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Part III

Department of Health and Human Services

Health Care Financing Administration

Medicaid Program; Payment for Long-Term Care Facility Services and Inpatient Hospital Services; Interim Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 447

Medicaid Program; Payment for Long-Term Care Facility Services and Inpatient Hospital Services

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

ACTION: Interim Final Rule With Comment Period.

SUMMARY: We are revising the regulations on Medicaid payment for long-term care (LTC) facility and inpatient hospital services. Revised regulations are needed to implement recent amendments to the Medicaid law (section 962 of the Omnibus Reconciliation Act of 1980 and section 2173 of the Omnibus Budget Reconciliation Act of 1981) that:

(1) Removed the requirements, in the previous law, that State agencies pay for LTC facility services on a reasonable cost-related basis and for inpatient hospital services on a reasonable cost basis, in accordance with methods and standards developed by the State and approved by the Secretary;

(2) Added the requirement that State agencies pay for both types of services through the use of rates that the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that efficiently and economically operated facilities must incur to provide care in conformity with applicable State and Federal laws, regulations, and quality and safety standards; and

(3) Specified that payments for inpatient hospital services must take into account certain other factors, as explained in the preamble to these regulations.

The purpose of the revised regulations is to set forth the procedures HCFA will use in obtaining and accepting States' assurances that their payment rates meet the requirements of the Medicaid law. These procedures are intended to increase States' discretion in setting rates, minimize the administrative requirements States, facilities, and hospitals must comply with, and ensure that facilities and hospitals receive the reasonable and adequate payments intended by law.

DATES: Effective date: September 30, 1981. Although these regulations are final, comments may be submitted as described below.

Comment date: To assure consideration, comments should be mailed by December 29, 1981.

ADDRESS: Address comments in writing to: Administrator, Department of Health and Human Services, Health Care Financing Administration, P.O. Box 17076, Baltimore, Maryland 21235.

If you prefer, you may deliver your comments to Room 309–G Hubert H. Humphrey Building, 200 Independence Ave. S.W., Washington, D.C., or to Room 789, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to BPP–148–FC. Agencies and organizations are requested to submit comments in duplicate.

Comments will be available for public inspection, beginning approximately two weeks after publication, in Room 309–G of the Department's office at 200 Independence Ave. S.W., Washington, D.C. 20201 on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (202–245–7890).

Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, we will consider all comments we receive. If as a result of comments we decide changes in these regulations are needed, we will publish these changes in the Federal Register and respond to the comments in the preamble of that document.

FOR FURTHER INFORMATION CONTACT: Alan Spielman, (301) 594–4010.

SUPPLEMENTARY INFORMATION:

General Background

The revised regulations set forth below implement both section 962 of the Omnibus Reconciliation Act of 1980 (Pub. L. 96–499), which deals with payment for long-term care facility services, and section 2173 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35), which deals with payment for inpatient hospital services. The first section of this preamble (Payment for Long-Term Care Facility Services) explains the general approach we followed in developing the regulations. Thus, most of the discussion in the first section is equally applicable to both LTC facilities and hospitals. The second section of this preamble (Payment for Inpatient Hospital Services) provides further background on the changes made by section 2173, and discusses certain issues that relate specifically to hospital reimbursement. The final section of the preamble (Impact Analysis) sets forth further information on the cost and burden of the revised regulations, as required by Executive Order 12291 and the Regulatory Flexibility Act.

Payment For Long-Term Care Facility Services

I. Background

A. *Previous Medicaid Law.* Since it was originally enacted in 1965, the Medicaid law (title XIX of the Social Security Act; 42 U.S.C. 1396–1396k) has required each State with an approved Medicaid plan to pay for skilled nursing facility (SNF) services to individuals eligible for those services under the plan. In 1971, Pub. L. 92–223 added intermediate care facility (ICF) services as an optional Medicaid service. SNFs, ICFs, and intermediate care facilities for the mentally retarded, ICF/MRs, are known, collectively, as long-term care (LTC) facilities.

The Medicaid law did not initially include any specific requirements regarding the methods of payment to be used to pay for either SNF or ICF services. As a result, individual States were permitted to develop their own payment methods, subject only to the general requirement, in section 1902(a)(30) of the Act, that payments not exceed reasonable charges consistent with efficiency, economy, and quality of care. Under the initial Medicaid law, States developed a variety of payment methods. These methods ranged from the retrospective, reasonable cost reimbursement system used by Medicare (see 42 CFR Part 405, Subpart D), to prospective rates based, in some instances, on State budgetary considerations and other factors not directly related to actual LTC facility costs.

B. *1972 Amendments.* In 1972, Congress enacted Pub. L. 92–603 (the Social Security Amendments of 1972). Section 249 of Pub. L. 92–603 added a new section 1902(a)(13)(E) to the Act, effective July 1, 1976. This section required that each State Medicaid plan provide for payment for SNF and ICF services on a reasonable cost-related basis, in accordance with payment methods and standards developed by the State on the basis of cost-finding methods approved and verified by the Secretary.

The Senate Finance Committee report accompanying Pub. L. 92–603 stated that, under previous law, some SNFs and ICFs were being overpaid, while others were being paid too little to support the quality of care needed by Medicaid patients. On the other hand, the committee noted that the reasonable cost reimbursement method used by Medicare and, in particular, the detailed

cost-finding requirements that are an integral part of that method, could cause difficulty for some LTC facilities. To avoid the problems that could arise either from the absence of specific requirements or from excessively detailed requirements, Congress enacted section 249. This provision required that payments to LTC facilities be related to the reasonable costs the facilities incur, but permitted States considerable flexibility, within limits established by the Secretary, to develop their own methods and standards for paying for these costs.

