DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 447

[HCFA–2071–P]

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: Proposed rule.

SUMMARY: This proposed rule would modify 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, current 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 proposed rule would establish a third aggregate upper limit that would apply to payments made to all other types of government facilities that are not State-owned or operated facilities.

With respect to outpatient hospital and clinic services, current regulations place a single upper limit on aggregate payments made to all facilities. For these services, this proposed rule would establish a separate aggregate upper limit on payments made to State-owned or operated facilities and an aggregate upper limit on payments made to all other government-owned or operated facilities.

These proposed upper limits are necessary to ensure State Medicaid payment systems promote economy and efficiency, while recognizing the higher cost of inpatient and outpatient services in public hospitals. In addition, to ensure continued access to care and the ability to adjust to proposed changes, the proposed rule includes a transition for States with approved State plan amendments.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on November 9, 2000.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address ONLY: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–2071–P, P.O. Box 8010, Baltimore, MD 21244–8010.

Because comments must be *received* by the date specified above, please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses: Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the two above addresses may be delayed and received too late to be considered.

FOR FURTHER INFORMATION CONTACT: Robert Weaver, (410) 786–5914—Nursing facility services and intermediate care facility services for the mentally retarded.

Larry Reed, (410) 786–3325—Inpatient and outpatient hospital services and clinic services.

SUPPLEMENTARY INFORMATION: Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–2071–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's office at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 to 5 p.m. (phone: (202) 690–7890).

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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 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, regulation and program guidance. Additionally, the plan must be approved by the Secretary, who has delegated this authority to HCFA.

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. This provision provides authority for specific upper payment limits (UPL) 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, upper payment limits are set forth in regulations at § 447.321, ''Outpatient hospital services and clinic services: Upper limits of payment.''

These regulations stipulate that aggregate State payments for services provided by each group of health care facilities, 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 resources. 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.

II. Background

Before 1981, 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, at section 962 of the Omnibus Reconciliation Act of 1980 (OBRA '80), Pub. L. 96–499 and section

2173 of the Omnibus Budget Reconciliation Act of 1981 (OBRA '81), Pub. L. 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 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 report on the legislation states 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. 96–471, 96 Cong., 1st Sess. 1979.

In 1986, the Congress 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 (Pub. L. 99–509) titled ''A Clarification of State Flexibility for State Medicaid Payment Systems for Inpatient Services'' precluded the Secretary from placing limits on State disproportionate share hospital (DSH) payments but maintained the application of limits on regular inpatient payment rates.

The current upper limits were last changed in a final rule in the **Federal Register** (52 FR 28141) on July 28, 1987 that addressed the application of the upper payment limit to States that had multiple payment rates for the same class of services. This rule addressed the differential rate issue in the context of State-operated facilities because several audits had revealed that the circumstances of State-operated facilities resulted in a lack of incentives to curb excessive payments. A high volume of uninsured patients will increase the costs of providing services in State-owned or operated facilities. These costs, in turn, are passed on to the State. To offset those higher costs, States established payment methodologies which paid State-owned or operated facilities at a higher rate than privately-operated facilities. Higher Medicaid payments to State-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 final rule applied the Medicare upper limit test to State-operated facilities separate from other facilities. However, the final rule did not create a separate upper payment limit for other government facilities, allowing their payments to count toward the same aggregate upper payment limit as private facilities.

Section 4711 of the Balanced Budget Act of 1997 (BBA)(Pub. L. 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. Under section 4711 of the BBA, 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.

III. Provisions of the Proposed Regulations

A. Description of the Problem

It has become apparent that the current regulation creates a financial incentive for States to overpay non-State-operated government facilities because States, counties, cities and/or public providers can, through this practice, lower current State or local spending and/or gain extra Federal matching payments. This practice is not consistent with Medicaid statute and has contributed to rapidly growing Medicaid spending.

The incentive and ability for States to pay excessive rates to non-State government-owned or operated Medicaid providers can be explained as follows. As stated previously, the current aggregate upper payment limit is applied to both private and non-State government-owned or operated facilities. By developing a payment methodology that sets rates for proprietary and nonprofit facilities at lower levels, States can set rates for county or city facilities at substantially higher levels and still comply with the current aggregate upper payment limit. The Federal government matches these higher payment rates to public facilities. Because these facilities are public entities, funds to cover the State share may be 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 intent of 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 that ''the Administration is developing a proposal to ensure that Medicaid payments meet the statutory definition of efficiency and economy'' and that we would issue a proposed rule to address this problem. The Office of the Inspector General (OIG) and the General Accounting Office (GAO) have begun to monitor States with State plans that permit these types of payments. Both the GAO and OIG testified on the scope of the 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.

