Balanced Budget Act of 1997 repealed certain sections of 1902(a)(13) of the Social Security Act (Boren amendments) which had previously allowed us to disapprove State plans that implemented payment rates that were not "reasonable and adequate to cover the costs of an efficient and economically operated provider." Therefore, the statutory basis for us to disapprove a plan based upon inadequate or unreasonable rates has been repealed. The Boren amendment requirements have been replaced with a requirement that States establish payment rates using a public process that allows for meaningful opportunities for public input. It is during this public process that providers should communicate their concerns regarding the adequacy of the payment rates to maintain Medicaid services at the optimum level required to care for the provider's Medicaid patient population.

While the objective of the new upper limits is to reduce excessive payments, we are concerned by the volume of comments we received relating to the impact these limits will have on Medicaid quality and to services access. Under Section 1902(a)(30) of the Act, States are required to make payments that are consistent with efficiency, economy, and quality of care and that is sufficient to enlist enough providers so that health care services covered by Medicaid are available to the extent such services are available to the general population in the geographic area. Section 1902(a)(30) is a Medicaid State plan requirement, and therefore, we can require States to report how proposed changes in payment rates are anticipated to impact the quality of care and access to Medicaid services.

Comment: One commenter noted that excessive Medicaid funding is necessary because Medicare reimbursement has been tightened.

Response: We disagree with this comment. Medicaid and Medicare are separate and distinct entitlement programs that are geared towards two different populations and administered under the statutory authority of two different titles in the Social Security

Act. A reduction in funds to providers under the Medicare program does not grant States the authority to make payments that do not meet the statutory requirements of Medicaid.

Comment: One commenter indicated that the money is currently being used to provide services to Medicaid eligible individuals.

Response: We realize that in some cases, States may be using enhanced payments to expand Medicaid eligibility or provide additional services. Since Federal-matching payments would necessarily be available for these program expansions, in this context, the States would be using the enhanced payments rather than the required State matching payments. In this case, we believe this practice violates the integrity of the Medicaid program and we intend to curtail it with the application of the new UPLs.

Comment: One commenter indicated that States should not be penalized for actions under plans approved by us in the past.

Response: States are not being penalized for methodologies permitted by us in the past. We recognize that the UPLs may disrupt State budgets. States with these plans have been given a transition period, however, and we have an obligation under 1902(a)(30) to ensure State payments are consistent with efficiency, economy and quality of care.

Comment: One commenter indicated that GAO and OIG have rushed to judgement.

Response: We believe that the OIG and GAO studies on State enhanced payment programs were extremely thorough, and the conclusion drawn from these studies well thought through. The OIG continues to study State programs and any specifics and further conclusions drawn from the study of these programs will be shared with us.

Comment: One commenter indicated that we are too focused on the process States use to meet their Medicaid needs.

Response: It is our responsibility, as the Federal agency that administers the Medicare and Medicaid program, to ensure that the fiscal integrity of the Medicaid program is maintained. If we find that States are making Medicaid payments which are not consistent with efficiency, economy, and quality of care, we, on behalf of the Secretary, must act upon the problem through regulation.

Comment: One commenter suggested that we modify rules to give States extra money for indigent care.

Response: We do not have the regulatory authority, under title XIX, to require States to designate specific funds to indigent care.

Comment: Two commenters recommended three categories of Federal funding for each group of hospitals: private, State, non-State government owned.

Response: We have revised the UPL at paragraph (a) of §§ 447.272 and 447.321 to account for these three separate groups. We have established a separate UPL for each of the following categories: privately-operated facilities, non-State government-operated facilities, and State government-operated facilities.

Comment: One commenter indicated that we should not allow States to use the Medicaid funds to build bridges, but did believe we should not place limits on New Hampshire's Medicaid funding.

Response: The new upper limits are intended to ensure Medicaid payments are consistent with efficiency and economy. Under the former UPLs, States could make excessive payments to certain public providers. Once paid to a provider, the provider had the flexibility to use the funds as it felt appropriate. As illustrated by the initial finding of the Inspector General, the funds may be used in a variety of ways. In cases in which the funds are donated back to the State, it ultimately becomes impossible to track the Medicaid payments due to the fungibility of money. By reducing excessive payments, we believe that the new UPLs preclude States from using Medicaid funds for non-Medicaid purposes. While New Hampshire does have a rate enhancement program, we do not know at this time how the new UPLs will ultimately impact them.

Comment: One commenter inquired about the term of "fair compensation". The commenter asked if we had a definition of fair compensation. The commenter asked if fair compensation was equivalent to "may not exceed a reasonable estimate of what would have been paid for those services under Medicare payment principles." The commenter felt that it was inconceivable to believe any State pays compensation rates to its providers that exceed any reasonable definition of fair compensation, which seemed to be our position.

Response: The term "fair compensation" is not defined in any Federal Medicaid regulations. In the context used in the proposed rule, we were pointing out that under the new UPLs we are establishing, States will be able to set service rates that fairly compensate individual providers for covered Medicaid services furnished to Medicaid eligible individuals. In other words, the UPL would permit a State to set facility specific rates that are based on the reasonable cost each provider incurs in furnishing Medicaid services

to Medicaid eligible individuals. While we can understand the commenter's dismay about States setting excessive rates, our analysis of nursing facility payment programs in several States shows that payments to public providers are often multiples above the price the State would have paid a private facility for the same service. When computed on a per-day basis, we have found payments in some States to be in the \$1,000-\$1500 range.