C. *Section 249 Regulations.* The section 249 regulations on payment for LTC facility services are currently codified at 42 CFR 447.272–447.316. These regulations specify that States must pay for LTC facility services on a reasonable cost-related basis, and require State plans to conform to specific requirements for:

- Cost-finding and cost reporting;
- Desk analysis of cost reports, and periodic audits of a specified percentage of facilities;
- Payment methods and standards that are based on approved cost-finding methods and reasonably account for allowable cost;
- Upper limits based on charges, and on amounts that would have been paid under Medicare; and
- A minimum payment level that is high enough to meet the costs of an economically and efficiently operated facility.

Although the current regulation on payment for LTC facility services do not include any specific provisions that either authorize or prohibit the use of payment rates that exceed actual facility costs, we have stated our policy on this issue in a separate Federal Register document. In response to a court order issued December 7, 1977, in *American Health Care Association v. Califano,* we published a notice in the Federal Register to explain the opportunities for profit that States may allow LTC providers (43 FR 4861, published February 6, 1978). This notice explains that profit, other than a return on equity capital for proprietary facilities, is available to facilities that can keep their costs below a prospectively determined class rate or individual facility rate, or can earn an incentive payment for performance relative to a standard established by the State. However, as specified in the preamble to the current regulations (41 FR 27300, published July 1, 1976), payment rates must not include flat amounts designated as growth allowances or efficiency bonuses. The preamble explains that these amounts are not to be included in payment rates because they are not reasonably related to incurred costs.

D. *Federal Review of State Plans Under Section 249.* The Secretary has delegated the approval authority for all State plans to the Administrator of HCFA, which is the Federal agency responsible for administration of the Medicare and Medicaid programs. All State plan provisions on payment for LTC facility services have been reviewed under the criteria in the regulations cited above.

Under section 249, our review focused on the State's LTC facility payment methods and standards, rather than on the rates paid to facilities. The term "rate" generally refers to the dollar amount payable to facilities under the State's payment method. The rate is simply the result of the payment method.

The primary purpose of the section 249 review was to determine whether the State's payment methods and standards would result in the reasonable cost-related payment required by that statute. To enable us to make this determination, we required each State that proposed to change its payment methods and standards to give us a detailed explanation of the rationale for the proposed change, and of the effects the change would have on other elements of the State's payment system.

After receiving this information, we first assessed the appropriateness of each element of the State's payment system. These elements include, among others, the State's definition of allowable costs; its methods of cost-finding; its system, if any, of classifying facilities into comparison groups for rate-setting purposes; and its specific methods for relating payment rates to facilities' costs and for adjusting these rates for inflation. We then considered the appropriateness of these elements as they relate to one another. This phase of our review was crucial, since an element of a payment system that would not meet the "reasonable cost-related" test if judged in isolation might be accepted if it were compensated for by other elements of the system. For example, a very restrictive standard on the amount of administrative salary cost considered acceptable by the State might result in payment for this specific type of cost that is not "reasonable cost-related". However, the effect of this restrictive standard might be offset by liberal incentive payments for efficiency, so that the payment system as a whole would result in reasonable cost-related payment. The approval that resulted from this review represents a comprehensive judgment that these elements, and their interaction, result in payments that are consistent with the requirements in section 249 and the regulations that implement it.

We wish to note that, under section 249, each State was responsible for developing specific methods and standards for determining its payment for LTC facility services. HCFA's responsibility was not to specify the payment methods and standards a State should adopt, but to review and approve or disapprove the particular plan, in light of the requirements in the Medicaid law and regulations.

II. Omnibus Reconciliation Act of 1980

A. *Major Provisions Relating to LTC Facility Reimbursement.* The Omnibus Reconciliation Act of 1980 (Pub. L. 96–499), which was enacted on December 5, 1980, made a significant change in the provisions of the Medicaid law that govern payments for LTC facility services. Specifically, section 962 of Pub. L. 96–499 amended section 1902(a)(13)(E) of the Social Security Act to remove the requirement that States pay for these services on a reasonable cost-related basis, and to substitute for it the requirement that States pay for SNF and ICF services through the use of rates (determined in accordance with methods and standards developed by the State) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide care in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Section 962 also requires the State to make further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each SNF or ICF, and for periodic audits by the State of these reports. The effective date specified in the amendment for this change is October 1, 1980.

B. *Legislative History.* In developing regulations to implement the amendment, we relied on the amendment and its legislative history, including the pertinent parts of the Senate Finance Committee Report entitled "Spending Reductions: Recommendations of the Committee on Finance Required by the Reconciliation Process in section 3(a)(115) of H. Con. Res. 307, The First Budget Resolution for Fiscal Year 1981 (96th Congress, 2nd session committee print, Serial No. 96–36.)." We also considered the parts of the Senate Finance Committee Report on H.R. 934 (Senate Report No. 96–471), which ultimately led to Pub. L. 96–499,

and of the Conference Report on Section 962 of Pub. L. 96-499 (Report No. 96-1479). We gave special emphasis to the expectation that, in implementing the amendment, the Secretary will keep the regulatory and other requirements States and facilities must comply with to the minimum level necessary to assure proper accountability.

C. *State Discretion in Establishing Payment Levels.* The Senate Finance Committee reports note that States have argued that complex Federal regulations implementing the statutory requirements of section 249 have unduly restrained their administrative and fiscal discretion, and that the Federal approval process has forced States to rely heavily on Medicare principles of reimbursement. (For example, the current regulations at 42 CFR 447.276(c) specify that Medicare cost-finding methods will be approved automatically. Other methods require specific justification.) The reports further state that neither of these consequences was intended when section 249 was enacted.

The reports also state that applying the Medicare reasonable cost reimbursement principles to LTC facility reimbursement is not entirely satisfactory, since these principles are inherently inflationary, and contain no incentives for efficient performance. The reports note that, under the amendment, States would be free to establish rates on a Statewide or other geographic basis, or on an institution-by-institution basis, without reference to Medicare reimbursement principles.