To date, the OIG has substantially completed reviews in three States and is continuing reviews in three additional States. Although the specifics of the enhanced payment programs and associated financing mechanisms differed somewhat in the three States they have reviewed thus far, they have found that the payment programs share some common characteristics. These similarities are included below:

- The States did not base the enhanced payments on the actual cost of providing services or increasing the quality of care to the Medicaid residents of the targeted nursing facilities.
- The counties involved in the enhanced payment process used little or none of the enhanced payments to provide services to Medicaid residents. Instead, the counties returned these funds to their original source. That is, the funds were returned to the State's general funds or used to repay loans that were made to initiate the transaction, or both.
- The States were clear winners in that they were able to reduce their share of Medicaid costs and cause the Federal government to pay significantly more than it should for the same volume and level of Medicaid services. The Federal share of the enhanced funding went into State accounts and, in some cases, could be used for any purpose.
- Some States effectively recycled the Federal funds received from these enhanced payments to generate additional Federal matching funds.

Similarly, the GAO testified that current arrangements violate the basic integrity of Medicaid as a joint Federal/State program. By taking advantage of a technicality, these financing schemes allow States, in effect, to replace State

Medicaid dollars with Federal Medicaid dollars.

B. Application of the Upper Payment Limit

To address these problems, we are proposing to revise the regulations at §§ 447.272, ''Application of upper payment limits,'' and 447.321, ''Outpatient hospital services and clinic services: Upper limits of payment,'' to establish separate upper payment limits for non-State government-owned or operated facilities. This approach is consistent with the last regulatory change which created separate upper payment limits for State-operated facilities. While the proposal would still allow for flexibility in payment methodologies, it prevents States from setting rates to public facilities well in excess of the average upper payment limit and the actual cost of providing Medicaid covered services to eligible individuals. This change is necessary to ensure that the Medicaid regulations conform to Medicaid statutory requirements that promote efficiency and economy.

The upper payment limit requirements for Medicaid inpatient hospital services, NF services and ICF/MR services are set forth in regulations at § 447.272. Paragraph (a) of this section provides that aggregate payments by an agency to each group of health care facilities (that is, hospitals, nursing facilities and ICFs for the mentally retarded (ICFs/MR)), may not exceed a reasonable estimate of what would have been paid for those services under Medicare payment principles. Paragraph (a) provides an exception to specify that disproportionate share hospital payments are not counted toward the general limit. We would amend paragraph (a) to specify that an exception also applies for payments made to non-State-owned or operated public hospitals under paragraph (b)(2) of this section.

Paragraph (b) of this section currently limits aggregate payment to State-operated facilities in each class of service. We would revise § 447.272(b) to establish an additional upper payment limit that would apply to payments made to all other types of government facilities. To establish this new upper payment limit, we propose to make the following changes to § 447.272(b).

Specifically, we propose to revise paragraph (b) of this section to specify that payments made to each type of government-owned or operated health care facility (that is, inpatient hospital, NF, ICF/MR) may not exceed the specified allowable limits. Proposed paragraph (b)(1) would continue the limitation on aggregate payments made to State-owned or operated facilities from exceeding a reasonable estimate of what would have been paid using Medicare payment principles. In addition, we propose to add a new paragraph (b)(2) that would impose an aggregate upper limit restriction on payments for services furnished by all other government-owned or operated facilities (other than Indian Health Service (IHS) facilities and tribal facilities funded through Pub. L. 93–638) that are not State-owned or operated. (Although we invite specific comments, we excluded IHS facilities because we believe there is little incentive for States to pay enhanced rates to these facilities. Rates to these facilities are generally set by the State in accordance with rates published by the Federal government.) Under paragraph (b)(2), we would specify that aggregate payments to NFs IFCs/MR may not exceed a reasonable estimate of what would have been paid for those services under Medicare payment principles. We would also specify that aggregate payment to non-State-owned or operated public hospitals may not exceed 150 percent of a reasonable estimate of what would have been paid for those services under Medicare payment principles.

