

diseases and injuries. The term includes, but is not limited to, hospitals, clinics, alcohol and drug abuse treatment centers, public health or treatment centers, research and health centers, geriatric centers, laboratories, medical schools, dental schools, nursing schools, and similar institutions. The term does not include institutions primarily engaged in domiciliary care, although a separate medical facility within such a domiciliary institution may qualify as a *medical institution*.

Museum means a public or nonprofit institution that is organized on a permanent basis for essentially educational or aesthetic purposes and which, using a professional staff, owns or uses tangible objects, either animate or inanimate; cares for these objects; and exhibits them to the public on a regular basis (at least 1000 hours a year). As used in this part, the term *museum* includes, but is not limited to, the following institutions if they satisfy all other provisions of this definition: Aquariums and zoological parks; botanical gardens and arboreta; nature centers; museums relating to art, history (including historic buildings), natural history, science, and technology; and planetariums. For the purposes of this definition, an institution uses a professional staff if it employs at least one fulltime staff member or the equivalent, whether paid or unpaid, primarily engaged in the acquisition, care, or public exhibition of objects owned or used by the institution. This definition of *museum* does not include any institution that exhibits objects to the public if the display or use of the objects is only incidental to the primary function of the institution.

Nationally recognized accrediting agency means an accrediting agency that the Department of Education recognizes under 34 CFR part 600. (For a list of accrediting agencies, see the Department's web site at <http://www.ed.gov/offices/OPE/accreditation/index.html>)

Nonprofit means not organized for profit and exempt from Federal income tax under section 501 of the Internal Revenue Code (26 U.S.C. 501).

Parks and recreation means a program(s) carried out or promoted by a public agency for public purposes that involve directly or indirectly the acquisition, development, improvement, maintenance, and protection of park and recreational facilities for the residents of a given political area.

Program for older individuals means a program conducted by a State or local government agency or nonprofit activity that receives funds appropriated for services or programs for older individuals under the Older Americans Act of 1965, as amended, under title IV or title XX of the Social Security Act (42 U.S.C. 601 *et seq.*), or under titles VIII and X of the Economic Opportunity Act of 1964 (42 U.S.C. 2991 *et seq.*) and the Community Services Block Grant Act (42 U.S.C. 9901 *et seq.*).

Provider of assistance to homeless individuals means a public agency or a nonprofit institution or organization that operates a program which provides assistance such as food, shelter, or other services to homeless individuals.

Provider of assistance to impoverished families and individuals means a public or

nonprofit organization whose primary function is to provide money, goods, or services to families or individuals whose annual incomes are below the poverty line (as defined in section 673 of the Community Services Block Grant Act) (42 U.S.C. 9902). Providers include food banks, self-help housing groups, and organizations providing services such as the following: Health care; medical transportation; scholarships and tuition assistance; tutoring and literacy instruction; job training and placement; employment counseling; child care assistance; meals or other nutritional support; clothing distribution; home construction or repairs; utility or rental assistance; and legal counsel.

Public agency means any State; political subdivision thereof, including any unit of local government or economic development district; any department, agency, or instrumentality thereof, including instrumentalities created by compact or other agreement between States or political subdivisions; multijurisdictional substate districts established by or pursuant to State law; or any Indian tribe, band, group, pueblo, or community located on a State reservation.

Public health means a program(s) to promote, maintain, and conserve the public's health by providing health services to individuals and/or by conducting research, investigations, examinations, training, and demonstrations. Public health services may include but are not limited to the control of communicable diseases, immunization, maternal and child health programs, sanitary engineering, sewage treatment and disposal, sanitation inspection and supervision, water purification and distribution, air pollution control, garbage and trash disposal, and the control and elimination of disease-carrying animals and insects.

Public health institution means an approved, accredited, or licensed public or nonprofit institution, facility, or organization conducting a public health program(s) such as a hospital, clinic, health center, or medical institution, including research for such programs, the services of which are available to the public.