D. *Minimizing Administrative Burden.* The Senate Finance Committee reports state the expectation that the Secretary will keep regulatory and other requirments to the minimum level necessary to assure proper accountability for Medicaid spending, and will not overburden States and facilities with marginal but massive paperwork requirements. In our view, this expectation requires us to develop Federal procedure for acceptance of State assurances that would be less burdensome to States than the review procedure used under Section 249.

III. Omnibus Reconciliation Act of 1981

On August 13, 1981 the Omnibus Reconciliation Act of 1981 (Pub. L. 97-35) was enacted. This legislation includes a provision that directly affects issuance of the regulations set forth below.

Section 2161 of Pub. L. 97-35 requires specific percentage reductions in the amount of Federal financial participation (FFP) that otherwise would be paid to each State for fiscal years 1982, 1983, and 1984. A special provision of this section specifies that these reductions in FFP shall not be made for any calendar quarter unless, as of the first day of that quarter, the Secretary has promulgated and has in effect final regulations implementing paragraphs (10)(C) and (13)(A) of section 1902(a) of the Social Security Act, as amended by Pub. L. 97-35. (Section 1092(a)(13)(A) incorporates the changes made by section 962 of the Omnibus Reconciliation Act of 1980.) This special provision means that, if we are to make the reductions in FFP required by section 2161, we must publish revised hospital and LTC facility payment regulations by October 1, 1981. To meet this deadline, we are issuing the regulations set forth below as interim final rules effective on the date they are published in the Federal Register (September 30, 1981).

Although these regulations are effective on their date of publication, we believe it is important that the public be given an opportunity to comment on them, and that we have the benefit of these comments. Therefore, we have provided a 90-day public comment period for the revised regulations. We will consider all comments we receive during this period, and if as a result of comments we decide changes in these regulations are needed, we will publish these changes in the Federal Register and respond to the comments in the preamble of that document.

IV. Summary of Major Features of Revised Regulations

For the convenience of the reader, the major features of the revised regulations are summarized below.

The revised regulations provide for:

- Elimination of all requirements, in current regulations, that relate to Medicaid payment for LTC facility services on a reasonable cost-related basis.
- A requirement that States submit assurances to HCFA that their rates meet the statutory requirements, and also submit related information on the estimated short-term, and to the extent feasible, long-term impact of the rates on availability of services, type of care furnished, extent of provider participation, and the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs. We will review the information a State submits with respect to these items to determine whether it is reasonable to justify acceptance of the State's assurances.
- A requirement that States resubmit assurances regarding rates before the end of the calendar quarter that includes the date on which the rate has been in effect for one year, or whenever they wish significantly to revise their methods of determining rates, whichever is earlier.
- A requirement that States submit assurances that they have provided the public with the opportunity to review and comment on significant changes in their methods for determining payment rates before the changes are implemented.
- A requirement that States develop appeals procedures that will give individual facilities an opportunity to seek administrative review and adjustment of the rates.
- Cost reporting and audit requirements, as provided by the statute. We are not specifying detailed requirements but are permitting States to implement their own systems in order to reduce the administrative burden, for States and facilities, of complying with the new regulations.
- Aggregate upper limits on payments to hospitals and LTC facilities that are based on Medicare payments, and limits on hospital payment rates based on charges.

V. Public Notice of Changes in Method of Reimbursement

On September 16, 1981, we published proposed regulations to remove the current requirement in 42 CFR 447.205 that Medicaid agencies give 60 days public notice of certain proposed changes in the statewide method or level of reimbursement for Medicaid services (46 FR 45964). We made this proposal to reduce the regulatory burden on States and allow them greater flexibility in adjusting reimbursement rates in response to changing fiscal situations. We indicated in the preamble to the proposed regulations published on September 16, 1981, that the Department was considering approaches to assure that State reimbursement decisions continue to be made through a public process.

With respect to institutional providers, i.e., hospitals and long-term care facilities, we believe that it is important that major changes in a State's reimbursement methodology be made only after public notice. We believe it is reasonable to expect that rates developed through a public process will represent an appropriate balance among provider concerns, beneficiary concerns, and budget and other limitations. Although most States have their own procedures for notifying the public of agency policy changes, we believe that the statutory requirements

governing long-term care facility and inpatient hospital reimbursement added by section 962 and section 2173 make it appropriate to establish a Federal requirement on the public notice procedures that must be followed by all States.

Under the regulations we are proposing, we have included a procedural requirement that the State continue to issue public notice of any major change in its method of calculating payment rates for inpatient hospital or LTC services. However, in the interest of limiting the State's flexibility as little as possible and to streamline the process, we are not establishing either an explicit expenditure threshold that would have to be exceeded before public notice is required, or a mandatory length for the comment period. (The existing rule in 42 CFR 447.205 would continue to apply, however, if we determine not to remove it as we have proposed.)

VI. Other Provisions

In addition to the provisions regarding the States' assurances, we have included, in the revised regulations, other provisions needed to implement the amendment. We also have revised our current regulations on payment for LTC facility services to eliminate all requirements relating to payment on a reasonable cost-related basis, and to simplify or eliminate many of the current recordkeeping, reporting and audit requirements. These changes are explained in the following paragraphs.

A. *Time limit for HCFA review.* We have specified in the revised regulations that HCFA will notify the agency of its decision regarding acceptance of the agency's assurances within 60 days of receiving the assurances and related information. We have also specified that if we do not notify the agency of our decision within this time limit, the State's assurances will be deemed accepted.

This time limit is based on the requirements in section 2177 of the Omnibus Budget Reconciliation Act of 1981. (Pub. L. 97–35). Under section 2177, a request for approval of a State plan, plan amendment, or waiver of plan requirement will be deemed approved unless, within 90 days after the request is submitted, the Secretary either disapproves the request or gives the State written notice of the additional information needed for a decision on it. If further information is needed, the request will be deemed approved unless the Secretary disapproves it within 90 days of receiving the additional information. Since the revised regulations merely establish minimal procedural and information reporting requirements for States, we decided that a shorter timeframe for processing State's assurances is both achievable and in the public interest.