We are proposing a higher upper payment limit for services in non-State-owned or operated public hospitals operated by governmental entities other than the State itself because we believe that allowing higher Medicaid payments will fully reflect the value of public hospitals' services to Medicaid and the populations it serves. Public hospitals are established to ensure access to needed care in underserved areas, and often provide a range of care not readily available in the community, including expensive specialized services, such as trauma and burn care and outpatient tuberculosis services. They also provide a significant proportion of the uncompensated care in the nation.

The size and scale of public hospitals create extreme stresses and uncertainties, especially given their dependence on public funding sources. We are concerned that these stresses may threaten the ability of these public hospitals to fulfill their mission and fully serve the Medicaid population. As such, we are proposing a higher UPL for these facilities. Specifically, this higher aggregate UPL would allow States to pay non-State-owned or operated public hospitals up to 150 percent of the amount that would have been paid for inpatient and outpatient services using Medicare payment principles.

We also recognize that, in some instances, these public hospitals may be required by State or local governments to transfer back a portion of payments that they receive under Medicaid. This practice raises serious concerns about whether the purposes of the higher payment limits being proposed for public hospitals will be met. To ensure that higher payment levels will assist in ensuring the stability of public hospitals as a vital link in the resources available for care to Medicaid beneficiaries, we intend to require in our final rule that payments made to public hospitals under this provision be separately identified and reported to HCFA. We request comment on the most suitable ways of reporting and accounting for these payments. In addition, we are soliciting comments on whether the 150 percent limit is appropriate.

For outpatient hospital services and clinic services, the current upper payment limit is in regulations at § 447.321. This limit precludes FFP on aggregate payments for outpatient hospital services and clinic services that exceed the amount that would be payable to all providers (State-owned or operated, other government-owned or operated, and private) under comparable circumstances under Medicare. Unlike other classes of services subject to the upper payment limit, there is no separate limit for State-owned or operated facilities. We propose to amend § 447.321 to establish additional upper payment limits that would apply to aggregate payments for Medicaid services furnished by State-owned or operated and all other government-owned or operated facilities.

We propose to move the current provisions under paragraph (a) of this section, as discussed below, to § 447.304 and add a new paragraph (a) to conform the language in this section to the language in § 447.272, for purposes of consistency within the Medicaid regulations. We would provide in § 447.321(a) that aggregate payments by an agency to each group of health care facilities (that is, outpatient hospitals and clinics) may not exceed a reasonable estimate of what would have been paid for each of those services under Medicare payment principles. We would also specify that an exception applies for payments made to non-State-owned or operated public hospitals under paragraph (b)(2) of this section. Consistent with the changes to § 447.272, we propose to establish separate upper payment limits for Medicaid services furnished by—(1) State-owned or operated facilities; and (2) all other government-owned or

operated facilities that are not State-owned or operated. In § 447.321, proposed paragraph (b)(1) would establish the upper payment limit for Medicaid services furnished by State-owned or operated facilities. Like the current UPL for inpatient hospital services, aggregate Medicaid payments for outpatient services or clinic services furnished by State facilities would be limited to a reasonable estimate of what would have been paid under Medicare reimbursement principles.

Proposed paragraph (b)(2) would establish a similar aggregate upper limit restriction for Medicaid services furnished by all other government providers that are not State-owned or operated except that the payment maximum for outpatient services would be set at 150 percent of what would have been paid using Medicare payment principles. See the earlier discussion of our rationale for the higher limit to these public hospitals. Under the proposed limits in §§ 447.272 and 447.321, States would have flexibility to consider either Medicare principles of reasonable cost reimbursement or a Medicare prospective payment system if available, to estimate the Medicare payment amount for Medicaid services.

In addition, we are moving the language regarding prohibition for FFP currently found in § 447.321(a) to § 447.304, ''Adherence to upper limits; FFP,'' paragraph (c). The provision in § 447.304(c) currently specifies that FFP is available for State expenditures that do not exceed upper limits. We propose to revise this section to specify that FFP is not available for payment that exceeds the upper limits specified in subpart F. This revision would conform to our approach in § 447.257.

C. Transition Periods for States That Have Approved Rate Enhancement Payment Arrangements

We recognize that the new upper payment limits we are proposing may disrupt State budget arrangements for States with approved enhanced plan amendments. Therefore, we are proposing a transition policy for States with approved rate enhancement amendments that would be affected by the proposed UPLs. We refer to these amendments as noncompliant because they result in payments that exceed the maximum amount allowable under the new UPLs. We are proposing two transition periods and are soliciting comments on the material elements of these transition periods, including the starting point for the phase-out, the percentage reduction each year, and whether a longer or shorter period would be appropriate.

