DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 433, 447, and 457

[CMS-2258-P]

RIN 0938-A057

Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would: clarify that entities involved in the financing of the non-Federal share of Medicaid payments must be a unit of government; clarify the documentation required to support a certified public expenditure; limit reimbursement for health care providers that are operated by units of government to an amount that does not exceed the provider's cost; require providers to receive and retain the full amount of total computable payments for services furnished under the approved State plan; and make conforming changes to provisions governing the State Child Health Insurance Program (SCHIP). The provisions of this regulation apply to all providers of Medicaid and SCHIP services, except that Medicaid managed care organizations and

SCHIP providers are not subject to the cost limit provision of this regulation. Except as noted above, all Medicaid payments (including disproportionate share hospital payments) made under the authority of the State plan and under Medicaid waiver and demonstration authorities are subject to all provisions of this regulation.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [OFR—insert date 60 days after the date of publication in the **Federal Register**].

ADDRESSES: In commenting, please refer to file code CMS-2258-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. Electronically. You may submit electronic comments on specific issues in this regulation to http://www.cms.hhs.gov/eRulemaking. Click on the link "Submit electronic comments on CMS regulations with an open comment period." (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. By regular mail. You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2258-P,

P.O. Box 8017,

Baltimore, MD 21244-8017.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2258-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201; or

7500 Security Boulevard,

Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Aaron Blight, (410) 786-9560.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS-2258-P and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://www.cms.hhs.gov/eRulemaking. Click on the link "Electronic Comments on CMS Regulations" on that Web site to view public comments.

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday

through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

The Medicaid program is a cooperative Federal-State program established in 1965 for the purpose of providing Federal financial participation (FFP) to States that choose to reimburse certain costs of medical treatment for needy persons. It is authorized under title XIX of the Social Security Act (the Act), and is administered by each State in accordance with an approved State plan. States have considerable flexibility in designing their programs, but must comply with Federal requirements specified in the Medicaid statute, regulations, and program guidance.

FFP is provided only when there is a corresponding State expenditure for a covered Medicaid service to a Medicaid recipient. Federal payment is based on statutorily-defined percentages of total computable State expenditures for medical assistance provided to recipients under the approved State plan, and of State expenditures related to the cost of administering the State plan.

Since the summer of 2003, we have reviewed and processed over 1,000 State plan amendments related to State payments to

providers. Of these, approximately 10 percent have been disapproved by the Centers for Medicare & Medicaid Services (CMS) or withdrawn by the States. Through examination of these State plan amendments and their associated funding arrangements, we have developed a greater understanding of how to ensure that payment and financing arrangements comply with statutory intent. As recently articulated by the U. S. Court of Appeals for the Ninth Circuit, "[t]he statutory text makes clear that the Secretary has the authority—indeed, the obligation—to ensure that each of the statutory prerequisites is satisfied before approving a Medicaid State plan amendment." We believe that this proposed rule strengthens accountability to ensure that statutory requirements within the Medicaid program are met in accordance with sections 1902, 1903, and 1905 of the Act.

Sections 1902(a)(2), 1903(a) and 1905(b) of the Act require States to share in the cost of medical assistance and in the cost of administering the State plan. Under section 1905(b) of the Act, the Federal medical assistance percentage (FMAP) is defined as "100 per centum less the State percentage," and section 1903(a) of the Act requires Federal reimbursement to the State of the FMAP of expenditures for medical assistance under the plan (and 50 percent of

expenditures necessary for the proper and efficient administration of the plan). Section 1902(a)(2) of the Act and implementing regulations at 42 CFR 433.50(a)(1) require States to share in the cost of medical assistance expenditures but permit the State to delegate some responsibility for the non-Federal share of medical assistance expenditures to units of local government under some circumstances.

Under Pub. L. 102-234, which inserted significant restrictions on States' use of provider related taxes and donations at section 1903(w) of the Act, the Congress again recognized the ability of units of government to participate in the funding of the non-Federal share of Medicaid payments through an exemption at section 1903(w)(6)(A) of the Act that reads:

> Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

Subsequent regulations implementing Pub. L. 102-234 give effect to this statutory language. Amendments made to the regulations at 42 CFR. part 433, at 47 FR 55119 (November 24, 1992) explained:

> Funds transferred from another unit of State or local government which are not restricted by the statute are not considered a provider-related donation or health care-related tax. Consequently, until the Secretary adopts regulations changing the treatment of intergovernmental transfer, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).

The above statutory and regulatory authorities clearly specify that in order for an intergovernmental transfer (IGT) or certified public expenditure (CPE) from a health care provider or other entity to be exempt from analysis as a provider-related tax or donation, it must be from a unit of State or local government. Section 1903(w)(7)(G) of the Act identifies the four types of local entities that, in addition to the State itself, are considered a unit of government: a city, a county, a special purpose district, or other governmental units in the State. The provisions of this proposed rule conform our regulations to the aforementioned

statutory language and further define the characteristics of a unit of government for purposes of Medicaid financing.

Intergovernmental Transfer (IGT).

The Medicaid statute does not define an IGT, but the plain meaning in the Medicaid context is a transfer of funding from a local governmental entity to the State. As we discuss below, this meaning would not include a transaction that does not in fact transfer funding but simply refunds Medicaid payments. IGTs from units of government that meet the conditions for protection under section 1903(w)(6)(A) of the Act, as described above, are a permissible source of State funding of Medicaid costs. Section 1903(w)(6)(A) of the Act is an exception to the very restrictive requirements governing provider-related donations. The IGT provision was meant to continue to allow units of local government, including government health care providers, to share in the cost of the State Medicaid program.

At section 1903(w)(6)(A) of the Act, the Medicaid statute provides that units of government within a State may transfer State and/or local tax revenue to the Medicaid agency for use as the non-Federal share of Medicaid payments. Because this provision does not override the definition of an expenditure as a net outlay, as discussed below, claimed expenditures must

be net of any redirection or assignment from a health care provider to any State or local governmental entity that makes IGTs to the Medicaid agency. Generally, for the State to receive Federal matching on a claimed Medicaid payment where a governmentally operated health care provider has transferred the non-Federal share, the State must be able to demonstrate: (1) that the source of the transferred funds is State or local tax revenue (which must be supported by consistent treatment on the provider's financial records); and (2) that the provider retains the full Medicaid payment and is not required to repay, or in fact does not repay, all or any portion of the Medicaid payment to the State or local tax revenue account.