Comment Period

Extend Comment Period

The proposed rule allowed a 30-day comment period.

Comment: A number of commenters urged HCFA to extend the comment period. Twelve commenters recommended that the comment period be extended to provide States more time because of the magnitude of the policy change. Fourteen commenters felt that the public was not given sufficient time to understand the implications of this ruling. A few commenters felt that the comment period should be extended to allow time to conduct impact analysis and to evaluate the effect of the rule on long term care. Two commenters stated that the comment period should be extended to allow more time to respond to the possible negative impact on resident care and Medicaid accessibility.

Response: While we appreciate all the comments requesting extension of the comment period, it is our belief that the comment period provided was reasonable and sufficient. We believe the thirty-day period was sufficient particularly in view of the intense national publicity given this issue over the last several months and extensive consultation with various stakeholders before the proposed rule was even published. In recognition that States may have budgetary disruptions resulting from the rule, we began advising States earlier this year that new SPAs may not be in effect for long and that long standing plans would need to come into compliance with a final rule change. On July 26, 2000, we issued a State Medicaid Director's letter formally informing States of our intention to publish a proposed rule to modify the current UPL. In addition, HCFA, the Office of the Inspector General and the General Accounting Office testified in September on the scope of the financing practices, their impact on State and Federal spending, and on the ways that States used the increased Federal funds. At this hearing, we informed the Committee and other stakeholders about

our intent to publish a proposed rule and change the current UPL regulations.

We also believe that the proposed transition period allows sufficient time for State legislatures and Medicaid programs to prepare for any budgetary consequences. As stated in our responses to comments on the transition period, our paramount interest in issuing these regulations is to preserve the integrity of the Medicaid program. Under section 1903(a) of the Social Security Act, States are required to share (in accordance with a statutory formula) in the burden of financing the costs of Medicaid covered health care services furnished to eligible individuals. We recognize that States may have diverted Federal matching funds for other purposes (whether health related or not). We provided a transition period which would allow all States that qualify for a transition period to have at least one legislative session to fully analyze and evaluate the effect of the rule and before SPAs would have to comply with the new upper limits.

Comment: One commenter believes that the comment period should be extended for at least 60 days because of concerns regarding the impact of the regulation on hospitals that serve a disproportionate share of low income and indigent patients.

Response: We do not believe that a longer comment period would address these concerns. First, before the publication of the proposed rule, the Administration conducted extensive consultations with many hospitals and associations serving a disproportionate share of low income and indigent patients. The proposed rule has accounted for potential effects on such hospitals by setting the UPL cap at 150 percent of what Medicare payment principles would have paid. In addition, the proposed rule granted transition periods to States to allow time to adjust State budgets to protect certain programs and providers. This transition was intended to balance the need to protect the fiscal integrity of the Medicaid program while accounting for State budget issues and provider impacts.

Delaying Action or Implementation

Comment: A number of commenters recommended that we not impose this regulation until a long term care policy can be developed with two dedicated sources of funding for nursing facilities. One commenter indicated that the regulation should not take effect until there is legislative change to FMAP formula.

Response: Delay in implementing this regulation would be contrary to

Medicaid statute and further contribute to the rapid growth in Federal Medicaid spending. Section 1902(a)(30) of the Act requires a State plan to meet certain requirements in setting payment amounts to obtain Medicaid care and services. One of these requirements is that payment for care and services under an approved State Medicaid plan be consistent with efficiency, economy, and quality of care. The Administration has found that the increase in title XIX Federal funding for enhanced payments to nursing homes and hospitals is not consistent with the statutory definition of efficiency and economy. Therefore, the Administration has charged us with the task of ensuring that State Medicaid payments meet the statutory definition of efficiency and economy by issuing this UPL regulation to address the enhanced program payments.

Comment: Several commenters requested that HCFA not enact the proposed rule.

Several commenters recommended that the implementation date be delayed to permit States to develop legislative and fiscal solutions, while one commenter suggested delaying implementation of the rule for 1 year to allow time to work cooperatively with the States to reach mutually agreeable solutions to HCFA's concerns. One commenter recommended that HCFA should assess the procedural and substantive ramifications on State budgets and Medicaid programs before proceeding with this rule.

Response: As stated in our responses to comments on the transition period, our paramount interest in issuing these regulations is to preserve the integrity of the Medicaid program. Under section 1903(a) of the Social Security Act, States are required to share (in accordance with a statutory formula) in the burden of financing the costs of Medicaid covered health care services furnished to eligible individuals. We recognize that States may have diverted Federal matching funds for other purposes (whether health related or not). We provided a transition period which would allow all States who qualify for a transition period to have at least one legislative session to fully analyze, evaluate and assess the procedural and substantive ramifications the rule and before SPAs would have to comply with the new upper limits.

We believe it is appropriate to phase-in the new UPLs over the timeframes proposed in the proposed rule. As addressed in the preamble, States, providers, and beneficiaries expressed concern over how the application of the upper limits would impact Medicaid access and quality of care. We believe

that the time permitted in the proposed rule is reasonable and balances the need to protect the fiscal integrity of the Medicaid program and State budget issues.