1. Transition period for noncompliant approved State plan amendments effective on or after October 1, 1999.

For noncompliant approved State plan amendments with an effective date on or after October 1,1999, we are proposing a transition period that would end on September 30, 2002. Because these programs are relatively new (in fact, some may be deemed approved during the comment period for this proposed rule), States are not likely to have developed the same level of reliance on the enhanced payments addressed in this proposed rule as States with older programs. Additionally, during the review period for these amendments, we have been informing States of our intent to curtail this practice and advising them not to rely on the continuation of this funding. For these reasons, we believe a short transition period is appropriate.

2. Transition period for noncompliant approved State plan amendments effective before October 1, 1999.

For noncompliant approved State plan amendments with an effective date before October 1, 1999, we are proposing a 3-year transition period beginning in the State FY that begins calendar year 2002.

We propose to implement the reductions on a State Fiscal Year (FY) basis starting with the first full State FY that begins in calendar year 2002. Specifically, the transition generally consists of reducing aggregate payments with the proposed classes to the proposed UPLs in increments, with the proposed UPL becoming fully effective in the first State FY beginning in Calendar Year 2005. In the first year of implementation, States would have to reduce the aggregate payments above the new UPL by 25 percent. In the second year, the amount of excess aggregate payments must be reduced by 50 percent and in the third year by 75 percent. By the first day of the fourth year, State payments would have to be in compliance with the new UPL policy.

We are proposing to use State FY 2000 as the base period to determine the excess payment that must be phased down. To compute the dollar amount of the excess, States would be required to compare State FY 2000 payments paid to the current class of providers to the maximum aggregate payments for its new class of providers (that is, State-owned or operated and other government-owned or operated) under the proposed UPL for State FY 2000. The difference is considered the excess payment that must be phased out over the transition period.

The table below illustrates the transition policy. In this example, State FY 2000 payments for nursing facility services provided by other government-owned or operated providers are $300 million and new UPL is $100 million. The amount in excess of the upper payment limit, $200 million, must be reduced in successive State FYs by 25 percent, 50 percent and 75 percent respectively. The steps to calculate the maximum allowable payment during this transition period are as follows:

- Subtract the amount that would have been allowed under the new UPL for State FY 2000 services from the State FY 2000 payment.
- Multiply that difference by the phase down rate.
- Add to that result, the new UPL for Medicaid services furnished on or after State FY 2000.

At the end of the transition period, State payments would have to be in full compliance with the new upper payment limit.

TABLE—ILLUSTRATIVE EXAMPLE OF TRANSITION [1] OTHER GOVERNMENT-OWNED OR OPERATED NURSING HOME PROVIDERS

[Dollars in millions]

	SFY 2003*	SFY 2004	SFY 2005	SFY 2006
Excess Payment in SFY 2000 [2]	200	200	200	200
Phase-out rate (in percent)	25%	50%	75%	100%
Maximum allowable excess	150	100	50	0
New UPL [3]	105	110	115	120
Transition UPL	255	210	165	120

* Assumes that the SFY 2003 begins on July 1, 2002.

[1] State FY 2001 and State FY 2002 payments would not be subject to this proposed rule because it assumes that the transition period begins in State FY 2003.

[2] The $200 million excess payment is derived by subtracting the new aggregate UPL for State FY 2000 services provided by other government-owned or operated providers from the actual FY 2000 payment made to these providers.

[3] Assumes $5 million annual growth in the program.

To implement these provisions, we propose to make further revisions to §§ 447.272 and 447.321 to include regulations that establish transition periods for States that will be affected by the new upper payment limits that we are proposing.

Specifically, § 447.272 sets forth the rules regarding the application of the upper payment limit requirements for Medicaid inpatient hospital services, NF services and ICF/MR services. We propose to revise § 447.272(b) to establish a shorter-term transition period and a 3-year transition period. Specifically, proposed paragraph (b)(2)(i) of this section would specify that noncompliant State plan amendments effective on or after October 1, 1999 and approved before the effective date of the final rule have until September 30, 2002 to come into compliance with the requirements of the new upper payment limits. Proposed paragraph (b)(2)(ii) of this section would specify that noncompliant approved State plan amendments effective before October 1, 1999 are allowed a 3-year transition period beginning in the State FY that begins in calendar year 2002. Paragraph (b)(2) of this section refers to payments made to those other government-owned or operated facilities that are not State-owned or operated.