B. *Effective Date of Rates.* Under the revised regulations, a proposed rate will be effective for the period for which the State wishes to use the rate. However, this period cannot begin earlier than the first day of the calendar quarter in which HCFA received the State's assurance that the proposed rate meets the statutory requirements. This limitation on the retroactivity of rates is necessary to conform the revised regulations to the current regulations on the effective date of new plans and plan amendments (see 45 CFR 201.3(g)).

C. *Resubmittal of Assurances and Related Information.* In discussing the presumed approval of payment rates not disapproved within 90 days after they were submitted, the Conference Committee Report on section 962 specifies that these rates are to be effective for the fiscal year for which they were proposed. We believe this indicates that the Committee expected each rate to apply only to a single 12-month rate period, or to all periods beginning within one year of the first date for which the rate is effective. Therefore, we have specified in the revised regulations that a State must submit new assurances and related information before the end of the calendar quarter that includes the date on which the rate has been in effect for one year, or whenever the agency significantly changes its payment methodology, whichever occurs first.

Because this requirement will apply to both prospective and retrospective rates, the current requirement, in 42 CFR 447.304, that prospective payment rates be redetermined at least annually is no longer needed. Therefore, we have deleted this more limited requirement.

D. *Cost Reporting Requirements.* Section 962 requires each State to make assurances satisfactory to the Secretary for the filing of uniform cost reports by each SNF or ICF. The revised regulations do not add any further requirements for cost reporting. In general, we believe each State is best equipped to develop its own standards and procedures for cost reporting.

E. *Recordkeeping.* We have deleted the current regulations, in 42 CFR 447.277, under which each provider is required to keep financial records accurately and in enough detail to support its report of these costs, to keep the records for at least 3 years after it submits the cost report to which the records relate, and to make these records available on request to representatives of the State or HHS. These requirements are not needed to implement the amendment and, if retained, could be interpreted as duplicating the more general record retention and access requirements in 45 CFR Part 74, Subpart D. These more general requirements are not affected by the amendment and therefore will continue in effect.

F. *Audits.* Section 962 requires the State to make assurances satisfactory to the Secretary that it will provide for periodic State audits of LTC facility cost reports. To implement this requirement, we are requiring only that States provide for periodic audits of providers' cost reports. We are deleting the current regulations dealing with a minimum level of audit activity (audit of 15 percent of all facilities each year), audit procedures, cost report desk analysis, audit of all facilities' records over a 3-year period, audit reports, and accounting for overpayments found in audits (see 42 CFR 447.290–447.296). We believe the specific requirements regarding desk reviews and audits are not needed to implement the amendment, and that retaining them could limit States' discretion to design audit programs to meet their needs. However, we expect that States will, under the revised regulations maintain the minimum level of audit activity needed to ensure that payments are being made in accordance with their State plans and to detect and correct provider fraud and abuse.

Although we have included audit requirements for all States, we are concerned that the retroactive adjustments in payments that could be required as a result of audit findings might, in some cases, conflict with the requirements of State payment systems. This potential for conflict could arise because some payment systems, especially those that use prospectively determined class rates, do not allow adjustments to be made after a payment rate is determined. We wish to solicit comments on the specific issue of how adjustments needed to act on overpayments or underpayments discovered as a result of audits could be made under these systems.

G. *Payment Methods and Standards.* In revising the current regulations on payment methods and standards (see 42 CFR 447.301–447.306) to reflect the changes made by section 962, we have deleted the requirements that relate to payment on a reasonable cost-related basis, but have retained the general requirements that specify that each State plan must describe the State's payment methods and standards. This

requirement is based on a general requirement in section 1902(a)(30) of the Social Security Act that plans must provide methods and procedures relating to payment for care and services provided under the plan. The requirement is also consistent with our current regulations at 45 CFR 201.2, which provide that each State plan must comprehensively describe the nature and scope of its program.

We also are requiring that, if the agency wishes to apply the Medicare limits on SNF costs to limit individual facility payments, it must state specifically in the plan that it intends to do so. We also are deleting the provisions of current regulations that require States to specify the types of service deficiencies, if any, for which rates will be reduced retroactively. We believe the requirement in the revised regulations, under which States must specify their payment methods and standards in their State plans, is adequate to ensure that this requirement will be met.

H. *Opportunity for Profit.* The current regulations do not specify the conditions under which facilities may be allowed a profit. Profit is a significant issue under the current regulations, because those regulations implement previous legislation (section 249 of Pub. L. 92–603), which required reasonable cost-related payment and thus raised the issue of when payments that exceed costs are justified. However, section 962 of Pub. L. 96–499 amended the Medicaid law to remove the cost-related payment requirement. We believe that, under section 962, each State should be free to decide, in setting its payment rate, whether to allow facilities an opportunity for profit. Therefore, in developing the proposed regulations to implement section 962, we have not included any specific rules on this issue.

I. *Upper Limits.* The revised regulations specify that the agency's total payments for all LTC facility services furnished under the plan must not be greater than the total amount that would be paid for the services under the Medicare principles of reimbursement in 42 CFR Part 405, Subpart D. To determine whether this requirement is met, the agency may consider payments to a random sample of all Medicaid facilities or average payments to all facilities in a class.

The regulations provide two separate approaches for determining what would have been paid under Medicare. For facilities that participate in both Medicare and Medicaid, the Medicare interim reimbursement rate, adjusted to account for services not covered under the Medicaid plan, may be used to determine the upper limit. For facilities that do not participate in Medicare, the regulations require the agency to use estimates of the amount Medicare would have paid these facilities. These estimates must be consistent with the intent that payments do not exceed what would be paid under Medicare principles.