Public purpose means a program(s) carried out by a public agency that is legally authorized in accordance with the laws of the State or political subdivision thereof and for which public funds may be expended. Public purposes include but are not limited to programs such as conservation, economic development, education, parks and recreation, public health, public safety, programs of assistance to the homeless or impoverished, and programs for older individuals.

Public safety means a program(s) carried out or promoted by a public agency for public purposes involving, directly or indirectly, the protection, safety, law enforcement activities, and criminal justice system of a given political area. Public safety programs may include, but are not limited to those carried out by:

- (1) Public police departments.
- (2) Sheriffs' offices.
- (3) The courts.
- (4) Penal and correctional institutions (including juvenile facilities).

(5) State and local civil defense organizations.

(6) Fire departments and rescue squads (including volunteer fire departments and rescue squads supported in whole or in part with public funds).

School (except schools for the mentally or physically disabled) means a public or nonprofit approved or accredited organizational entity devoted primarily to approved academic, vocational, or professional study and instruction, that operates primarily for educational purposes on a full-time basis for a minimum school year and employs a full-time staff of qualified instructors.

School for the mentally or physically disabled means a facility or institution operated primarily to provide specialized instruction to students of limited mental or physical capacity. It must be public or nonprofit and must operate on a full-time basis for the equivalent of a minimum school year prescribed for public school instruction for the mentally or physically disabled, have a staff of qualified instructors, and demonstrate that the facility meets the health and safety standards of the State or local government.

University means a public or nonprofit approved or accredited institution for instruction and study in the higher branches of learning and empowered to confer degrees in special departments or colleges.

Dated: January 2, 2002.

Stephen A. Perry,

Administrator of General Services.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS-2134-F]

RIN 0938-AL05

Medicaid Program; Modification of the Medicaid Upper Payment Limit for Non-State Government-Owned or Operated Hospitals

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

ACTION: Final rule.

SUMMARY: This final rule modifies the Medicaid upper payment limit (UPL) provisions to remove the 150 percent UPL for inpatient hospital services and outpatient hospital services furnished by non-State government-owned or operated hospitals. This final rule is part of this Administration's efforts to restore fiscal integrity to the Medicaid program and reduce the opportunity for abusive funding practices based on

payments unrelated to actual covered Medicaid services.

EFFECTIVE DATE: These regulations are effective on March 19, 2002.

FOR FURTHER INFORMATION CONTACT: Marge Lee, (410) 786-4361.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that Medicaid State plans have methods and procedures relating to the payment for care and services to ensure that payments are consistent with efficiency, economy, and quality of care. This provision is implemented in regulations at 42 CFR part 447 that set upper payment limits (UPLs) for different types of items and services. For certain institutional providers, including hospitals, these upper payment limits apply in the aggregate to all payments to a particular class of providers, and are based on the estimated payment under Medicare payment principles.

In a final rule published on January 12, 2001 in the **Federal Register** (66 FR 3148), we revised the Medicaid UPL for inpatient and outpatient hospitals to require separate UPLs for State-owned or operated facilities, non-State government-owned or operated facilities, and privately owned and operated facilities. In that final rule, we also created an exception for payments to non-State government-owned or operated hospitals. That exception provided that the aggregate Medicaid payments to those hospitals may not exceed 150 percent of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles. At that time, we believed that payments to these public hospitals needed a higher UPL because of their important role in serving the Medicaid population.

Based on further analysis, we do not believe that a higher UPL is necessary to achieve the objective of assuring access for Medicaid patients to the services of public hospitals. Our rationale is partly based on the following:

- We believe that the 100 percent UPL is more than sufficient to ensure adequate access to services for Medicaid beneficiaries at public hospitals. Under this limit, States may pay public providers up to 100 percent of a reasonable estimate of what Medicare would have paid for services provided to Medicaid beneficiaries. States also retain some flexibility to make enhanced payments to selected public hospitals under the aggregate limit.