Section 447.321 sets forth rules regarding the application of the upper payment limit requirements for Medicaid outpatient hospital services and clinic services. We are proposing similar revisions to § 447.321(b) to include our proposed transition periods. We apply these transition periods to States for payments made to State-owned or operated facilities and other government-owned or operated facilities described in proposed paragraphs (b)(1) and (b)(2) of this section. Specifically, proposed paragraphs (b)(1)(i) and (b)(1)(ii) of this section would specify the requirements for the short-term and the 3-year transition periods for State-owned or operated facilities. Proposed paragraphs (b)(2)(i) and (b)(2)(ii) of this section would set forth the short-term and the 3-year transition periods for all other government-owned or operated facilities.

To the extent this regulation alters allowable Medicaid expenditures in a State with a section 1115 title XIX waiver, the estimates of the expected cost to the Federal government without the waiver will be adjusted (upward or downward) to accurately reflect these changes in allowable Medicaid expenditures. These adjustments are consistent with current section 1115 waiver budget neutrality policy.

IV. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, 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, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Introduction

We have examined the impact of this rule as required by Executive Order (EO) 12866, the Unfunded Mandates Act of 1995, and the Regulatory Flexibility Act (RFA) (Pub. L. 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).

B. Overall Impact

We are unable to provide a specific dollar estimate of the economic impact this proposed regulation will have on State and local governments and Medicaid participating health care facilities due to data limitations and State behavioral responses. This proposed 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 proposed limitations, States will be able to set reasonable rates as determined under Medicare payment principles for Medicaid services furnished by public providers to eligible individuals. The amount of spending permitted under the proposed limits will vary directly with the amount of Medicaid services furnished by public providers to eligible individuals. While the proposed regulation does not affect the overall aggregate amount States can spend, by setting an upper payment limit for government providers, it may impact how States distribute available funding to participating health care facilities.

We have identified 28 States with approved and/or pending rate proposals that target enhanced Medicaid payments to hospital and nursing service providers that are owned or operated by county or local governments. There are 17 States with approved State plan amendments or waivers and 7 States with pending plan amendments. In addition, there are 4 States that have both approved and pending plan amendments. We estimate that these proposals currently account for approximately $3.7 billion in Federal spending annually. 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 providers. 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. In the final rule, we may revise our estimate of $3.7 billion in Federal spending to reflect findings reported by the OIG and the GAO.

Of this $3.7 billion in spending, we do not have sufficient information to permit us to quantify accurately the amount of payments to State and local government providers that may exceed the proposed upper payment limits. In addition, because some States may be using the Federal share of enhanced payments in a manner that allows some funds to be re-invested in Medicaid (and thereby drawing down additional FFP), the potential impact may extend to other Medicaid services not reflected in the above spending. Because we believe that the potential impact will exceed $100 million, we consider this proposed rule to be a major rule.

We are seeking information to help us quantify the impact of this proposed rule. We invite comments on how the proposed rule may affect State Medicaid programs and other State programs. In particular, we seek information to help us quantify the fiscal impact of this proposed rule (also taking into account the proposed transition periods and higher UPLs for non-State-owned or operated public hospitals) on State Medicaid programs and other State programs.

C. Impact on Small Entities and Rural Hospitals

The Regulatory Flexibility Act requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include 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, all hospitals, nursing facilities, intermediate care facilities for the mentally retarded, and clinics 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 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 50 beds.

The chart below indicates the type and number of providers potentially affected by this regulation in all 50 States and the District of Columbia. We included facilities in all 50 States because although every State is not 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 States have payment arrangements with providers of ICF/MR services or clinic services that will be affected by this regulation 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	254	1,275	1,529

[1] These facilities are already subject to a separate aggregate UPL and will not be affected by the final rule.

As explained earlier in the preamble, it is very difficult to predict how States will respond to the proposed 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 providers use Medicaid payments to support, we cannot determine how potential payment rate adjustments will affect providers or the patients they serve. Under the proposed UPLs, States would continue to be able to set rates that provide fair compensation for Medicaid services furnished to Medicaid patients. Hospitals that are owned or operated by local governments may benefit from the higher UPLs we are proposing for inpatient and outpatient services. 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 small entities that are not government-owned or operated, the proposed UPLs do not apply to them and therefore, they should not be impacted.