The upper limit based on Medicare payments is needed to implement the general requirement in section 1902(a)(30) of the Act that Medicaid payments be consistent with efficiency, economy, and quality of care. In addition, the Senate Finance Committee Reports on the amendment state 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 the Medicare principles of reimbursement. These reports also state that, since States would be free to establish payment rates without reference to Medicare principles of reimbursement, the Secretary would be expected only to compare the average rates paid to SNFs participating in Medicare with the average rates paid to SNFs participating in Medicaid, in applying this limitation. In our view, these statements make it clear that the Committee expected that the upper limits based on Medicare payments would remain in effect.

In developing the revised regulations, we revised the current upper limits as follows.

(a) *Revision to upper limit based on charges.* We deleted the current provision, in 42 CFR 447.315, that prohibits States from paying more for long-term care facility services than the providers' customary charges. We believe that the intent of section 962 to provide States with greater flexibility in the setting of payment rates warrants the removal of this upper limit requirement, which is not required by the statute. We believe that an aggregate upper limit based on Medicare payments is sufficient to assure that the increased flexibility granted by section 962 does not result in unacceptable increases in Federal Medicaid payments.

(b) *Medicare upper limit revisions.* We have extended the Medicare upper limit, which currently applies only to payments under retrospective payment systems, to payments under both retrospective and prospective systems. We made this change because we believe that a payment limit designed to implement section 1902(a)(30), which applies to Medicaid payments generally, should be applicable to all Medicaid plans and not only to those with retrospective payment systems. Currently, only 16 of the 53 Medicaid plans use retrospective payment systems, and we expect the number of retrospective systems to decline further as States exercise the increased flexibility provided by section 962. We do not believe it would be either equitable or effective to apply the limit based on Medicare payments only to the few States that use retrospective systems.

In making this change, we are aware that some States have expressed concern that applying the limit based on Medicare payments to prospective systems that use significantly different reimbursement principles could be costly and burdensome, since it could require the agency to apply Medicare's detailed cost-finding principles to determine what would have been paid under Medicare. However, we do not believe application of these principles would be necessary. Our current regulations permit agencies to use Medicare interim payments to determine what Medicare would have paid facilities that participate in both Medicare and Medicaid, and allow agencies considerable discretion in calculating what Medicare would have paid to Medicaid-only facilities. The revised regulations will allow agencies similar discretion in estimating what Medicare would have paid to facilities that participate only in Medicaid. Therefore, we believe that the limit could be extended to cover prospective systems without creating excessive administrative burdens for States with these systems.

In addition to making this change, we have specified that States must adjust the Medicare interim rate, (or other amount they estimate would have been paid under Medicare) to reflect services not included in the Medicaid plan. Although our current regulations do not explicitly require States to make this adjustment in applying the limit to Medicaid-only facilities, the adjustment has been required under our current policy on review of State plan provisions dealing with the limits, and is needed to assure that the limit applies equitably to all facilities. We believe, therefore, that the requirement should be stated explicitly in the upper limit regulations.

J. *Provider appeals.* The revised regulations require each State agency to develop an appeals procedure that allows a provider to submit evidence to the agency and seek prompt administrative review of its payment rate. We believe the appeals requirement described above is needed

because individual facility rates will not receive Federal review under the revised regulations.

We believe that individual facilities must be given some opportunity to request review and adjustment of their rates. We recognize, however, that another approach could be used to achieve this purpose. Therefore, we wish to invite comments on the following issues:

- Is there a procedure other than an appeals process that would help ensure that facilities' payment rates are reviewed as necessary?
- If there is no appropriate alternative to an appeals process, should conditions for appeals be specified?

Payment for Inpatient Hospital Services

I. Omnibus Reconciliation Act of 1980

Section 902 of the Omnibus Reconciliation Act of 1980 (Pub. L. 96–499) amended the Medicaid law by providing special rules on payment for inpatient hospital services to a patient who does not require an inpatient level of care but must be kept in the hospital because the SNF or ICF care the patient requires is not available. These rules specified that if the services are furnished in a hospital that meets the occupancy standard set forth in the amendment (80 percent average daily occupancy in the calendar year immediately preceding the year in which the services were furnished), the State must pay for the services at its regular rate of payment for inpatient hospital services. If the services were furnished in a hospital that does not meet the occupancy standard, the State must pay for the services at the estimated adjusted Statewide per diem rate for the level of care (SNF or ICF) the patient required or, for hospitals with distinct parts certified as SNFs or ICFs, at the lesser of the Statewide rate or the actual rate for the particular SNF or ICF. The effective date specified in the legislation for this amendment is the date the Secretary issues final regulations implementing the amendment. When the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35) was enacted, regulations implementing section 902 of Pub. L. 96–499 had not been issued.

II. Omnibus Budget Reconciliation Act of 1981

A. *Major Provisions Relating to Hospital Reimbursement Under Medicaid.* The Omnibus Budget Reconciliation Act of 1981, which was enacted on August 13, 1981, made several significant changes in the provisions of the Medicaid law that govern payments for inpatients hospital services. Specifically, section 2173 of Pub. L. 97–35:

- Removed the requirement that States pay for the reasonable cost of inpatient hospital services in accordance with methods and standards, consistent with section 1122 of the Act, that are developed by the States, and reviewed and approved by the Secretary;
- Removed the requirements, added by section 902 of Pub. L. 96–499, that specify how States are to determine their payments for inappropriate inpatient hospital services to patients who require a lower level of care;
- Added the requirement that States pay for hospital services through the use of rates (determined in accordance with methods and standards developed by the State) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide care in conformity with applicable State and Federal laws, regulations, and quality and safety standards. (This is the same requirement that was added, for LTC facility reimbursement, by section 962 of Pub. L. 96–499);
- Added the requirements that States' methods and standards for determining payment rates for hospital services take into account the situation of hospitals that serve a disproportionate number of low income patients with special needs and provide, in the case of hospital inpatients receiving an inappropriate level of care (under conditions similar to those in section 1861(v)(1)(G) of the Act), for lower reimbursement rates reflecting the level of care the patients actually received (in a manner consistent with section 1861(v)(1)(G)). (Section 2101 of Pub. L. 97–35 amended section 1861(v)(1)(G) by removing the 80 percent occupancy standard added by section 902, and substituting more general provisions under which Medicare will pay for inappropriate services at the acute care rate only if the Secretary determines there is no excess of hospital beds.);
- Added the requirement that States' payment rates for hospital services be reasonable and adequate to assure that Medicaid patients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality; and
- Added the requirement that each State make further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital and for periodic audits by the State of those reports.