Under section 1903(a)(1) of the Act, the Federal government pays a share of State expenditures for medical assistance. Consistent with Office of Management and Budget (OMB) Circular A-87, an expenditure must be net of all "applicable credits" which include discounts, rebates, and refunds. Since the summer of 2003, we have examined Medicaid State financing arrangements across the country, and we have identified numerous instances in which health care providers did not retain the full amount of their Medicaid payments but were required to refund or return a portion of the payments received, either directly or indirectly. Failure by the

provider to retain the full amount of reimbursement is inappropriate and inconsistent with statutory construction that the Federal government pay only its proportional cost for the delivery of Medicaid services. When a State claims Federal reimbursement in excess of net payments to providers, the FMAP rate has effectively been increased. To the extent that these State practices have come to light through the State plan amendment process, we have systematically required the States to eliminate these financing arrangements.

Therefore, we have concluded that requirements that a governmentally-operated health care provider transfer to the State more than the non-Federal share of a Medicaid payment creates an arrangement in which the net payment to the provider is necessarily reduced; the provider cannot retain the full Medicaid payment claimed by the State. This practice is not consistent with section 1902(a)(30)(A) of the Act.

We have found instances in which the State or local government has used the funds returned by the health care provider for costs outside the Medicaid program or to help draw additional Federal dollars for other Medicaid program costs. The Government Accountability Office (GAO) and the Department of Health and Human Services Office of Inspector General (OIG) have reviewed these practices and shared our

concerns that they are not consistent with Medicaid financing requirements. The net effect of this re-direction of Medicaid payments is that the Federal government incurs a greater level of Medicaid program costs, which is inconsistent with the FMAP. This is because the claimed expenditure, which is matched by the Federal government according to the FMAP rate, is actually greater than the net expenditure, effectively producing an increase in the FMAP rate.

Some States and providers have defended the practices in question as means for financing the cost of providing services to non-Medicaid populations or financing public health activities or even justifying what they consider to be "unfair" FMAPs. Whether the Federal Medicaid program should participate in a general way in that financing, however, is an important decision that the Congress has not expressly addressed. As we discuss below, the Congress has expressly provided for certain kinds of limited Federal participation in the costs of providing services to non-Medicaid populations and public health activities.

Examples of limited congressional authorization of Federal financing for non-Medicaid populations and public health activities include the following. The Congress authorized disproportionate share hospital (DSH) payments to

assist hospitals that serve a disproportionate share of low income patients which may include hospitals that furnish significant amounts of inpatient hospital services and outpatient hospital services to individuals with no source of third party coverage (that is, the uninsured). Under section 4723 of the Balanced Budget Act of 1997, the Congress also provided direct funding to the States to offset expenditures on behalf of aliens. Additional funding for payments to eligible providers for emergency health services to undocumented aliens was also provided by Congress under section 1011 of the Medicare Modernization Act. The Congress has periodically, and as recently as the Deficit Reduction Act of 2005 (DRA, Pub. L. 109-171, enacted on February 8, 2006), adjusted FMAPs for certain States and certain activities such as an enhanced FMAP to create incentives for States to assist individuals in institutions return to their homes. These examples are provided to illustrate that the Congress has previously authorized limited Federal financing of non-Medicaid populations and public health activities, but has not to date authorized wider use of Federal Medicaid funding for these purposes.

Indeed, the Congress indicated that Medicaid funding was not to be used for non-Medicaid purposes when in the Balanced

Budget Act of 1997 (BBA, Pub.L.105-33, enacted on August 5, 1997), it added section 1903(i)(17) to the Act to prohibit the use of FFP "with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this title." Non-Medicaid populations and non-Medicaid services simply are not eligible for Federal reimbursements except where expressly provided for by the Congress.

We believe the lack of transparency and accountability undermine public confidence in the integrity of the Medicaid program as it is extremely difficult to track the flow of taxpayer dollars. These arrangements, regardless of the merits, are hidden in archaic, nearly indecipherable language that may be further re-interpreted over time, placing Federal and State dollars at risk as well as creating tensions and conflicts among the States.

Certified Public Expenditure (CPE).

As we have worked with States to promote appropriate Medicaid financing, it has become apparent that an increasing number of States are choosing to use CPEs as a method of financing the non-Federal share. Therefore, we are taking this opportunity to review key provisions governing the use of CPEs.

A discussion about CPEs begins with the concept of an expenditure. The term "expenditure" is defined in timing rules at 45 CFR 95.13. According to 45 CFR 95.13(b), for expenditures for services under the Medicaid program, an expenditure is made "in the quarter in which any State agency made a payment to the service provider." There is an alternate rule for administration or training expenditures at 45 CFR 95.13(d), under which the expenditure is made in the quarter to which the costs were allocated or, for non-cash expenditures, in the quarter in which "the expenditure was recorded in the accounting records of any State agency in accordance with generally accepted accounting principles." In the State Medicaid Manual, at section 2560.4.G.1.a(1), we indicated that "the expenditure is made when it is paid or recorded, whichever is earlier, by any State agency." In either case, there must be a record of an actual expenditure, either through cash or a transfer of funds in accounting records. It is clear from these authorities that an expenditure must involve a shift of funds (either by an actual transfer or a debit in the accounting records of the contributing unit of government and a credit in the records of a provider of medical care and services) and cannot merely be a refund or reduction in accounts receivable.

Furthermore, provisions at §433.51 clearly state that the CPE must, itself, be "eligible for FFP." In keeping with this language, there must be a provision in the State plan that would authorize the State to make the expenditure itself if the certifying governmental unit had not done so. In other words, a CPE must be an expenditure by another unit of government on behalf of the single State Medicaid agency.

A CPE equals 100 percent of a total computable Medicaid expenditure, and the Federal share of the expenditure is paid in accordance with the appropriate FMAP rate. In a State with a 60 percent FMAP rate, the CPE would be equal to $100 in order to draw down $60 in FFP.

The approach a unit of government can permissibly take to a CPE depends on whether or not the unit of government is the provider of the service. A governmental non-provider that pays for a covered Medicaid service furnished by a provider (whether governmental or not) can certify its actual expenditure, in an amount equal to the State plan rate (or the approved provisions of a waiver or demonstration, if applicable) for the service. In this case, the CPE would represent the expenditure by the governmental unit to the service provider (and would not necessarily be related to the actual cost to the provider for providing the service).