We would not want to delay the implementation of the rule for one year because that would allow additional States to submit SPAs to take advantage of the current UPL loophole. This could dramatically increase Medicaid expenditures in the near term.

Comments on Impact Analysis

We received comments on the impact analysis of the proposed rule. We invited comment on alternatives we considered and on other possible approaches for achieving our objective to ensure Medicaid service payments are consistent with efficiency and economy. We specifically solicited comment on alternative means of setting the maximum amount that may be paid to public hospitals that have traditionally provided "safety-net" care and services to underserved communities and individuals who are uninsured. In addition, we requested information regarding the mechanisms used to finance these hospitals under the existing regulations, as well as suggestions for a means of curbing excessive payments while allowing States the flexibility to recognize higher costs faced by these hospitals.

Comment: We received several comments that were critical of the impact analysis published in the proposed rule. These commenters asserted that the lack of data or uncertainty over how States may respond to the new UPLs does not excuse HCFA from its obligations under the RFA. Several commenters wanted us to provide a better analysis of the impact on small entities, specifically including children's hospitals, as well as the impact on State Medicaid programs before publication of the final rule.

Response: Due to data limitations and uncertainty with respect to how States may re-adjust payments to maintain the same level of Federal Medicaid dollars, we specifically solicited comments on how the new UPLs in this final rule would impact Medicaid participating health care providers. Unfortunately, we did not receive any information that would help us more accurately quantify the impact at the individual provider level. In the proposed rule as well as in this final rule, we have tried to explain the difficulties and complexities of trying to project the potential impact of the new UPLs. Since State Medicaid programs do not routinely report the type of data that would be necessary to

accurately quantify the impact on affected providers, in our analysis we have tried to explain the factors that would cause the regulation to have an impact.

Comment: One commenter took strong exception with our assessment that non-government owned or operated small entities should not be impacted because the UPLs, as proposed, did not apply to them. The commenter stated that many community-service providers depend on Medicaid for a large part of their revenues, and because they have less political influence than hospitals, nursing homes, or physicians, it is likely these small community providers would bear a disproportionate share of payment reductions resulting from the rules. The commenter stated that the State of Michigan claims that the entire cost of its home and community-based waiver (HCBW) program is funded by UPL revenues and according to one State official, the entire community-based program may be eliminated if the UPL rule is adopted.

Response: The commenter's real concern appears to be with State budget priorities, which are beyond the scope of this rule. This rule will not alter federal funding of HCBW services, and will not preclude States from funding their share of such services. We have acknowledged that, in some States, public institutional providers may return these payments to the State and the State may use the returned payments to fund HCBW services. Since States do not report to us on their internal funding sources, we do not have data that would allow us to quantify the effect of potential State budget reductions on some providers because of internal funding shortfalls. The commenter did not furnish any specific data. Moreover, any comments on the impact internal funding shortfalls may have on providers is necessarily speculative since, ultimately, the allocation of State resources is an issue of State discretion beyond federal purview. We have emphasized that, under the new UPLs, States will be able to set service rates that fairly compensate institutional providers. Such rates must be set using a public process that includes input from providers. Non-institutional HCBW services are not subject to this UPL, and rates for those services will not be affected. Furthermore, there are substantial reasons, including civil rights requirements and net cost savings in comparison to institutional services, why States should continue to fund HCBW services. Thus, we do not believe there will be a substantial impact on HCBW services from this rule.

Comment: One Commenter stated that HCFA should ensure that the final rule does not exacerbate the financial stresses that rural hospitals continue to face in light of the myriad provisions of the Balanced Budget Act of 1997 that have resulted in a budget-crushing domino effect.

Response: We do not believe this rule will have a significant impact on rural hospitals. These regulations do not interfere with States' ability to set adequate payment rates for all providers including rural hospitals. In addition, rural hospital owned or operated by local governments may benefit from the higher UPLs set for hospital providers.

Due to data limitations, mainly because States do not routinely report payment information that would allow us to quantify the impact on providers, we have tried, in the absence of data, to explain what would and would not be permitted under the final UPL rules. We have emphasized that the new UPLs will permit States to set service rates that fairly compensate providers. The rules are intended to preclude States from setting rates that far exceed the amount of costs a provider would be expected to incur relative to the services provided to Medicaid individuals.

Comment: Several commenters indicate that the rule changes will put considerable pressure on State budgets. This in turn will make it exceptionally difficult to administer programs for children, the working poor, and community social service programs, all of which provide health care, food, shelter and child care to those populations most in need. It will weaken the part of the health organization and safety-net providers who run these programs because they will no longer have the ability to negotiate for inflationary updates to State health care budgets and may even jeopardize the small updates they have realized for FY 2001. Without these funds, one commenter noted a deficit will result in fractured financing systems and a rising number of uninsured individuals. These shortfalls would have to be offset through tax increases. The commenters added that HCFA should target abuses of the system and control the use of funds.

Response: The Medicaid program is available to assist States in paying for the costs of needed health care services provided to Medicaid eligible individuals. While we appreciate the concern over State budgets and access to non-Medicaid programs, State funding issues are outside of the scope of the Medicaid program. We believe these rules will help ensure that Medicaid payments are used to pay for Medicaid

services provided to Medicaid eligible individuals.