- We do not believe that the higher payments are necessarily being used to further the mission of these hospitals or their role in serving Medicaid patients. The OIG has issued several reports demonstrating that a portion of the enhanced payments made as part of the UPL process are being transferred directly back to the State via intergovernmental transfers and used for other purposes (which may include funding the State share of other Medicaid expenditures). In cases for which hospitals did retain UPL-related enhanced payments, the OIG found that these same hospitals either did not receive disproportionate share hospital (DSH) payments or if they did, typically returned the DSH payments directly back to the State through intergovernmental transfers. We believe that Medicaid provisions permitting enhanced payments to disproportionate share hospitals should be sufficient to ensure that Medicaid beneficiaries have access to the services of these hospitals.

- Many of the public safety net hospitals affected by this rule qualify as DSH hospitals. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), enacted on December 21, 2000, provides additional funding to public hospitals by increasing the hospital-specific DSH limits originally set under the Omnibus Budget Reconciliation Act of 1993. States will have the ability to make Medicaid DSH payments to public hospitals up to 175 percent of a hospital's reasonable costs of treating the uninsured and Medicaid beneficiaries for a period of two State fiscal years beginning after September 30, 2002.

- We wish to restore payment equity among hospital providers and across other provider types.

Furthermore, the OIG stated in a report dated September 11, 2001 that the need for the higher UPL for non-State government-owned or operated hospitals has not been adequately supported through an analysis of these hospitals' financial operations. Since the public hospitals are not retaining all of the funds available under the UPL or DSH program, we believe the higher UPL is neither furthering their special mission nor ensuring continued access to these facilities for the Medicaid population. Instead, the main result is that the Federal government is effectively paying more than its share of State Medicaid expenditures.

II. Provisions of the Proposed Regulations

On November 23, 2001, we published a proposed rule in the **Federal Register**

(66 FR 58694) proposing to lower the UPL for non-State government-owned or operated hospitals from 150 percent to 100 percent. The proposed rule is part of this Administration's efforts to promote fiscal integrity to the Medicaid program and restore the appropriate balance between the Federal Government and States with respect to funding the Medicaid program. In the November 2001 proposed rule, we proposed to revise §§ 447.272(c) and 447.321(c) to remove the exception in paragraph (c)(1) regarding payments to non-State government-owned or operated hospitals. In § 447.272(c), we proposed to redesignate the exceptions in paragraph (c)(2) to (c)(1) and (c)(3) to (c)(2) for payments to Indian Health Services and tribal facilities and disproportionate share hospitals (subject to a separate limit on payments to disproportionate share hospitals). We also proposed to revise the compliance dates described in §§ 447.272(d) and 447.321(d) to make clear that States would need to comply with the UPL for these non-State government-owned or operated hospitals as of the effective date of the final rule.

In addition to eliminating the higher UPL, we proposed conforming technical changes to §§ 447.272(b) and 447.321(b) that would clarify the single UPL standard generally applicable to aggregate payments to each group of facilities, including non-State government-owned or operated hospitals. This proposal would not change the substantive standard that aggregate payments would be limited to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles. Except as permitted under the transition periods, payments under an approved State plan would need to be reduced to comply with this limit as of the effective date of the final rule. We stated in the preamble of the proposed rule that we would not approve any State plan amendments that would allow payments in excess of this limit as of the effective date of the final rule. And we referenced a letter to State Medicaid Directors issued November 20, 2001, in which we indicated that we did not intend to approve any amendments submitted after the publication date of the proposed rule that would provide for payments that exceed those permitted under this proposed rule because we did not believe that States should have any reasonable reliance that such plan amendments would be approved.

We did not propose any change to the standards for determining transition periods; thus there would be no change

in the State payment methodologies that qualified for a transition described in §§ 447.272(e) and 447.321(e). However, aggregate payments to non-State government-owned or operated hospitals during the transition period would need to be reduced to 100 percent of a reasonable estimate of the amount that would be paid for the services furnished by this group of facilities under Medicare payment principles rather than 150 percent as described in the final rule published on January 12, 2001. As noted above, we proposed a compliance provision at §§ 447.272(d) and 447.321(d) that would require that State payment methodologies that do not qualify for a transition period must be in compliance with the 100 percent UPL for non-State government-owned or operated hospitals as of the effective date of a subsequent final rule.