If the unit of government is the health care provider, then it may generate a CPE from its own costs if the State plan (or the approved provisions of a waiver or demonstration, if applicable) contains an actual cost reimbursement methodology. If this is the case, the governmental provider may certify the costs that it actually incurred that would be paid under the State plan. If the State plan does not contain an actual cost reimbursement methodology, then the governmental provider may not use a CPE because it would not be able to establish an expenditure under the plan, consistent with the requirements of 45 CFR 95.13, where there was no cost incurred that would be recognized under the State plan. A provider cannot establish an expenditure under the plan by asserting that it would pay itself.

As part of the review of proposed State plan amendments and focused financial reviews, we have examined CPE arrangements in many States that include various service categories within the Medicaid program. We note that currently there are a variety of practices used by State and local governments in submitting a CPE as the basis of matching FFP for the provision of Medicaid services. Different practices often make it difficult to (1) align claimed expenditures with specific services covered under the State

plan or identifiable administrative activities; (2) properly identify the actual cost to the governmental entity of providing services to Medicaid recipients or performing administrative activities; and (3) audit and review Medicaid claims to ensure that Medicaid payments are appropriately made. Further, we find that in many instances State Medicaid agencies do not currently review the CPE submitted by another unit of government to confirm that the CPE properly reflects the actual expenditure by the unit of government for providing Medicaid services or performing administrative activities. These circumstances do not serve to advance or promote the fiscal integrity of the Medicaid program. By establishing minimum standards for the documentation supporting CPEs, we anticipate that this proposed rule would serve to enhance the fiscal integrity of CPE practices within the Medicaid program.

State and Local Tax Revenue.

As explained previously, the Medicaid statute recognizes State and/or local tax revenue as a permissible source of the non-Federal share of Medicaid expenditures. In order for State and/or local tax dollars to be eligible as the non-Federal share of Medicaid expenditures, that tax revenue cannot be committed or earmarked for non-Medicaid activities. Tax revenue that is contractually obligated between a unit of

State or local government and health care providers to provide indigent care is not considered a permissible source of non-Federal share funding for purposes of Medicaid payments. Health care providers that forego generally applicable tax revenue that has been contractually obligated for the provision of health care services to the indigent or for any other non-Medicaid activity, which is then used by the State or local government as the non-Federal share of Medicaid payments, are making provider-related donations. Any Medicaid payment linked to a provider-related donation renders that provider-related donation non-bona fide.

State Child Health Insurance Program (SCHIP)

Section 2107(e)(1)(C) of the Act stipulates that section 1903(w) applies to the SCHIP program as well as Medicaid. Accordingly, SCHIP regulations at 42 CFR 457.628 incorporate by reference the provisions at 42 CFR 433.51 through 433.74 concerning the source of the non-Federal share and donations and taxes. Moreover, SCHIP rules at 42 CFR 457.220 mirror the language in 42 CFR 433.51.

II. Provisions of the Proposed Rule

The background section conveys critical information about the statutory and regulatory context of this proposed rule. We are proposing this rule specifically to (1) clarify that

only units of government are able to participate in the financing of the non-Federal share; (2) establish minimum requirements for documenting cost when using a CPE; (3) limit providers operated by units of government to reimbursement that does not exceed the cost of providing covered services to eligible Medicaid recipients; (4) establish a new regulatory provision explicitly requiring that providers receive and retain the total computable amount of their Medicaid payments; and (5) make conforming changes to the SCHIP regulations.

The provisions of this regulation apply to all providers of Medicaid and SCHIP services, except that Medicaid managed care organizations and SCHIP providers are not subject to the cost limit provision of this regulation. Except as noted above, all Medicaid payments (including disproportionate share hospital payments) made under the authority of the State plan and under Medicaid waiver and demonstration authorities are subject to all provisions of this regulation.

Defining a Unit of Government (§433.50)

We are proposing to add new language to §433.50 to define a unit of government to conform to the provisions of section 1903(w)(7)(G) of the Act. As discussed earlier, section 1903(w)(7)(G) of the Act identifies the five types of units of government that may participate in the non-Federal

share of Medicaid payments: a State, a city, a county, a special purpose district, or other governmental units within the State. The proposed provisions at §433.50 are modified to be consistent with this statutory reference. The newly proposed regulatory definition of unit of government includes:

- Any State or local government entity (including Indian tribes) that can demonstrate it has generally applicable taxing authority, and
- Any State-operated, city-operated, county-operated, or tribally-operated health care provider.

Under the proposed rule, health care providers that assert status to make IGTs or CPEs as a "special purpose district" or some form of "other" local government must demonstrate they are operated by a unit of government by showing that:

- The health care provider has generally applicable taxing authority; or
- The health care provider is able to access funding as an integral part of a governmental unit with taxing authority (that is legally obligated to fund the governmental health care provider's expenses, liabilities, and deficits), so that

- A contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues.

In some cases, evidence that a health care provider is operated by a unit of government must be assessed by examining the relationship of the unit of government to the health care provider. If the unit of government appropriates funding derived from taxes it collected to finance the health care providers general operating budget (which would not include special purpose grants, construction loans, or other similar funding arrangements), the provider would be considered governmentally operated. The inclusion of a health care provider as a component unit on the government's consolidated annual financial report indicates the governmentally operated status of the health care provider. If the unit of government merely uses its funds to reimburse the health care provider for the provision of Medicaid or other services, that alone is not sufficient to demonstrate that the entity is a unit of government. The unit of government must have a greater role in funding the entity's operations, including its expenses, liabilities, and deficits.

In recent reviews, we have found that health care providers asserting status as a "special purpose district" or

"other" local government unit often do not meet this definition. Although the special purpose district or a unit of government with taxing authority may be required, either by law or contract, to provide limited support to the health care provider, the health care provider is an independent entity and not an integral part of the unit of government. Typically, the independent entity will have liability for the operation of the health care provider and will not have access to the unit of government's tax revenue without the express permission of the unit of government. Some of these types of health care providers are organized and operated under a not-for-profit status. Under these circumstances, the independently operated health care provider cannot participate in the financing of the non-Federal share of Medicaid payments, whether by IGT or CPE, because such arrangements would be considered provider-related donations.

The rule also includes language in §433.50 referencing that units of government may participate in the financing of the non-Federal share of Medicaid expenditures.