Comment: One commenter notes that this regulation will reduce funding to both public hospitals and private hospitals that have emergency rooms or trauma centers. As this funding is used to support safety-net hospitals with emergency rooms and trauma centers, its loss would force the closure of portions of the trauma network. Another impact identified by the commenter is that affected facilities will not be able to provide care to the indigent and uninsured.

Response: We recognize the important role non-State public hospitals play in providing emergency room and trauma care and in caring for the indigent. For these reasons we have set a higher UPL for these facilities. Ultimately, we believe these higher limits will substantially increase the overall amount of Federal funding that will be available to States for inpatient and outpatient hospital expenditures.

Comment: Several commenters asserted that their State and health care facilities stand to lose substantial funding under the implementation of the UPL.

Response: Because commenters did not support these assertions with Medicaid service utilization and payment information, we were not able to use these comments in trying to quantify the impact of these UPLs in this final rule. Since these rules allow States to set reasonable Medicaid service rates, we do not believe the asserted impact can be fairly attributed to the UPLs.

Comments: Several commenters supported grandfathering in existing arrangements.

Response: As we indicated in the preamble, we do not think this alternative would effectively address the problem of excessive Medicaid payments. This approach would permanently permit the continuation of excessive payments by States that are currently making them and therefore would not achieve our objective to have Medicaid payments be consistent with efficiency and economy. We also believe this approach would not withstand legal challenge if it were to be effected through a regulatory change.

Comment: One commenter urged us to consider additional alternatives which would minimize the impact of the rules on children's hospitals. Noting the purpose of the rule, the commenter asserted it is not within those provisions to adopt a rule which will result in the severe underpayment of children's hospitals and threaten their ability to furnish needed health care services.

Response: Because the UPLs will allow States to set rates that compensate providers fairly for needed health care services they furnish to Medicaid individuals, we do not believe children's hospitals will experience underpayments as a result of this rule. This comment appears to more directly relate to State budget priorities which are outside the scope of this rule.

Comment: One commenter disagreed with our assessment that the proposed UPLs are not subject to unfunded mandate reform act. The commenters stated that the term "Federal Mandate" as used in the unfunded mandate reform act means any provision in a regulation that imposes an enforceable duty upon State governments including a condition of federal assistance. (2 U.S.C. section 1555) Under the proposed rule, States have an enforceable duty to amend their State plans and claiming procedures. The commenter added that the regulations shift the costs of existing federal mandates currently being assumed by the Federal government through IGTs to the States. The commenter believed the impact is well in excess of \$100 million in any one year and, therefore, believed an unfunded mandate reform act impact analysis is required.

Response: We disagree with the commenter and maintain our position that these new upper limits in this final rule have no unfunded mandate implications.

Comment: One commenter noted that our regulatory approach is distinctly superior to any of the other alternatives considered.

Response: We appreciate the commenter's support of our approach. We did explore alternative approaches but none of the options were suitable measures to solve the current situation within the current laws and regulations without changing the statute or taking away some degree of State flexibility.

V. Summary of Changes to the Proposed Rule

In response to comments on the proposed rule and to provide policy clarification and eliminate redundancy, we made a number of changes in the final rule. A summary of these changes is as follows:

- Restructured §§ 447.272 and 447.321 to more clearly present our policy.
- Restructured §§ 447.272(a) and 447.321(a) to identify the different categories of facilities that furnish inpatient and outpatient services, respectively. Under the proposed rule, these categories included State government-owned or operated and

non-State government-owned or operated facilities. In this final rule, we added a third category for privately-owned and operated facilities.

- Restructured the regulations at §§ 447.272(a) and 447.321(a) and added language to clarify that "State government-owned or operated facilities" are "all facilities that are either owned or operated by the State" to clarify that facilities that qualify for both the State-government and non-State government categories must be put into the State government category.

- Restructured §§ 447.272(a) and 447.321(a) and included at paragraph (a)(2) of these sections, the category, "non-State government-owned or operated facilities" formerly "other government-owned or operated facilities."

- Clarified our definition of non-State-owned or operated facilities to specify that this category includes "all facilities that are neither owned nor operated by the State."

- Removed the term "outpatient hospitals" from proposed § 447.321(a) and (b) and replaced it with the phrase "outpatient services furnished by hospitals."

- Provided clarification in §§ 447.272 and 447.321 for references to the term "services" by replacing it with the phrase "services furnished by the group of facilities."

- Added §§ 447.272(e) and 447.321(e) to provide the provisions for our "Transition periods".

- Clarified that States with approved payment methodologies before October 1, 1999 and subsequently amended may select either transition option.

- Modified the short transition period in § 447.272(e) and § 447.321(e) so that it does not erroneously does not make reference to States with excessive payment amendments approved after the publication date of the rule.

- Modified the transition period in § 447.272(e) and § 447.321(e) to add a third transition period for State plan amendments effective on or before October 1, 1992 based on section 705 of BIPA.

- Added §§ 447.272(f) and 447.321(f) to include reporting requirements for States that make Medicaid payments to non-State public providers and providers within the groups of providers that exceed the UPL during the transition period on a facility specific basis.

- Specified in the preamble that residential treatment facilities are governed by regulations at § 447.325, "Other inpatient and outpatient facility services: Upper Limits of Payment.