With respect to the impact on small rural hospitals, we do not believe the proposed rule will have a significant overall impact on rural hospitals. With respect to Medicaid services furnished by rural hospitals, the proposed upper payment limits 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 UPLs we are proposing 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.

We invite public comment on the possible effects this proposed rule may have on small entities in general and on small rural hospitals in particular.

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 proposing in this proposed 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 on 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 over-payment 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 the 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 Upper Payment Limit. This proposal would limit, in the aggregate, the amount of payment States can make to public providers. Under this proposal, 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 we are proposing, 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 genuine incentive to set Medicaid service rates at levels consistent with economy and efficiency since they share the financial burden with the Federal government. As explained in section III of the preamble, the use of IGTs to move funds between government entities makes it possible 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 arrangement. Under this proposal, we would not approve any new plan amendments after the effective date of the final rule. This would permit States that are currently making excessive payments to local government facilities to continue making such payments indefinitely. 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.

We invite comment on these 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 invite 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. We request information regarding the mechanisms used to finance these hospitals under current regulations, as well as proposals for a means of curbing excessive payments while allowing States the flexibility to recognize higher costs faced by these hospitals.

E. The Unfunded Mandates Act

The Unfunded Mandates Reform Act of 1995 also requires (in section 202) that agencies perform an assessment of anticipated costs and benefits before proposing any rule that may result in a mandated expenditure in any one year by State, local, or Tribal governments, in the 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 type of payments to Medicaid public providers and therefore we do not believe the proposed limits have any unfunded mandate implications.

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 proposed rule, we met with interested parties and listened to their ideas and concerns. These discussions were held with members of Congress and their staff. We also met 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. We do not believe this proposed rule in any way imposes substantial direct compliance costs on State and local governments or preempts or supersedes State or local law.

The financial implications of this proposed 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 we are proposing. 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 proposed limits, they will have to fund the amount in excess 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.

G. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this regulation 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.

For the reasons set forth in the preamble, 42 CFR part 447 is proposed to be amended as follows:

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. In § 447.272 revise paragraphs (a) and (b) to read as follows:

§ 447.272 Application of upper payment limits.

(a) *General rule.* Except as provided in paragraphs (b)(2) and (c) of this section, aggregate payments by an agency to each group of health care facilities (that is, hospitals, nursing facilities and ICFs for the mentally retarded (ICFs/MR)), may not exceed a reasonable estimate of what would have been paid for those services under Medicare payment principles.

(b) *Government-owned or operated facilities.* In addition to being subject to the requirements in paragraph (a) of this section, payments by an agency to each group of government-owned or operated health care facilities (that is, hospitals, nursing facilities and ICFs for the mentally retarded (ICFs/MR)), may not exceed the limits specified in paragraph (b)(1) or (b)(2) of this section.

(1) *State-owned or operated facilities.* Aggregate payments to State-owned or operated facilities may not exceed a reasonable estimate of what would have been paid for those services under Medicare payment principles.

(2) *Other government-owned or operated facilities.* Except for public hospitals, aggregate payments to all other government-owned or operated facilities (other than Indian Health Services facilities (IHS) and tribal facilities funded through Pub. L. 93–638) may not exceed a reasonable estimate of what would have been paid for those services under Medicare payment principles. Payment to non-State-owned or operated public hospitals may not exceed 150 percent of a reasonable estimate of what would have been paid for those services under Medicare payment principles, except as provided below.

(i) *Transition period for noncompliant State plan amendments effective on or after October 1, 1999 and approved before the effective date of the final rule.* Enhanced payment arrangements with an effective date on or after October 1, 1999 and approved before the effective date of the final rule must come into compliance by September 30, 2002.

(ii) *Transition period for noncompliant approved State plan amendments effective before October 1, 1999.* A 3-year transition period applies to approved State payment arrangements with an effective date before October 1, 1999. During the 3 successive State fiscal years beginning in State FY 2003, State payments must comply with the excessive payment phase down payment reduction schedule.

(iii) State payments may not exceed the lower of the base State FY 2000 payments or the following limits:

State FY 2003 UPL + .75x
State FY 2004 UPL + .50x
State FY 2005 UPL + .25x
UPL = Upper Payment Limit.
X = Payments to local government providers less the UPL described in § 447.272(b)(2) for services furnished in State FY 2000.