Sources of State Share and Documentation of Certified Public Expenditures. (§433.51(b))

This rule proposes to amend the provisions of §433.51 to conform the language to the provisions of sections

1903(w)(6)(A) and 1903(w)(7)(G) of the Act that are discussed above, and thus to clarify that the State share of Medicaid expenditures may be contributed only by units of government. This rule also proposes to include provisions requiring documentation of CPEs that are used as part of the State share of claimed expenditures.

The regulatory provisions of §433.51 predate the statutory amendments found in section 1903(w) of the Act, which established a broad prohibition against provider-related donations and included provisions specifically identifying permissible IGTs and CPEs from units of government. Recently, some have expressed the view that the term "public agency" in §433.51(b) suggests that an entity which is not governmental in nature but has a public-oriented mission (such as a not-for-profit hospital, for example) may participate in the financing of the non-Federal share by CPEs. This view is inconsistent with the plain meaning of the Act; however, to avoid any further confusion, we are proposing to amend the regulation to conform the regulatory language to the current statutory language in section 1903(w) of the Act. This amendment also makes clear that a broader reading would be inconsistent with section 1902(a)(2) of the Act and §433.50(a)(1), which have historically stipulated that State

and local governments are the entities eligible to finance the non-Federal share.

As discussed previously, the donations and taxes amendments specifically allowed units of government to continue providing funding by IGT or CPE because of explicit statutory and regulatory provisions that allow units of government to share in the burden of financing the non-Federal share of Medicaid payments. To make regulatory language consistent with the statute and avoid confusion about whether there is a different regulatory standard, this rule proposes to modify §433.51 by removing the terms "public" and "public agency" from §433.51 and replacing these with references to units of government.

This rule also proposes to clarify that appropriate documentation is required whenever a CPE is used to fund the non-Federal share of expenditures in the Medicaid program. The governmental entity using a CPE must submit a certification statement to the State Medicaid agency attesting that the total computable amount of its claimed expenditures are eligible for FFP, in accordance with the Medicaid State plan and the revised provisions of §433.51. That certification must be submitted and used as the basis for a State claim for FFP within 2 years from the date of the

expenditure.

In this regard, the rule proposes to modify §433.51(b) to require that a CPE must be supported by auditable documentation in a form approved by the Secretary that will minimally: (1) identify the relevant category of expenditure under the State plan; (2) explain whether the contributing unit of government is within the scope of the exception to the statutory limitations on provider-related taxes and donations; (3) demonstrate the actual expenditures incurred by the contributing unit of government in providing services to Medicaid recipients or in administration of the State plan; and (4) be subject to periodic State audit and review.

To implement this rule, the Secretary would issue a form (or forms) that would be required for governments using a CPE for certain types of Medicaid services where we have found improper claims (for example, school-based services). These forms will be published in the **Federal Register** using procedures consistent with the Paperwork Reduction Act requirements. In preparing the way for these forms, this rule would serve to enhance fiscal integrity and improve accountability with respect to CPE practices in the Medicaid program.

Costs that are certified by units of government for

purposes of CPE cannot include the costs of providing services to the non-Medicaid population or costs of services that are not covered by Medicaid, except that a hospital may certify costs for inpatient and outpatient hospital services that are not covered under the State plan but are the basis for a disproportionate share hospital payment consistent with the requirements of section 1923 of the Act.

It is important to note that the following conditions do not constitute compliance with the Federal statute and regulation governing CPEs:

1. A certification that funds are available at a State or local level. This certification is irrelevant to whether or not State or local dollars have actually been expended to provide health care services to Medicaid individuals.
2. An estimate of Medicaid costs derived from surveys of health care providers.
3. A certification that is higher than the actual cost or expenditure of the governmental unit that has generated the CPE based on its provision of services to Medicaid recipients.
4. A certification that presents costs as anything less than 100 percent of the total computable expenditure. Federal match is available only as a percentage of the

total computable Medicaid expenditure documented through a CPE. A certification equal to the amount of the State share only is not acceptable.

The above list is not all-inclusive of arrangements that do not constitute compliance.

Cost Limit for Providers Operated by Units of Government. (§447.206)

As we have examined Medicaid financing arrangements across the country, we have found that many States make supplemental payments to governmentally operated providers that are in excess of cost. These providers, in turn, use the excess of Medicaid revenue over cost to subsidize health care operations that are unrelated to Medicaid, or they may return a portion of the supplemental payments to the State as a source of revenue. In either case, we do not find that Medicaid payments in excess of cost to governmentally operated health care providers are consistent with the statutory principles of economy and efficiency as required by section 1902(a)(30)(A) of the Act. Consequently, this rule proposes to limit reimbursement for governmentally operated providers to amounts consistent with economy and efficiency by establishing a limit of reimbursement not to exceed cost.

The cost limit in §447.206 specifies that the Secretary

will determine a reasonable method for identifying allowable Medicaid costs that incorporates not only OMB Circular A-87 cost principles but also Medicare cost principles, as appropriate, and the statutory requirements of sections 1902, 1903, and 1905 of the Act. While OMB Circular A-87 provides a framework for cost analysis, not all cost principles under OMB Circular A-87 are consistent with Medicare cost principles or requirements found in the Act for economy and efficiency and the proper and efficient administration of the Medicaid State plan. Developing cost finding methodologies more directly to the Medicaid program will provide for a more accurate allocation of allowable costs to the Medicaid program.

For hospital and nursing facility services, we find that Medicaid costs are best documented when based upon a standard, auditable, nationally recognized cost report (for example, Medicare 2552-96 hospital cost report). Any hospital and nursing facility services that are not documented based on a standardized, nationally recognized cost report are generally not reimbursable Medicaid costs. We will address any exceptions to this on a case-by-case basis.

For non-hospital and non-nursing facility services in Medicaid, we note that a nationally recognized, standard cost report does not presently exist. Therefore, the proposed rule

stipulates that Medicaid costs must be supported by auditable documentation in a form approved by the Secretary that, at a minimum, will: (1) identify the relevant category of expenditure under the State plan; (2) explain whether the contributing unit of government is within the scope of the exception to the statutory limitations on provider-related taxes and donations; (3) demonstrate the actual expenditures incurred by the contributing unit of government in providing services to Medicaid recipients or in administration of the State plan; and (4) be subject to periodic State audit and review.

Each governmentally operated health care provider that is subject to cost reimbursement and using CPEs must file a cost report with the State Medicaid agency annually and retain records in accordance with 42 CFR 431.17 and 45 CFR 92.42.