B. *Legislative History of Section 2173.* In developing regulations to implement this amendment, we relied on section 2173 and its legislative history, including the parts of the Conference Report on Pub. L. 97–35 that deal with section 2173. We also considered the pertinent parts of the Senate Budget Committee Report on S. 1377 (Senate Report No. 97–139) and of the House Budget Committee Report on H.R. 3982 (House Report No. 97–158). (The Conference Committee considered both S. 1377 and H.R. 3982 in deciding to recommend enactment of section 2173.) We gave special emphasis, in developing the revised regulations set forth below, to the parts of the amendment and its legislative history that deal with the issues described in items (1) through (5).

1. *State discretion in determining payment levels.* Both the House Budget Committee Report on H.R. 3982 and the Senate Budget Committee Report on S. 1377 make it clear that removal of the requirement that hospitals be paid on a reasonable cost basis is intended to increase State discretion in setting payment rates. Specifically, the report on H.R. 3982 notes that even the alternative payment methods approved under the previous law must offer a reasonable cost basis for reimbursement, and that the requirement that hospitals be paid on this basis results in higher levels of payment than States might set if granted more flexibility. The report on S. 1377 expresses the view that States should have flexibility in developing methods of payment for their Medicaid programs, and states that application of Medicare's reasonable cost reimbursement principles is not entirely satisfactory, since these principles are inherently inflationary and contain no incentives for efficient performance.

2. *Minimizing administrative burden.* The report on S. 1377 emphasizes the need for the Federal Government to keep its administrative requirements to the minimum necessary to assure proper accountability, and not to overburden States and facilities with unnecessary and burdensome paperwork requirements.

3. *Hospitals with disproportionate numbers of low-income patients with special needs.* The report on H.R. 3982 expresses concern about the impact of State payment practices on hospitals that treat a large volume of Medicaid patients and patients without health insurance. The report notes that these hospitals, especially those in urban areas, provide many public health and social services to residents of their areas, as well as serving as hospitals of

last resort for the poor. As a result, these hospitals experience special costs. Meeting these costs is often difficult, since these hospitals also frequently receive only a small proportion of their overall revenues from non-public sources. The report states that, for these reasons, many of these hospitals are now and will continue to be financially distressed, and will experience special costs that States should take into consideration.

4. *Payment for inappropriate inpatient hospital services.* Although the reports cited above do not explicitly discuss this issue, section 2173 repealed the detailed provisions on payment for these services that were added by section 902 of Pub. L. 96–499, and substituted for them the more general requirement that State payment methods and standards provide lower reimbursement rates for these services in a manner consistent with section 1861(v)(1)(G) of the Act. (This section sets forth the requirements added by section 902, on Medicare payment for these services. As noted earlier, section 2102 modified these requirements by deleting the 80 percent occupancy standard and substituting more general provisions relating to situations in which the Secretary determines there is no excess of hospital beds.) In our view, the purpose of this change is to allow States greater flexibility than under previous law to develop appropriate ways of calculating their payments for these services.

5. *Reasonable access to inpatient hospital services.* The report on H.R. 3982 states the expectation that payment levels for inpatient services will be adequate to assure that a sufficient number of facilities providing a sufficient level of services actively participate in the Medicaid program to enable all Medicaid beneficiaries to obtain quality inpatient services. This report further states that payments should be set at a level that ensures the active treatment of Medicaid patients in a majority of the hospitals in the State.

III. Implementation of Section 2173

A. *General Implementation Approach.* We believe that section 2173, which extended the changes made by section 962 of Pub. L. 96–499 to apply to hospital as well as LTC facility reimbursement, requires that we adopt the same basic implementation approach with respect to payments for both inpatient hospital and LTC facility services. In addition, we believe that use of the same approach to implement both section 962 and section 2173 will simplify the administration of the Medicaid program for both the Federal and State governments and will make it easier for hospitals and facilities to understand Federal policy in this area. Therefore, we will use the revised regulations set forth below, which deal with payments to hospitals as well as LTC facilities, to implement section 2173. Except as specified otherwise in the following paragraphs, we will apply the requirements and procedures described in the section of this preamble that deals with payment for LTC facility services to payment for hospital services as well.

We wish to point out that our use of the same general approach to implement the changes in the Medicaid law relating to LTC facility and hospital services does not mean that States must use the same reimbursement method for both types of facility services. We also wish to note that the term "rates" as used in the revised regulations refers to the payment amounts produced under whatever specific payment method the State adopts for a particular type of facility.

B. *Issues Related to Payment for Inpatient Hospital Services.*

1. *Additional requirements for hospital payments.* In the revised regulations, we have set forth three requirements that apply only to payments for inpatient hospital services, as follows:

- The methods and standards used by States to determine payment rates must take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs;
- The methods and standards used by States to determine payment rates must provide that reimbursement for hospital patients receiving services at an inappropriate level of care, under conditions similar to those described in section 1861(v)(1)(G) of the Act, will be made at lower rates reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G); and
- The payment rates for inpatient hospital services must be adequate to assure that beneficiaries have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

We have included these additional requirements because they are identified in section 2173 as basic conditions that must be met by hospital, but not LTC facility, payments. We have not, however, developed any standard methodology for States to use in ensuring that they meet these standards. We believe development of this methodology should be the responsibility of each State.