- Clarified that the institutional UPL specified in the final rule will continue to apply only to fee-for-service payments, and we made it clear that it is not appropriate to include managed care services and payments in the UPL specified in this regulation.

- Specified that changes in the budget neutrality ceilings for section 1115 demonstration programs become effective upon the effective date of the new law or regulation that necessitated the change.

- Clarified in the preamble that these UPLs do not regulate IGTs.

- Revised the regulations to update our references to the Balanced Budget Act of 1997 legislation for DSH requirements. (See § 447.272(c)(3) and § 447.321(c)(3))

VI. Collection of Information Requirements—Paperwork Reduction Act

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to solicit public comment when a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirements discussed below.

Section 447.272 Inpatient Services: Application of Upper Payment Limits

For payments that exceed the 100 percent limit, the agency must annually report to HCFA the total Medicaid payments made to each hospital described under paragraph (c)(1) of this section and the reasonable estimate of the amount that would be paid for the services furnished by each hospital under Medicare payment principles. In addition, States that are eligible for a transition period described in paragraph (e) of this section, and that make payment that exceed the limit under paragraph (b) of this section, must report annually to HCFA the total

Medicaid payments made to each Facility and a reasonable estimate of the amount that would be paid for the services furnished by the facility under Medicare payment principles.

It is estimated that there will be approximately 57 State agency reports submitted on an annual basis and that it will take 8 hours per instance to submit the reporting requirements to HCFA. The total amount burden associated with this requirement is 456 hours.

Section 447.321 Outpatient Hospital Services: Application of Upper Payment Limits.

For payments that exceed the 100 percent limit, the agency must annually report to HCFA the total Medicaid payments made to each hospital described under paragraph (c)(1) of this section and the reasonable estimate of the amount that would be paid for the services furnished by each hospital under Medicare payment principles. In addition, States that are eligible for a transaction period described in paragraph (e) of this section, and that make payment that exceed the limit under paragraph (b) of this section, must report annually to HCFA the total Medicaid payments made to each Facility and a reasonable estimate of the amount that would be paid for the services furnished by the facility under Medicare payment principles.

It is estimated that there will be approximately 31 State agency reports submitted on an annual basis and that it will take 8 hours per instance to submit the reporting requirements to HCFA. The total annual burden associated with this requirement is 248 hours.

We have submitted a copy of this final rule to OMB for its review of the information collection requirements in §§ 447.272 and 447.321. These requirements are not effective until they have been approved by OMB.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and 3 copies within 30 days of this publication date directly to the following:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room N2-14-26, 7500 Security Boulevard, Baltimore, MD 21244-1850. Attn: John Burke HCFA-2071-F; Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, HCFA Desk Officer.

VII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impact of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Public Law 96-354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any one year). We consider this final rule to be a major rule and we have provided an analysis below.

The RFA requires agencies to analyze options for regulatory relief of small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$5 million or less annually. For purposes of the RFA, many hospitals, nursing facilities and intermediate care facilities are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural

hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million. We do not believe that this threshold applies for this final rule.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We do not believe this final rule in any way imposes substantial direct compliance costs on State and local governments or preempts or supersedes State or local law.

As we explained in the proposed rule and reiterate in more detail below, the impact of the new UPLs are highly uncertain. To be impacted by the regulation, a State would have to be making payments to government providers as a class that substantially exceed a reasonable estimate of the costs expected to be incurred based on the volume of services furnished to Medicaid eligible individuals by that class of providers.

A. Anticipated Effects

Effects on States and Medicaid programs

In this final regulation we have attempted to estimate the aggregate impact these new rules will have on Federal reimbursements to States for Medicaid expenditures.

Impact on the Federal Budget Baseline

The estimated impact of this final rule on the President's FY 2001 budget baseline is shown in the table below:

[Dollars in Billions]

	FFY 2001	FFY 2002	FFY 2003	FFY 2004	FFY 2005	FFY 2006	Total
Federal Share of Enhanced payments in Medicaid FY 2001 budget baseline ¹	2.9	3.0	3.2	3.3	3.5	3.6	19.5
Estimated payments in excess of UPL ²	1.9	2.0	2.1	2.2	2.3	2.5	13.0
Estimated reduction in FFP as a result of phase-down of excess payments ³	0.0	-0.2	-0.6	-1.1	-1.6	-2.0	-5.4
Estimated increase in FFP from raising UPL for hospitals ⁴	0.1	0.4	0.6	0.8	1.0	1.1	4.0
Net change in FFP (sum of previous two lines—may not add due to rounding)	0.1	0.2	0.0	-0.3	-0.5	-0.9	-1.4

¹ Derived from fiscal estimates submitted with State plan amendments approved by HCFA before 10/1/99; projected using President's FY 2001 budget growth rates.

²Based on data on government non-State providers from Online Survey and Certification Reporting System (OSCAR) and Medicaid financial management data.

³Calculated using transition UPL formula described in this rule (See Table illustrative example.)

⁴FFP on increase in spending anticipated as a result of raising the UPL for hospital services from 100 percent to 150 percent of what would be paid using Medicare payment principles.