Under a Medicaid cost reimbursement payment system funded by CPEs, States may utilize most recently filed cost reports to develop interim Medicaid payment rates and may trend these interim rates by an applicable health care-related index. Interim reconciliations must be performed by reconciling the interim Medicaid payment rates to the filed cost report for the spending year in which interim payment rates were made. Final reconciliation must also be performed by reconciling the

interim payments and interim adjustments to the finalized cost report for the spending year in which interim payment rates were made.

When States do not use CPEs to pay providers operated by units of government, the new provisions would require the State Medicaid agency to review annual cost reports to verify that actual payments to each governmentally operated provider did not exceed the provider's cost.

Under this provision, if it is determined that a governmentally-operated health care provider received an overpayment, amounts related to the overpayment would be properly credited to the Federal government, in accordance with part 433, subpart F.

Retention of Payments. (§447.207)

In order to strengthen efforts to remove any potential for abuse involving the re-direction of Medicaid payments by IGTs in the future, this rule proposes a new regulatory provision at §447.207 requiring that providers receive and retain the full amount of the total computable payment provided to them for services furnished under the approved State plan (or the approved provisions of a waiver or demonstration, if applicable). Compliance with this provision will be determined by examining any transactions that are

associated with the provider's Medicaid payments to ensure that expenditures have been appropriately claimed and the non-Federal share has been satisfied.

Compliance may be demonstrated by showing that the funding source of an IGT is clearly separated from the Medicaid payment that a health care provider received. Generally, an IGT that takes place before the Medicaid payment, which originates from an account funded by taxes that is separate from the account in which the health care provider receives Medicaid payments, is usually acceptable.

Elimination of Payment Flexibility to Pay Public Providers in Excess of Cost. (§447.271(b))

We are proposing to eliminate §447.271(b), as this provision is no longer relevant due to the new cost limit for units of government proposed in this rule.

Conforming Changes to Reflect Upper Payment Limits for Governmental Providers. (§447.272 and §447.321)

We are proposing a corresponding modification to the Medicaid upper payment limit (UPL) rules found at §447.272 for inpatient hospital and nursing facility services, as well as the UPL rules at §447.321 for outpatient hospital and clinic services, to incorporate by reference the new cost limit for providers operated by units of government and to make the

defined UPL facility groups consistent with the new provisions of §433.50.

With respect to the UPL regulations at §447.272 and §447.321, this rule proposes to limit Medicaid reimbursement for State government operated and non-State government operated facilities to the individual provider's cost, whereas the current UPL regulations provide an aggregate limit based on the UPL facility group. Formerly established UPL transition periods remain unchanged; therefore, any States that are still in transition periods under §447.272(e) or §447.321(e) when this rule becomes effective will be permitted to make additional payments above the cost UPL to governmentally operated providers throughout the duration of their transition periods. The UPL rules at §447.272 and §447.321 for privately operated facilities and Indian Health Service and tribal facilities remain unchanged.

It is important to note that the provisions of this proposed rule are consistent with the regulatory provisions concerning Medicaid DSH payments. Medicaid DSH payments are limited to the uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid beneficiaries and individuals with no source of third party coverage for the services they receive. To the extent any

governmentally operated hospital is reimbursed by Medicaid at the level of cost, there will be no Medicaid shortfall factored into the facility's calculation of uncompensated care for purposes of DSH. This is true whether the Medicaid cost reimbursement is funded by CPEs or any other means.

Conforming Changes to Public Funds as the State Share of Financial Participation. (§457.220)

Current provisions on the financing of the SCHIP at §457.220 mirror the provisions at §433.51. Because the changes we are making to §433.51 apply equally to SCHIP programs, we are proposing to make conforming changes to §457.220 so that this provision continues to mirror §433.51.

Conforming Changes to Other Applicable Federal Regulations. (§457.628)

Current provisions on the financing of the SCHIP at §457.628 incorporate by reference the provisions at §433.51 through §433.74. Because the changes we are making to §433.50, which implement section 1903(w) of the Act, apply equally to SCHIP programs, we propose to make conforming changes to §457.628 to incorporate §433.50. In addition, the new provision at §447.207 requiring retention of payments is also incorporated by reference in §457.628 because this provision applies to SCHIP providers as well as Medicaid

providers.

Tool to Evaluate the Governmental Status of Providers.

With the issuance of this proposed rule, we recognize the need to evaluate individual health care providers to determine whether or not they are units of government as prescribed by the rule. States will need to identify each health care provider purportedly operated by a unit of government to CMS and provide information needed for CMS to make a determination as to whether or not the provider is a unit of government. We have developed a form questionnaire to collect information necessary to make that determination. The questionnaire will be published in connection with this proposed rule. For new State plan amendments that will reimburse governmentally operated providers or rely on the participation of health care providers for the financing of the non-Federal share, States will be required to complete this questionnaire regarding each provider that is said to be governmentally operated. For any existing arrangement that involves payment to governmentally operated providers or relies on the participation of health care providers for the non-Federal share, States will be required to provide the information requested on this form questionnaire relative to each applicable provider within

three (3) months of the effective date of the final rule following this proposed rule.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain

information collection requirements (ICRs):

§433.51 Public Funds as the State Share of Financial Participation.

Section 433.51 requires that a certified public expenditure (CPE) be supported by auditable documentation in a form(s) approved by the Secretary that, at a minimum, identifies the relevant category of expenditures under the Medicaid State Plan, demonstrates the cost of providing services to Medicaid recipients, and is subject to periodic State audit and review.

The burden associated with this requirement is the time and effort put forth by a provider to complete the approved form(s) to be submitted with a CPE. Depending upon provider size, we believe that it could take approximately 10-60 hours to fill out the form(s) that would be required for an annual certified public expenditure. We estimate that providers in 50 States will be affected by this requirement, but we are unable to identify the total number of providers affected or the estimated total aggregate hours of paperwork burden for all providers, as such figures will be a direct result of the number of providers that are determined to be governmentally operated.

§447.206 Cost Limit for Providers Operated by Units of

Government.

Section 447.206(e) states that each provider must submit annually a cost report to the Medicaid agency which reflects the individual providers cost of serving Medicaid recipients during the year. The Medicaid Agency must review the cost report to determine that costs on the report were properly allocated to Medicaid and verify that Medicaid payments to the provider during the year did not exceed the providers cost.