2. *Upper limit based on charges.* Section 1903(i) of the Act states that FFP for payments for inpatient hospital services is not available to the extent those payments exceed the hospital's customary charges for the services or, for services of a public institution that furnishes services free or at nominal charges, the amount that would provide fair compensation for the services. The upper limit based on charges is based on this provision of the Medicaid law as well as on the more general provisions of section 1902(a)(30).

Impact Analysis

I. Executive Order 12291

We have determined that these regulations do not meet the criteria for a major rule that are set forth in section 1(b) of Executive Order 12291. That is, the regulations will not:

(1) Have an annual effect on the economy of $100 million or more;

(2) Cause a major increase in costs or prices for consumers, individual industries, government agencies, or geographic regions; or

(3) Have significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

We have made this determination because the revised regulations will not require States to make any specific changes in their hospital or LTC facility payment systems or payment rates. On the contrary, those regulations will simplify the current procedures for Federal action with respect to States' proposed payment rates, and thus increase State discretion in setting rates. Therefore, we believe the initial economic effect of the revised regulations will be to reduce the costs of administering State Medicaid plans.

In making this determination, we are aware that the increased State discretion in rate-setting that will be allowed by the revised regulations may induce some States to make changes in their payment rates, and that these changes could have economic consequences for States, hospitals, and facilities. However, we do not now have any basis for predicting the extent of these changes, or for estimating their economic impact.

II. Regulatory Flexibility Analysis

The Secretary certifies, under section 605(b) of the Regulatory Flexibility Act (Pub. L. 96–354), that these regulations will not have a significant economic impact on a substantial number of small

businesses, nonprofit entities or small local governments.

The reason for the Secretary's negative certification is that, as explained in the Executive Order discussion, these regulations will not require States to make any specific changes in their hospital or LTC facility payment systems or payment rates. By simplifying Federal rules, they increase State discretion in setting rates, and thereby should reduce the costs of administering State Medicaid plans.

As also noted above, State changes in payment rates could have a fiscal impact on States, hospitals, and facilities. However, changes of this type are not required by these regulations, and we do not now have any basis for predicting the extent of these changes, or for estimating their economic impact.

Waiver of Proposed Rulemaking

As indicated in the first part of this preamble, section 2161 of Pub. L. 97-35 requires that the amount of Federal financial participation (FFP) that would otherwise be paid to each State under the Medicaid law be reduced by specific percentages (3 percent for fiscal year 1982, by 4 percent for fiscal year 1983, and by 4.5 percent for fiscal year 1984). These reductions cannot be made for any quarter unless, as of the first day of that quarter, the Secretary has promulgated and has in effect final regulations implementing paragraphs (10)(C) and (13)(A) of section 1902(a) of the Social Security Act. The effect of this special provision is to require that the regulations set forth below, which are needed to implement paragraph (13)(A) of section 1902(a) of the Act, be published in final form (on an interim or other basis) on or before October 1, 1981. If this were not done, we would be prohibited from making the reductions in FFP required by section 2161 for the first quarter of fiscal year 1982.

Because of the statutory deadline imposed by the special provision of section 2161 described above, we believe it would be impractical to delay publication of the final rules set forth below by the amount of time needed to obtain and analyze public comments on them. Moreover, if these regulations are not published on or before October 1, 1981, we would be precluded from making a part of the reduction in FFP for fiscal year 1982 that is required by section 2161. We believe this would be contrary to the public interest. Finally, since Congress expressly referred in section 2161 to the use of interim final regulations, their use in this case has been explicitly authorized. Therefore, we find good cause to waive publication of a notice of proposed rulemaking, and to publish these regulations in final form.

The statutory deadline for implementing these regulations does not permit States time to submit revised State plan amendments before the effective date of the regulations. To accommodate this problem, HCFA will not hold a State out of compliance with the regulations if the Medicaid agency submits the preprinted plan amendment required by the revised regulations by December 31, 1981.

PART 447—PAYMENTS FOR SERVICES

42 CFR Part 447 is amended as set forth below:

1. In Subpart C, §§ 447.250—447.316 are removed and revised §§ 447.250—447.272 are added to read as follows:

Subpart C—Payment For Inpatient Hospital and Long-Term Care Facility Services

Sec.

Subpart D—Payment for Other Institutional and Noninstitutional Services

* * * * *

Subpart C—Payment for Inpatient Hospital and Long-Term Care Facility Services

§ 447.250 Basis and purpose.

Sections 447.251 through 447.265 of this subpart implement section 1902(a)(13)(A) of the Act, which requires that the State plan provide for payment for hospital and long-term care facility services through the use of rates that the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulations, and quality and safety standards. Sections 447.271 and 447.273 implement section 1902(a)(30) of the Act, which requires that payments be consistent with efficiency, economy, and quality of care; and section 1903(i)(3), which requires that payments for inpatient hospital services not exceed the hospital's customary charges.

Payment Rates

§ 447.251 Definitions

For the purposes of this subpart—

"Long-term care facility services" means skilled nursing facility (SNF) services and intermediate care facility (ICF) services, including intermediate care facility services for the mentally retarded (ICF/MR).

"Provider" means an institution that furnishes inpatient hospital services or an institution that furnishes long-term care facilities services.

§ 447.252 General requirements.

(a) *Payment rates.* (1) The Medicaid agency must pay for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(2) The payment rates used by the Medicaid agency must be determined in accordance with methods and standards developed by the agency.

(3) With respect to inpatient hospital services—

(i) The methods and standards used to determine payment rates must take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs;

(ii) The methods and standards used to determine payment rates must provide that reimbursement for hospital patients receiving services at an inappropriate level of care under conditions similar to those described in section 1861(v)(1)(G) of the Act will be made at lower rates, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G); and

(iii) The payment rates for such services must be adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

(b) *State findings.* The Medicaid agency must find that the rates used to

reimburse providers satisfy the requirements of paragraphs (a)(1) and (a)(3) of this section.