3. In § 447.304, revise paragraph (c) and remove the note 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.

4. Section 447.321 is revised to read as follows:

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

(a) *General rule.* Except as provided in paragraph (b)(2) of this section, aggregate payments by an agency to each group of health care facilities, (that is, outpatient hospitals or clinics) may not exceed a reasonable estimate of what would have been paid for each of those services under Medicare payment principles.

(b) *Government-owned or operated facilities.* In addition to being subject to the requirements in paragraph (a) of this section, payments by an agency to each group of government-owned or operated health care facilities, (that is, outpatient hospitals or clinics) may not exceed the limits specified in paragraph (b)(1) or (b)(2) of this section.

(1) *State-owned or operated facilities.* Aggregate payments to State-owned or operated facilities may not exceed a reasonable estimate of what would have been paid for those services under Medicare payment principles, except as provided below.

(i) *Transition period for noncompliant State plan amendments effective on or after October 1, 1999 and approved before the effective date of the final rule.* Enhanced payment arrangements with an effective date on or after October 1, 1999 and approved before the effective date of the final rule must come into compliance by September 30, 2002.

(ii) *Three-year phase down transition period for noncompliant approved State plan amendments effective before October 1, 1999.* A 3-year transition period applies to approved State payment arrangements with an effective date before October 1, 1999. During the 3 successive State fiscal years beginning in State FY 2003, State payments must comply with the excessive payment phase down payment reduction schedule.

(iii) State payments may not exceed the lower of the base State FY 2000 payments or the following limits:

State FY 2003 UPL + .75X
State FY 2004 UPL + .50x
State FY 2005 UPL + .25x
State FY 2006 UPL
UPL = Upper Payment Limit
X = Payments to local government providers and State-owned or operated providers less the applicable UPL described in § 447.321(b) for services furnished in State FY 2000.

(2) *Other government-owned or operated facilities.* Except for public hospitals, aggregate payments to all other government-owned or operated facilities (other than Indian Health Services facilities (IHS) and tribal facilities funded through Pub. L. 93–638) may not exceed a reasonable estimate of what would have been paid for those services under Medicare payment principles. Payment to non-State-owned or operated public hospitals may not exceed 150 percent of a reasonable estimate of what would have been paid for those services under Medicare payment principles, except as provided below.

(i) *Transition period for noncompliant State plan amendments effective on or after October 1, 1999 and approved before the effective date of the final rule.* Enhanced payment arrangements with an effective date on or after October 1, 1999 and approved before the effective date of the final rule must come into compliance by September 30, 2002.

(ii) *Three-year phase down transition period for noncompliant approved State plan amendments effective before October 1, 1999.* A 3-year transition period applies to approved State payment arrangements with an effective date before October 1, 1999. During the 3 successive State fiscal years beginning in State FY 2003, State payments must comply with the excessive payment phase down payment reduction schedule.

(iii) State payments may not exceed the lower of the base State FY 2000 payments or the following limits:

State FY 2003 UPL + .75X
State FY 2004 UPL + .50x
State FY 2005 UPL + .25x
State FY 2006 UPL
UPL = Upper Payment Limit
X = Payments to local government providers and State-owned or operated providers less the UPL described in § 447.321(b)(1) for services furnished in State FY 2000.

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

Dated: October 3, 2000.

Michael M. Hash,

Acting, Administrator, Health Care Financing Administration.

Approved: October 4, 2000.

Donna E. Shalala,

Secretary.

[FR Doc. 00–25935 Filed 10–5–00; 1:00 pm]

BILLING CODE 4120–01–P

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 65

RIN 3067–AD13

National Flood Insurance Program (NFIP); Letter of Map Revision Based on Fill Requests

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Proposed rule.

SUMMARY: We, FEMA, propose to amend our procedures for issuing Letters of Map Revision Based on Fill (also referred to as LOMR–F) under the criteria of 44 CFR 65. We use the criteria established in § 65.5 to determine whether we can issue a LOMR–F to remove unimproved land or land with structures from the Special Flood Hazard Area (SFHA) by raising ground elevations using engineered earthen fill.

DATES: We invite your comments on this proposed rule. Please send any comments on or before November 9, 2000.