The burden associated with this requirement is the time and effort for the provider to report the cost information annually to the Medicaid Agency and the time and effort involved in the review and verification of the report by the Medicaid Agency. We estimate that it will take a provider 10 to 60 hours to prepare and submit the report annually to the Medicaid Agency. We estimate it will take the Medicaid Agency 1 to 10 hours to review and verify the information provided. We are unable to identify the total number of providers affected or the estimated total aggregate hours of paperwork burden for all providers, as such figures will be a direct result of the number of providers that are determined to be governmentally operated.

In the preamble of this proposed regulation, under the section titled "Tool to Evaluate Governmental Status of

Providers", we discuss a form questionnaire that we have developed to assist us in making a determination as to whether or not the provider is a unit of government. We have submitted this proposed information collection to OMB for its review and approval. To view the "Governmental Status of Health Care Provider" form and obtain additional supporting information, please access CMS' Web Site address at http://www.cms.hhs.gov/PaperworkReductionActof1995 or email your request and include CMS-10176 as the document identifier to Paperwork@cms.hhs.gov.

As required by section 3504(h) of the Paperwork Reduction Act of 1995, we have submitted a copy of this document to the Office of Management and Budget (OMB) for its review of these information collection requirements.

If you comment on these information collection and record keeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services,

Office of Strategic Operations and Regulatory Affairs

Division of Regulations Development

Attn.: Melissa Musotto, CMS-2258-P

Room C5-14-03, 7500 Security Boulevard,

Baltimore, MD 21244-1850.

Office of Information and Regulatory Affairs,

Office of Management and Budget,

Room 10235, New Executive Office Building,

Washington, DC 20503,

Attn: Katherine T. Astrich, CMS Desk Officer, CMS-2258-P,

Katherine_T._Astrich@omb.eop.gov. Fax (202) 395-6974.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order

13258, which merely reassigns responsibility of duties) 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 1 year).

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. 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 603 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 100 beds. For the reasons cited below, we have determined that this rule may have a significant impact on small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. We have determined that the rule will have an effect on State and local governments in an amount greater than $120 million. We have explained this assessment in the section entitled "Anticipated Effects" below.

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 requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. For purposes of Executive Order 13132, we also find that this rule will have a substantial effect on State or local governments.

B. Costs and Benefits

This rule is a major rule because it is estimated to

result in $120 million in savings during the first year and $3.87 billion in savings over five years.

As CMS has examined Medicaid State financing arrangements across the country, we have identified numerous instances in which State financing practices do not comport with the Medicaid statute. As explained in the preamble, Section 1903(w) of the Act permits units of government to participate in the financing of the non-Federal share; however, in some instances States rely on funding from non-governmental entities for the non-Federal share. Because such practices are expressly prohibited by the donations and taxes amendments at Section 1903(w), we are issuing this rule to clarify the requirements of entities and health care providers that are able to finance the non-Federal share.

Furthermore, CMS has found several arrangements in which providers did not retain the full amount of their Medicaid payments but were required to refund or return a portion of the payments received, either directly or indirectly. Failure by the provider to retain the full amount of reimbursement is inappropriate and inconsistent with statutory construction that the Federal government pays only its proportional cost for the delivery of Medicaid services. When a State claims Federal reimbursement in excess of net payments to providers,

the FMAP rate has effectively been increased, and federal Medicaid funds are redirected toward non-Medicaid services. When a State chooses to recycle FFP in this manner, the Federal taxpayers in other States disproportionately finance the Medicaid program in the State that is recycling FFP. This rule is designed to eliminate such practices.

The rule should also have a beneficial distributive impact on governmental providers because in many States there are a few selected governmental providers receiving payments in excess of cost, while other governmental providers receive a lower rate of reimbursement. This rule will reduce inflated payments to those few governmental providers and promote a more even distribution of funds among all governmental providers. This is because all governmental providers will be limited to a level of reimbursement that does not exceed the individual provider's cost.

We have observed that there are a variety of practices used by State and local governments in identifying costs and submitting a CPE as the basis of matching FFP for the provision of Medicaid services. These different cost methods and CPE practices make it difficult to (1) align claimed expenditures with specific services covered under the State plan or identifiable administrative activities; (2) properly

identify the actual cost to the governmental entity of providing services to Medicaid recipients or performing administrative activities; and (3) audit and review Medicaid claims to ensure that Medicaid payments are appropriately made. Such circumstances present risks of inflationary costs being certified and excessive claims of FFP. This rule will facilitate a more consistent methodology in Medicaid cost identification and allocation across the country, thereby improving the fiscal integrity of the program.

Because the RFA includes small governmental jurisdictions in its definition of small entities, we expect this rule to have a significant economic impact on a substantial number of small entities, specifically health care providers that are operated by units of government, including governmentally operated small rural hospitals, as they will be subject to the new cost limit imposed by this rule. We have reviewed CMS's Online Survey and Certification and Reporting System (OSCAR) data for information about select provider types that may be impacted by this rule. According to the OSCAR data, there are:

- 1,153 hospitals that have identified themselves as operated by local governments or hospital districts/authorities;

- 822 nursing facilities that have identified themselves as operated by counties, cities, or governmental hospital districts;
- 113 intermediate care facilities for the mentally retarded (ICF/MR) that have identified themselves as operated by cities, towns, or counties.

We have not counted State operated facilities in the above numbers because for purposes of the RFA, States are not included in the definition of a small entity. Note further that OSCAR data is self-reported, so the figures provided above do not necessarily reflect the number of providers CMS recognizes as governmentally operated according to the provisions of this rule.

Some of the governmental providers identified as small entities for RFA purposes may have been receiving Medicaid payments in excess of cost, but as a result of this rule, payments will not be permitted to exceed cost. Governmentally operated providers will also be required under this rule to receive and retain the full amount of their Medicaid payments, which would result in a net increase in revenue to the extent such providers were returning a portion of their Medicaid payments to the State and payment rates remain the same following the effective date of this rule. On the other hand,

if States reduce payment rates to such providers after this rule is effective, these providers may experience a decrease in net revenue. Finally, there are health care providers that are considered under the RFA as small entities (including small rural hospitals) but are not governmentally operated; to the extent these providers have been involved in financing the non-Federal share of Medicaid payments, this rule will clarify whether or not such practices may continue. However, for the most part, private health care providers are not affected by this rule. As stated earlier, for purposes of the RFA, the small entities principally affected by this rule are governmentally operated health care providers. In light of the specific universe of small entities impacted by the rule, the fact that this rule requires States to allow governmentally operated health care providers to receive and retain their Medicaid payments, and the allowance for governmentally operated health care providers to receive a Medicaid rate up to cost, we have not identified a need for regulatory relief under the RFA.