(c) *State assurances.* The Medicaid agency must make assurances satisfactory to the Secretary that the requirements of paragraphs (a)(1), (a)(3)(iii), (b), and (f) of this section are met and that, in making significant changes in its methods and standards for determining payment rates, it has complied with the public notice requirements in § 447.254.

(d) *Submittal of assurances and related information.* The Medicaid agency must comply with the requirements regarding submittal of assurances and related information in § 447.255.

(e) *Provider appeals.* The Medicaid agency must provide for a system of provider appeals, as specified in § 447.258.

(f) *Uniform reporting and audit requirements.* The Medicaid agency must provide for uniform cost reporting and periodic audits, as specific in §§ 447.260 and 447.265, respectively.

(g) *Upper limits.* The Medicaid agency must comply with the requirements regarding upper limits specified in §§ 447.271 and 447.272.

§ 447.253 State plan requirements.

(a) The plan must provide that the requirements of this subpart are met.

(b) The plan must specify the methods and standards used by the agency to set payment rates.

(c) If the agency chooses to apply the hospital or SNF services cost limits established under Medicare (see § 405.460 of this chapter) on an individual provider basis, the plan must specify this requirement.

(d) The plan must provide that the agency will make the findings and sumbit the assurances and related information to HCFA, as required under §§ 447.252 and 447.255.

§ 447.254 Public notice requirements.

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

(b) *When notice is not required.* Notice is not required if the change is required by court order.

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

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

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

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

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

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

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

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

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

(2) Appear as a public announcement in—

(i) A State register similar to the Federal Register;

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

(iii) The newspaper of widest circulation in the State, if there is not a city with a population of 50,000 or more; and

(3) Be sent to the HCFA Regional Office upon publication.

§ 447.255 Submittal of assurances and related information.

(a) *Assurances.* The Medicaid agency must submit the assurances in § 447.252(c) before the end of the calendar quarter that includes the date on which the rate has been in effect for one year, or whenever the agency wishes to make a significant change in its methods and standards for determining the rate, whichever is earlier.

(b) *Related information.* The Medicaid agency must submit, with the assurances described in § 447.252(c), the following information:

(1) The amount of the average proposed payment rate for each type of provider (hospital, SNF, ICF, or ICF/MR), and the amount by which that average rate increased or decreased relative to the average payment rate in effect for each type of provider for the immediately preceding rate period;

(2) A quantified estimate of the short-term and, to the extent feasible, long-term effect the change in the rate will have on—

(i) The availability of services on a Statewide and geographic area basis;

(ii) The type of care furnished (for example, secondary or tertiary care);

(iii) The extent of provider participation; and

(iv) The degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

§ 447.256 Procedures for HCFA action on assurances.

(a) *Time limit for action.* HCFA will review the related information described in § 447.255 to determine the reasonableness of significant changes in the items specified in paragraph (b)(2) of that section that result from a change in the average proposed payment rate. HCFA will notify the agency of its determination as to whether the agency's assurances regarding a proposed rate are acceptable within 60 days of the date HCFA receives the assurances described in paragraph (c) of § 447.252 and the related information described in paragraph (b) of § 447.255.

If HCFA does not notify the agency of its determination within this time limit, the assurances will be deemed accepted.

(b) *Effective date.* (1) Except as specified in paragraph (b)(2) of this section, a proposed payment rate with respect to which HCFA has accepted assurances or with respect to which an assurance has been deemed accepted under this section will be effective on the date specified in the agency's assurances.

(2) A payment rate with respect to which HCFA has accepted assurances or with respect to which an assurance has been deemed accepted under this section will not be effective for any period beginning before the first day of the calendar quarter in which the agency submits the assurances and related information described in § 447.255.

Provider Appeals

§ 447.258 Provider appeals of State rate determinations.

The agency must provide an appeals procedure that allows individual providers an opportunity to submit additional evidence and request prompt administrative review of payment rates.

Cost Reporting

§ 447.260 Provider cost reporting.

The agency must provide for the filing of uniform cost reports by each participating provider.

Audits

§ 447.265 Audit requirement.

The agency must provide for periodic audits of the financial and statistical records of participating providers.

Upper Limits

§ 447.271 Upper limits based on customary charges.

(a) Except as provided in paragraph (b) of this section, the agency may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.

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

§ 447.272 Upper limits based on Medicare payments.

(a) An agency may not pay more in the aggregate for inpatient hospital services or long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement under Part 405, Subpart D of this chapter. Payments meet this requirement—

(1) If, in a random sample of all Medicaid providers, the payment is not more than the amount that would have been paid under Medicare in at least 90 percent of the providers in the sample; or

(2) If the average payment to all providers in a class is not more than the average amount that would have been paid under Medicare.

(b) To determine what would have been paid for a class of providers under Medicare—

(1) For providers that participate in Medicare, the interim rate paid to the provider under Medicare (adjusted for services not included in the State plan and for the Medicare inpatient routine nursing salary cost differential paid under § 405.430 of this chapter) may be used to determine the upper limit; and

(2) For hospitals and SNFs that do not participate in Medicare and for ICFs, the agency must estimate the amounts Medicare would have paid those providers. These estimates must be consistent with the intent that payments do not exceed amounts (adjusted for services not included in the State plan and for the Medicare inpatient routine nursing salary cost differential paid under § 405.430 of this chapter) that would be determined using Medicare's principles.

2. A new heading is added before § 447.321, as follows:

Subpart D—Payment for Other Institutional and Noninstitutional Services

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(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

Dated: September 23, 1981.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: September 24, 1981.

Richard S. Schweiker,

Secretary.

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