ADDRESSES: Please send written comments to the Rules Docket Clerk, Office of the General Counsel, Federal Emergency Management Agency, 500 C Street, SW., room 840, Washington, DC 20472, (facsimile) 202–646–4536, or (email) *rules@fema.gov.*

FOR FURTHER INFORMATION CONTACT: Matthew B. Miller, P.E., Chief, Hazards Study Branch, Technical Services Division, Mitigation Directorate, at (202) 646–3461, or (email) *matt.miller@fema.gov.*

SUPPLEMENTARY INFORMATION:

Background

Congress created the National Flood Insurance Program (NFIP) in 1968 to provide federally supported flood insurance coverage, which generally had not been available through private insurance companies. The program is based on an agreement between the Federal Government and each community that chooses to participate in the program. We make flood insurance available to property owners within a community provided that the community adopts and enforces floodplain management regulations that meet or exceed the minimum requirements of the NFIP set forth in part 60 of the NFIP Floodplain Management Regulations (44 CFR 60).

Identifying and mapping flood hazards. FEMA identifies and maps flood hazard areas by conducting flood hazard studies and publishing Flood Insurance Rate Maps (FIRMs). These flood hazard areas, referred to as Special Flood Hazard Areas (SFHAs), are based on a flood that would have a 1-percent chance of being equaled or exceeded in any given year (the 100-year flood or base flood). We determine the 1-percent annual chance flood, shown on the FIRMs as A Zones or V Zones, from information that we obtain through consultation with the community, floodplain topographic surveys, and detailed hydrologic and hydraulic analyses.

Floodplain management requirements. The NFIP minimum building and development regulations require that new or substantially improved buildings in A Zones have their lowest floor (including basement) elevated to or above the Base Flood Elevation (BFE) (the elevation of the 1-percent annual chance flood). Non-residential buildings in A Zones can either be dry floodproofed or elevated to the BFE. In V Zones, the bottom of the lowest horizontal structural member of the lowest floor of all new or substantially improved buildings must be elevated to or above the BFE. We have designed the NFIP floodplain management requirements at 44 CFR 60.3 to protect buildings constructed in floodplains from flood damages.

Freeboard and Floodplain Storage. Freeboard, generally expressed in terms of feet above a flood level for purposes of floodplain management, proves to be a successful method for reducing damage due to flooding and acts to compensate for the many uncertain factors that contribute to flood heights greater than the base flood. We recognize communities that incorporate the concept of freeboard in their permitting and planning processes through the Community Rating System, Project Impact, and insurance rating in general.

Local officials, developers, and the public at large should understand that the placement of fill in the SFHA could result in an increase in the base flood elevation by reducing the ability of the floodplain to convey and store floodwaters. Communities may want to consider prohibiting or limiting fill in floodplains, or requiring compensatory storage, and zero rise floodways as extra protection. Furthermore, development outside the SFHA but within the watershed can further increase the flood hazard by aggravating downstream flooding conditions. Therefore, FEMA will continue to encourage local officials, planners, design professionals, and developers to consider the long term benefits of elevating above the published base flood elevation when constructing projects in and near the SFHA.

Local responsibility. When a community joins the NFIP, it must initially adopt a resolution or ordinance that expresses a commitment to recognize and evaluate flood hazards in all official actions and to take such other official action as reasonably necessary to carry out the objectives of the program [44 CFR 59.22(a)(8)]. This is in addition to the general requirement that the community take into account flood hazards to the extent that they are known in all official actions relating to land management and use [44 CFR 60.1(c)]. Furthermore, all communities participating in the NFIP must ''determine whether proposed building sites will be reasonably safe from flooding'' [44 CFR 60.3(a)(3)]. This proposed rule emphasizes the role and responsibility of the community in permitting development and ensuring that areas within their jurisdiction are reasonably safe from flood hazards.

Flood insurance. The National Flood Insurance Act of 1968 requires that we charge full actuarial rates reflecting the complete flood risk to buildings built or substantially improved on or after the effective date of the initial FIRM for the community or after December 31, 1974, whichever is later, so that the risks associated with buildings in flood prone areas are borne by those located in such areas and not by the taxpayers at large. We refer to these buildings as Post-FIRM. The NFIP bases flood insurance rates for new construction on the degree of the flood risk reflected by the flood risk zone on the FIRM. Flood insurance rates also take into account a number of other factors including the elevation of the lowest floor above or below the BFE, type of building, and the existence of a basement or an enclosure.

Mandatory purchase of insurance. The Flood Disaster Protection Act of 1973 and the National Flood Insurance Reform Act of 1994 mandate the purchase of flood insurance as a condition of Federal or federally-related financial assistance for acquisition or construction of buildings in SFHAs of any community. The two Acts prohibit Federal agency lenders, such as the Small Business Administration, United