We also proposed some minor technical changes to §§ 447.272 and 447.321 redesignating paragraph (e)(2)(ii)(C)(8) regarding when a reduction begins as paragraph (e)(2)(iii). We also proposed to redesignate paragraph (e)(2)(iii) as (e)(2)(iv).

We also proposed to remove § 447.272(f)(1)(i) and (f)(1)(ii) and § 447.321(f)(1)(i) and (f)(1)(ii), which describe the reporting requirements for non-State government-owned or operated hospitals, and retain paragraph (f)(1) that describes the reporting requirements for payments made by States in excess of the amount described in paragraph (b) of this section during the transition periods. The reporting requirements for these States would not change.

III. Analysis of and Responses to Public Comments

We received approximately 200 timely comments in response to the November 23, 2001 proposed rule. We received letters from State government officials, county government organizations, beneficiary organizations, health care providers and provider organizations, and private citizens. We reviewed each comment and grouped like or related comments. The comments and our responses are summarized below.

Support for Eliminating the 150 Percent UPL

Comment: Several commenters expressed support for removing the 150 percent UPL for inpatient and outpatient hospital services furnished by non-State government-owned or operated facilities, stating that one group of providers should not have a financial benefit over another group of

providers who provide the same type of services.

Response: We agree. Our intent in this rule is to treat all facilities equally, and apply the same aggregate UPL to each group of facilities, regardless of who owns or operates the facilities.

Support for Retaining the 150 Percent UPL

Comment: Several commenters urged us to retain the 150 percent UPL and not publish this final rule.

Response: We believe that the 150 percent provision is not being used to increase real payments to hospitals but instead to replace State funds with Federal funds. We have not accepted this comment because this rule is critical for maintaining the fiscal integrity of the Medicaid program and ensuring that all facilities are treated equally under Federal Medicaid UPL regulations.

Comment: One commenter urged us to withdraw the rule and submit a report to the Congress on how future changes would impact public hospitals.

Response: Reports from the OIG demonstrate that, in many cases, higher upper payment limits are not being used to support the mission of public hospitals. As a result, we believe that the impact of this rule will not be severe for many hospitals, as they have not kept all of the funds generated by the upper payment limits. Moreover, as noted elsewhere in this rule, we are not making any changes to Medicaid DSH payments, which are designed to be the primary vehicle for supporting hospitals that serve a large number of indigent or uninsured patients. The expected impact on hospitals is discussed more fully in the Regulatory Impact Analysis in section VI of this final rule.

Comment: Several commenters expressed concern about the effect of this rule on the health care safety net in specific States. They indicated that a reduction in funds resulting from this final rule would cause hospitals to cut services or close altogether. Further, commenters indicated this rule would cut access to critically needed health services for the uninsured, including immigrants and working families. One commenter pointed out that the reduction in reimbursement rates would produce a crisis in health care in one State, which would result in many more serious illnesses and deaths across that State. Another commenter expressed particular concern with the impact of the rule on children's hospitals.

Response: This rule would permit States to reimburse hospitals for 100 percent of their reasonable costs of providing care to Medicaid patients,

based on a reasonable estimate of what Medicare would have paid for services provided to Medicaid patients. Although we previously believed a higher UPL was necessary to ensure the availability of safety net facilities, we have concluded that a 100 percent UPL will achieve that purpose because it is adequate to pay hospitals their reasonable costs of serving Medicaid patients. States also have the ability to pay additional Medicaid payments to safety-net hospitals and receive Federal funding under the Medicaid disproportionate share hospital program. The statutory authority for such payments permits States to recognize those hospitals that treat a high number of Medicaid and low-income patients by increasing Medicaid payments to those hospitals that qualify.

Comment: One commenter noted that the 150 percent UPL was adopted by us in the January 12, 2001 regulation to help mitigate the impact of reduced Federal Medicaid funding available to public hospitals. The commenter was concerned that this modification would withdraw Federal funds available to help States with the special problems facing these hospitals.