Ultimately, this rule is designed to ensure that Medicaid payments to governmentally operated health care providers are based on actual costs and that the financing arrangements supporting those payments are consistent with the statute.

While some health care providers may lose revenues in light of this rule, those revenues were likely in excess of cost or may have been financed using methods that did not permit the provider to retain payments received. Other health care providers that were adversely affected by questionable reimbursement and financing arrangements may now, under this rule, benefit from a more equitable distribution of funds. Private providers are generally unaffected by this rule, except for limited situations where the clarification provided by the rule may require a change to current financing arrangements.

With respect to clinical care, we anticipate that this rule's effect on actual patient services to be minimal. The rule presents no changes to coverage or eligibility requirements under Medicaid. The rule clarifies statutory financing requirements and allows governmentally operated providers to be reimbursed at levels up to cost. Federal matching funds will continue to be made available based on expenditures for appropriately covered and financed services. While States may need to change reimbursement or financing methods, we do not anticipate that services delivered by governmentally operated providers or private providers will change.

C. Anticipated Effects

The following chart summarizes our estimate of the anticipated effects of this rule.

Estimated Reduction in Federal Medicaid Outlays
Resulting from the Provider Payment Reform Proposal
Being Implemented by CMS-2258-P
(amounts in millions)

	Fiscal Year				
	2007	2008	2009	2010	2011
Payment Reform	-120	-530	-840	-1,170	-1,210

These estimates are based on recent reviews of state Medicaid spending. Payment reform addresses both spending through intergovernmental transfers (IGT) and limiting payments to government providers to cost. For IGT spending, recent reports on spending on Disproportionate Share Hospitals (DSH) and Upper Payment Limit (UPL) spending were reviewed. From these reports, an estimate of the total spending that would be subject to the net expenditure policy was developed and then projected forward using assumptions consistent with the most recent President's Budget projections. The estimate of the savings in federal Medicaid spending as a result of this policy factors in the current authority and efforts of CMS and the impact of recent waivers; the estimate also accounts for the potential effectiveness of future efforts. There is uncertainty in this estimate to the extent that the

projections of IGT spending may not match actual future spending and to the extent that the effectiveness of this policy is greater than or less than assumed.

Reports on UPL spending following the most recent legislation concerning UPL were reviewed to develop a projection for total enhanced payments in Medicaid spending. The estimate of savings from this policy reflects both estimates of the amount of UPL spending that exceeds cost and the effectiveness of this policy in limiting payments to cost. The estimate also accounts for transitional UPL payments, which are unchanged under this policy, and for the impact of recent waivers. There is uncertainty in this estimate to the extent that the projections of UPL spending may not match actual future spending, to the extent that the amount of UPL spending above cost differs from the estimated amount, and to the extent that the effectiveness of this policy is greater than or less than assumed.

D. Alternatives Considered

There is an option to implement policies surrounding retention of payments, certain elements of certified public expenditures, and the definition of a unit of government under existing statutory and regulatory authority. However, the proposed rule is a more effective method of implementation

because it promotes statutory intent, strengthens accountability for financing the non-Federal share of Medicaid payments, and clarifies existing regulations based on issues we have identified. Similarly, an option exists to continue to allow governmental providers to be reimbursed at current rates; however, given the information CMS has gathered regarding the use of Medicaid payments to governmental providers, we find that the proposal to limit governmental providers to cost offers a way to reasonably reimburse providers while ensuring that Federal matching funds are used for their intended purpose, which is to pay for a covered Medicaid service to a Medicaid beneficiary and not something else.

E. Accounting Statement

As required by OMB Circular A-4 (available at http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf), in the table below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. This table provides our best estimate of the proposed decrease in Federal Medicaid outlays resulting from the provider payment reform proposal being implemented by CMS-2258-P (Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the

Integrity of Federal-State Financial Partnerships). The sum total of these expenditures is classified as savings in Federal Medicaid spending.

Accounting Statement: Classification of Estimated Expenditures, from Fiscal Year 2007 to Fiscal Year 2011 (in Millions)	
Category	TRANSFERS
Annualized Monetized Transfers	Negative Transfer-Estimated decrease in expenditures: $774
From Whom To Whom?	Federal Government to States

F. Conclusion

We expect that this rule will promote the fiscal integrity of the Medicaid program. The proposed rule will enhance accountability for States to properly finance the non-Federal share of Medicaid expenditures and allow them to pay reasonable rates to governmental providers. To the extent prior payments to governmentally operated providers were inflated, the rule will reduce such payments to levels that more accurately reflect the actual cost of Medicaid services and ensure that the non-Federal share of Medicaid payments has been satisfied in a manner consistent with the statute. Private providers are predominately unaffected by the rule, and the effect on actual patient services should be minimal.

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

List of Subjects

42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs-health, Medicaid, Reporting and recordkeeping requirements.

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 457

Administrative practice and procedure, Grant programs-health, Health insurance, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 433- STATE FISCAL ADMINISTRATION

1. The authority citation for part 433 continues to read as follows:

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

2. Amend §433.50 by revising paragraph (a)(1) to read as follows:

§433.50 Basis, scope, and applicability.

(a) * * *

(1) Section 1902(a)(2) and section 1903(w)(7)(G) of the Act, which require States to share in the cost of medical assistance expenditures and permits State and local units of government to participate in the financing of the non-Federal portion of medical assistance expenditures.

(i) A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority.

(ii) A health care provider may be considered a unit of government only when it is operated by a unit of government as demonstrated by a showing of the following:

(A) The health care provider has generally applicable taxing authority; or

(B) The health care provider is able to access funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider’s expenses, liabilities, and deficits, so that a contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues.

*****

3. Section 433.51 is revised to read as follows:

§433.51 Funds from units of government as the State share of financial participation.

(a) Funds from units of government may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.

(b) The funds from units of government are appropriated directly to the State or local Medicaid agency, or are transferred from other units of government (including Indian tribes) to the State or local agency and are under its

administrative control, or are certified by the contributing unit of government as representing expenditures eligible for FFP under this section. Certified public expenditures must be expenditures within the meaning of 45 CFR 95.13 that are supported by auditable documentation in a form approved by the Secretary that, at a minimum --

(1) Identifies the relevant category of expenditures under the State plan;

(2) Explains whether the contributing unit of government is within the scope of the exception to limitations on provider-related taxes and donations;

(3) Demonstrates the actual expenditures incurred by the contributing unit of government in providing services to eligible individuals receiving medical assistance or in administration of the State plan; and

(4) Is subject to periodic State audit and review.