As indicated in the table, these estimates have been derived from a number of sources, including the States' own estimates of the fiscal impact of enhanced payment arrangements, data on the number and types of providers of nursing home and inpatient and outpatient hospital services, Medicaid financial management data, and Medicaid budget projections developed for the President's FY 2001 budget. In addition, we also consulted draft reports, prepared by the Inspector General of the Department of Health and Human Services, on the use of intergovernmental transfers to finance enhanced Medicaid payments.

We have identified 29 States with approved and/or pending rate proposals that target enhanced Medicaid payments to hospitals and NF facilities that are owned or operated by county or local governments. There are 18 States with approved State plan amendments or waivers and 5 States with pending plan amendments. In addition, there are 6 States that have both approved and pending plan amendments. We estimate that these proposals currently account for approximately \$4.5 billion in Federal spending in FY 2001. This estimate is based on State-reported Federal fiscal information submitted with State plan amendments and State expenditure information where available. It may be understated or overstated to the degree that actual State expenditures would vary from the estimates included with State plan submissions. For example, a State could include a provision in its State Medicaid plan that would enable it to spend up to allowable amounts by making additional payments to designated facilities. Under this scenario, if the upper payment limitation permitted the State to spend an additional \$200 million, the actual annual expenditure could vary from zero to \$200 million depending upon the State's willingness to finance its share of the payment.

As indicated in the table above, we estimate that about \$2.9 billion of this \$4.5 billion in FY 2001 is currently reflected in the Medicaid budget baseline, and that about two-thirds of this amount (\$1.9 billion in FFY 2001) currently exceeds the upper payment limit imposed by this rule. These excess payments will be phased down beginning in FY 2002 and, as shown in

the table, are projected to result in a cumulative FFP reduction of \$5.4 billion by FY 2006. (Note: Our estimates do not include excess payment amounts subject to the 2-year transition period for non-compliant plan amendments effective on or after October 1, 1999, since these payment amounts are not included in the President's FY 2001 budget baseline. According to fiscal impact estimates submitted with State plan amendments, these plans entail about \$0.9 billion in annual FFP for enhanced payments.) Because some States may be using the Federal share of enhanced payments in a manner that allows some funds to be reinvested in Medicaid (and thereby drawing down additional FFP), the potential impact of this reduction in FFP may extend to other Medicaid services not reflected in the above spending.

It is important to note that, although it will reduce FFP on excess enhanced payments as estimated above, this regulation does not reduce the overall aggregate amount States can spend on Medicaid services or place a fixed ceiling on the amount of State spending that will be eligible for Federal matching dollars. Under the limitations in this final rule, States will be able to set reasonable rates as determined under Medicare payment principles for Medicaid services furnished by public facilities to eligible individuals. The amount of spending permitted under the limits will vary directly with the amount of Medicaid services furnished by public facilities to eligible individuals. While this final rule does not affect the overall aggregate amount States can spend, by setting an upper payment limit for government facilities, it may impact how States distribute available funding to participating health care facilities.

In addition to potential reductions in FFP, this rule will also provide opportunities for increased spending through the provisions which increase the UPL for non-State government-owned or operated hospitals to 150 percent of the amount which would have been paid for inpatient or outpatient services under Medicare payment principles. As shown in the table, based on current projections of Medicaid fee-for-service inpatient and outpatient expenditures, we estimate that increasing payment rates for these services to 150 percent of Medicare-

based rates could add \$4 billion to federal reimbursements for State Medicaid expenditures over the next six years.

Impact on Medicaid Spending Beyond the Current Budget Baseline

Projections completed since the President's FY 2001 budget now indicate that the Federal share of enhanced payments to government facilities that are not State-owned or operated could reach \$10 billion per year by FY 2006 and may account for cumulative spending of more than \$90 billion over the next ten years. These projections include States with approved or pending plan amendments and assume that one-half of the remaining States would eventually submit amendments providing for enhanced payments in the absence of these revised rules.

Based on the preceding budget analysis, potentially two-thirds of these enhanced payments could be in excess of the upper payment limits imposed by this final rule and could result in FFP reductions of nearly \$55 billion over the next 10 years.

Since our estimates of the potential impact of the policies implemented by this regulation exceed \$100 million annually, we consider this final rule to be a major rule.

Audit Results From the Office of the Inspector General (OIG)

Earlier this year, OIG initiated audits on 7 hospital and nursing facility rate enhancement programs in 6 States. The OIG has completed and forwarded draft audit reports to HCFA on 4 nursing facility programs. These audit reports provide considerable detail on each State's enhancement program. The reports also illustrate how each audited program would be impacted if States reduced payments to the new allowable UPL levels and chose not to reinvest the excess payments to support other Medicaid activities that are eligible for Federal matching. In the table below, we have listed the dollar amounts associated with each State's enhancement program. The table shows the base amount, the new UPL at the end of the transition period, and the amount in the base that exceeds the new UPL.

OIG STATE REPORT
[Dollars in millions]

State	Base enhancement	New UPL amount	Excess above UPL
Pennsylvania	\$858	\$127	\$731
Alabama	28.8	1.55	27.25
Nebraska	47.6	11	36.6
Washington State	76.2	2.8	73.4
Total	1005.6	142.35	863.25

C. Effects on Providers

The chart below indicates the types and number of providers potentially affected by this final rule in all 50 States and the District of Columbia. We included facilities in all 50 States

because although not every State is currently making enhanced payments to government non-State-owned or -operated facilities, this rule will prevent new proposals from all States in the future. We do not believe any State

has payment arrangements with providers of ICF/MR services or clinic services that will be affected by this final rule and, therefore, we did not include those providers in the chart below.

POTENTIALLY AFFECTED PROVIDERS BY NUMBER AND TYPE

Provider type	Government State-owned or operated	Government Non-State-owned or operated	Total
Nursing Facilities	¹ N/A	892	892
Hospitals	² 254	1,275	1,529

¹ These facilities are already subject to a separate aggregate upper payment limit and will not be affected by the final rule.

² Only hospitals that provide outpatient hospital services may be impacted as inpatient hospital services are already subject to a separate aggregate limit.

As explained earlier in the preamble, it is very difficult to predict how States will respond to this final rule and consequently how State decisions will impact Medicaid providers. Each State makes its own budgetary and rate setting decisions. Since we do not collect information about the specific services that facilities use Medicaid payments to support, we cannot determine how potential payment rate adjustments will affect providers or the patients they serve. Under the upper payment limits in this final rule, States will continue to be able to set rates that provide fair compensation for Medicaid services furnished to Medicaid patients. In addition, hospitals owned or operated by local governments could still receive higher payments than other hospitals since this rule provides for a higher upper payment limit for the facilities. We believe this will ensure Medicaid access to the safety-net providers and minimize the impact on those providers. Additionally, if these hospitals furnish services to indigent patients, they may qualify as a DSH and qualify for funding under a State's program.

With respect to the impact on small rural hospitals, we do not believe the final rule will have a significant overall impact on rural hospitals. With respect to Medicaid services furnished by rural

hospitals, the upper payment limits in the final rule do not interfere with States setting rates that result in fair compensation. Additionally, rural hospitals that are owned or operated by local governments should be able to benefit from the higher upper payment limits for inpatient and outpatient hospital services. Finally, if a rural hospital provides services to indigent patients, they may qualify as a DSH and qualify for funding under a State's DSH payment program.

D. Alternatives Considered

Section 1902(a)(30) of the Act requires in part that Medicaid service payments be consistent with efficiency and economy. In addition to the interpretation we are providing in this final rule, we considered several other alternatives to ensure Medicaid service payments are consistent with economy and efficiency. In this section, we will explain these other alternatives and why we did not select them.

1. Facility-Specific Upper Payment Limit

Under this option, Medicaid spending would be limited to a provider-specific application of Medicare payment principles. FFP would not be available on the amount of Medicaid service payment in excess of what a provider

would have been paid using Medicare payment principles. These limits would be applied to all institutions, or just to public institutions where the incentives for overpayment are significant. While a facility-specific limitation may be the most effective method to ensure State service payments are consistent with economy and efficiency, when balanced against the additional administrative requirements on States and HCFA, coupled with Congressional intent for States to have flexibility in rate setting, we are not sure that the increased amount of cost efficiency, if any, justifies this approach as a viable option.

2. Government-Owned or Operated Facilities Upper Payment Limit

This option would limit, in the aggregate, the amount of payment States can make to public providers. Under this option, State and local government providers would be grouped together and payments to them as a group could not exceed an aggregate limit. The aggregate limit would continue to be based on Medicare payment principles. This option, relative to upper payment limitations provided in this final rule, would have allowed States to exercise more flexibility granted to them in the rate setting process. While this option permits more flexibility, we believe the

aggregation of Medicaid service payments by all types of government providers would have the unintended consequence of reopening differential rate issues between State facilities and other types of government facilities.

3. Intergovernmental Transfers (IGTs)

Because in many cases we believe there is a connection between excessive payments and IGTs, we gave consideration to formulating policy with respect to them. Generally, States have a genuine incentive to set Medicaid service rates at levels consistent with economy and efficiency since they share the financial responsibility with the Federal Government. However, as explained earlier, the ability of government counties to make IGTs create incentives for States to overpay these government facilities to generate enhanced Federal matching payment. However, we did not pursue this alternative because we recognize that States, counties, and cities have developed their own unique arrangements for sharing in Medicaid costs. Furthermore, there are statutory limitations placed on the Secretary which limit the authority to place restrictions on IGTs.

4. "Grandfathering" Existing Arrangements

Under this option, we would not approve any new plan amendments after the effective date of the final rule but would allow those that have been approved to continue operating. This would permit States that are currently making excessive payments to local government facilities to continue making such payments indefinitely. However, allowing some States to permanently continue making excessive payments solely because they were approved before this rule is published and effective appears to be arbitrary, capricious, and inconsistent with our administrative authority.

E. The Unfunded Mandates Act

The Unfunded Mandate Reform Act of 1995 also requires (in section 202) that agencies perform an assessment of anticipated costs and benefits before proposing a rule that may result in a mandated expenditure in any one year by State, local, or Tribal governments, in aggregate, or by the private sector, of \$100 million. Absent FFP, we do not believe States will continue to set excessive payment rates for Medicaid services furnished by government providers. Generally, discontinuing an expenditure should not result in new costs, unless the State has to fund the portion of the expenditure that is no

longer Federally funded with all State and local dollars. There are no Federal requirements under the Medicaid statute that mandate States to make these types of excessive Medicaid payments to public providers. To the contrary, the Medicaid statute requires that Medicaid plans ensure that payments to providers under the State Medicaid plan are consistent with efficiency and economy. Under the standard set forth in this rule, State Medicaid payments to providers under the State Medicaid plan may be set at levels that are consistent with efficiency and economy, and no additional payments are required. We do not believe the aggregate upper payment limits in this final rule have any unfunded mandate implications because they do not require any additional expenditures by States to providers under their Medicaid program.