(c) The funds from units of government are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

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 447.206 is added to read as follows:

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

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

(b) Exceptions. Indian Health Services and tribal facilities. The limitation in paragraph (c) 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 (Pub. L. 93-638).

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

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

(3) For hospital and nursing facility services, Medicaid costs must be supported using information based on the

Medicare cost report for hospitals or nursing homes, as applicable.

(4) For non-hospital and non-nursing facility services, Medicaid costs must be supported by auditable documentation in a form approved by the Secretary that is consistent with §433.51(b)(1) through (b)(4) of this chapter.

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

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

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

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

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

(f) Overpayments. If, under paragraph (d) or (e) of this section, it is determined that a governmentally-operated health care provider received an overpayment, amounts related to the overpayment will be properly credited to the Federal government, in accordance with part 433, subpart F of this chapter.

(g) Compliance dates. A State must comply with the cost limit described in paragraph (c) of this section for services furnished after September 1, 2007.

3. Section 447.207 is added to read as follows:

§447.207 Retention of payments.

(a) All providers are required to receive and retain the

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

(b) [Reserved]

4. Section §447.271 is revised to read as follows:

§447.271 Upper limits based on customary charges.

(a) The agency may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.

(b) [Reserved]

5. Section 447.272 is amended by revising paragraphs (a) through (d) 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 operated facilities (that is, all facilities that are operated by the State) as defined at §433.50(a) of this chapter.

(2) Non-State government operated facilities (that is, all governmentally operated facilities that are not operated by the State) as defined at §433.50(a) of this chapter.

(3) Privately operated facilities, that is, all facilities that are not operated by a unit of government as defined at §433.50(a) of this chapter.

(b) General rules. (1) For privately operated facilities, upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.

(2) For State government operated facilities and for non-State government operated facilities, upper payment limit refers to the individual provider's cost as defined at §447.206.

(3) Except as provided in paragraph (c) of this section, aggregate Medicaid payments to the group of privately operated

facilities described in paragraph (a) of this section may not exceed the upper payment limit described in paragraph (b)(1) of this section.

(4) Except as provided in paragraph (c) of this section, Medicaid payments to State government operated facilities and non-State government operated facilities must not exceed the individual provider's cost as documented in accordance with §447.206.

(c) Exceptions. (1) Indian Health Services and tribal facilities. The limitation in paragraph (b) of this section does not apply to Indian Health Services facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638).

(2) Disproportionate share hospitals. The limitation in paragraph (b) of this section does not apply to payment adjustments made under section 1923 of the Act that are made under a State plan to hospitals found to serve a disproportionate number of low-income patients with special needs as provided in section 1902(a)(13)(A)(iv) of the Act. Disproportionate share hospital (DSH) payments are subject to the following limits:

(i) The aggregate DSH limit using the Federal share of the DSH limit under section 1923(f) of the Act.

(ii) The hospital-specific DSH limit in section 1923(g) of the Act.

(iii) The aggregate DSH limit for institutions for mental disease (IMDs) under section 1923(h) of the Act.

(d) Compliance dates. Except as permitted under paragraph (e) of this section, a State must comply with the upper payment limit described in paragraph (b) of this section by one of the following dates:

(1) For State government operated and non-State government operated hospitals—September 1, 2007.

(2) For all other facilities--March 13, 2001.

* * * * *

Section 447.321 is amended by revising paragraphs (a) through (d) 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 operated facilities (that is, all

facilities that are operated by the State) as defined at §433.50(a) of this chapter.

(2) Non-State government operated facilities (that is, all governmentally operated facilities that are not operated by the State) as defined at §433.50(a) of this chapter.

(3) Privately operated facilities that is, all facilities that are not operated by a unit of government as defined at §433.50(a) of this chapter.

(b) General rules. (1) For privately operated facilities, upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.

(2) For State government operated facilities and for non-State government operated facilities, upper payment limit refers to the individual provider's cost as defined at §447.206.

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

(4) Except as provided in paragraph (c) of this section, Medicaid payments to State government operated facilities and non-State government operated facilities must not exceed the individual provider's cost as documented in accordance with §447.206.

(c) Exception. 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 (Pub. L. 93-638).

(d) Compliance dates. Except as permitted under paragraph (e) of this section, a State must comply with the upper payment limit described in paragraph (b) of this section by one of the following dates:

(1) For State government operated and non-State government operated hospitals--September 1, 2007.

(2) For all other facilities--March 13, 2001.

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PART 457- ALLOTMENTS AND GRANTS TO STATES

1. The authority for part 457 continues to read as follows:

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

2. Section 457.220 is revised to read as follows:

§457.220 Funds from units of government as the State share of financial participation.

(a) Funds from units of government may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.

(b) The funds from units of government are appropriated directly to the State or local Medicaid agency, or are transferred from other units of government (including Indian tribes) to the State or local agency and are under its administrative control, or are certified by the contributing unit of government as representing expenditures eligible for FFP under this section. Certified public expenditures must be expenditures within the meaning of 45 CFR 95.13 that are supported by auditable documentation in a form approved by the Secretary that, at a minimum--

(1) Identifies the relevant category of expenditures under the State plan;

(2) Explains whether the contributing unit of government is within the scope of the exception to limitations on provider-related taxes and donations;

(3) Demonstrates the actual expenditures incurred by the contributing unit of government in providing services to eligible individuals receiving medical assistance or in administration of the State plan; and

(4) Is subject to periodic State audit and review.

(c) The funds from units of government are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

3. Amend §457.628 by—

A. Republishing the introductory text to the section.

B. Revising paragraph (a).

The republication and revision read as follows:

§457.628 Other applicable Federal regulations.

Other regulations applicable to SCHIP programs include the following:

(a) HHS regulations in §433.50 through §433.74 of this chapter (sources of non-Federal share and Health Care-Related Taxes and Provider-Related Donations) and §447.207 of this chapter (Retention of payments) apply to States' SCHIPs in the same manner as they apply to States' Medicaid programs.

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

Dated: _____

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Mark B. McClellan,

Administrator,

Centers for Medicare & Medicaid

Services.

Approved: _____

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Michael O. Leavitt,

Secretary.

BILLING CODE 4120-01-P