F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct compliance costs on State and local governments, preempts State law, or otherwise has Federalism implications. In developing the interpretative policies set forth in this final rule, we met with interested parties and listened to their ideas and concerns. These discussions were held with members of Congress and their staff and with various associations representing State and local governments, including the National Governors' Association, the National Conference of State Legislatures, and the National Association of State Medicaid Directors. In addition, we met with many hospital associations, advocacy groups, labor organizations, and numerous other interested parties.

G. Conclusion

The financial implications of this final rule are highly uncertain for the reasons we have previously indicated. We anticipate that many State Medicaid programs will be unaffected by the upper payment limits. With respect to affected States, to some degree we will be limiting flexibility in the management of their Medicaid programs. If these States wish to continue to make payments in excess of the aggregate upper payment limits, they will have to fund the excess amount with only State and local resources. In the absence of FFP, we anticipate States will reinvest these resources to support other Medicaid activities to take advantage of and maintain Federal resources. Should

States realign their payment systems or divert State matching dollars to support other Medicaid activities, the total amount of available Federal funds should remain unchanged.

Executive Order 12866

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs—health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR part 447 is amended as set forth below:

PART 447—PAYMENTS FOR SERVICES

1. The authority citation for part 447 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section § 447.272 is revised to read as follows:

§ 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 rule.* 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 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.

(c) *Exceptions—(1) Non-State government-owned or operated hospitals.* The aggregate Medicaid payments may not exceed 150 percent of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles in subchapter B of this chapter.

(2) *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).

(3) *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 date.* 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 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 maximum payment level under the upper payment limit described in paragraph (b) 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 approved plan provisions that are effective on or after October 1, 1999, payments may exceed the 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.

(8) 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.

(iii) 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.

(f) *Reporting requirements.* If the reporting requirements in paragraphs (f)(1) and (f)(2) of this section apply, a State must include payments for services furnished during the entire State FY.

(1) *Non-State government-owned or operated hospitals.* If a State makes payments to a group of facilities in this category that exceed the limit under paragraph (b) of this section, the agency must annually report the following information to HCFA:

(i) The total Medicaid payments made to each hospital described under paragraph (c)(1) of this section.

(ii) The reasonable estimate of the amount that would be paid for the services furnished by each hospital under Medicare payment principles.

(2) *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 limit under paragraph (b) of this section, must report annually the following information to HCFA:

(i) The total Medicaid payments made to each facility.

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

3. Section 447.304 is amended by revising paragraph (c) and the note that follows paragraph (c) to read as follows:

§ 447.304 Adherence to upper limits; FFP.

* * * * *

(c) FFP is not available for a State's expenditures for services that are in excess of the amounts allowable under this subpart.

Note: The Secretary may waive any limitation on reimbursement imposed by subpart F of this part for experiments conducted under section 402 of Pub. L. 90-428, Incentives for Economy Experimentation, as amended by section 222(b) of Pub. L. 92-603, and under section 222(a) of Pub. L. 92-603.

4. Section 447.321 is revised to read as follows:

§ 447.321 Outpatient hospital and clinic services: Application of upper payment limits.

(a) *Scope.* This section applies to rates set by the agency to pay for outpatient services furnished by hospitals and clinics 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 rule.* Except as provided for 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 a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles specified in subchapter B of this chapter.

(c) *Exceptions—(1) Non-State government-owned or operated*

hospitals. The aggregate Medicaid payments may not exceed 150 percent of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles in subchapter B of this chapter.

(2) *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).

(d) *Compliance date.* 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 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 maximum payment level under the upper payment limit described in paragraph (b) of this section for the referenced year.

(iii) *X* stands for the payments to a specific group of providers described in paragraph (a) 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 paragraph (a) of this section may follow the respective transition schedule:

(A) For approved plan provisions that are effective on or after October 1, 1999, payments may exceed the 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.

(8) 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.

(iii) 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.

(f) *Reporting requirements.* If the reporting requirements in paragraphs (f)(1) and (f)(2) of this section apply, a State must include payments for services furnished during the entire State FY.

(1) *Non-State government-owned or operated hospitals.* If a State makes payments to a group of facilities in this category that exceed the limit under paragraph (b) of this section, the agency must annually report the following information to HCFA:

(i) The total Medicaid payments made to each hospital described under paragraph (c)(1) of this section.

(ii) The reasonable estimate of the amount that would be paid for the services furnished by each hospital under Medicare payment principles.

(2) *Payments during the transition periods.* States that are eligible for a transition period described in paragraph (e) of this section, and that make payment that exceed the limit under paragraph (b) of this section, must report annually the following information to HCFA:

(i) The total Medicaid payments made to each facility.

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

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: December 20, 2000.

Robert A. Berenson,

Acting Deputy Administrator, Health Care Financing Administration.

Dated: December 20, 2000.

Donna E. Shalala,

Secretary.

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