Response: For those States that have relied on Federal funds generated through UPL payments to assist public hospitals, relief can be sought from two sources. First, this rule does not remove the transition periods set forth in the January 12, 2001 final regulation for those States and hospitals that have relied on the funding available under the UPL for a number of years. Second, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), enacted on December 21, 2000, provides additional funding to public hospitals by increasing the hospital-specific disproportionate share hospital limits originally set under the Omnibus Budget Reconciliation Act of 1993. States will have the ability to make Medicaid disproportionate share hospital payments to public hospitals up to 175 percent of a hospital's reasonable costs of treating the uninsured and Medicaid beneficiaries for a period of two State fiscal years beginning after September 30, 2002 and receive Federal matching funds for these higher DSH payments.

Comment: Several commenters pointed out that in the wake of September 11, 2001, rising unemployment will not only increase the number of Medicaid beneficiaries and indigents but will also reduce State tax revenues needed to finance Medicaid costs. Other commenters further added that the decrease is

inappropriate given the increased demands being made on hospitals since September 11, 2001. Another commenter voiced the opinion that issuing this rule is contrary to democratic views and will exacerbate the social problems of our highly diverse society.

Response: We recognize that the events of September 11, 2001 have affected many Americans and caused States to incur costs not otherwise anticipated. We want to stress that this rule addresses only the Federal responsibility to assist States to pay for health care services provided to Medicaid beneficiaries at public hospitals. This rule is not intended to have an adverse effect on reimbursement for Medicaid services provided to Medicaid beneficiaries. Under this rule, States will retain the flexibility to pay these facilities up to 100 percent of a reasonable estimate of what Medicare would have paid for services provided to Medicaid beneficiaries. If the number or severity of Medicaid beneficiaries increases for whatever reason, the payment that can be made consistent with the UPL will likewise increase commensurate with the reasonable cost of serving the Medicaid population in each State. While we understand the situation of States that are faced with reduced budgets and strained tax revenues in the current national economic climate, we want to point out that the Congress established the Medicaid program as a joint Federal and State partnership, where each party shares in the financial responsibility of providing care to Medicaid beneficiaries.

Comment: One commenter noted that this rule will have a significant negative impact on the State's continued ability to draw down Federal funds, and, therefore, will be detrimental to all health and human services.

Response: Under this rule, States will be able to receive Federal funding for hospital expenditures incurred on behalf of Medicaid-eligibles, as permitted under Federal law. While the rule will limit States' ability to receive Federal funding for excessive payments, we believe States will retain flexibility to set fair and appropriate payment rates to public hospitals.

Comment: Several commenters stated that the 150 percent UPL is part of an agreement between Congressional leaders, CMS, and the Office of Management and Budget (OMB). The agreement aimed to protect the fragile network of health care services for low-income individuals. It is neither prudent nor fair to change the rules so quickly and nullify an agreement that

was supposed to help ensure health care for those in need.

Response: We have a responsibility to interpret and apply the provisions of the Medicaid statute, including the requirement at section 1902(a)(30)(A) of the Social Security Act that payments under State plans must be consistent with efficiency, economy and quality of care. Whether or not any particular individuals had an agreement in the past about how this requirement should apply is not at issue.

Comment: One commenter suggested that we add a requirement that public hospitals have a net gain of at least two-thirds of the additional Federal funds collected under hospital-based UPL plans in order to ensure that public hospitals are, in fact, primary beneficiaries of any UPL arrangements.

Response: It is not clear what the commenter believes would be the legal authority for CMS to limit a hospital's use of its own funds. Furthermore, while the suggested approach allows public hospitals to retain the Federal funds, it does not limit other public hospital revenues from being transferred from the hospital to the State government. Federal funds, once received by the hospital, are fungible. We do not believe this alternative would increase the net funding available to these hospitals, nor do we believe that this alternative would improve access to hospital services for Medicaid beneficiaries. We do not believe this alternative would decrease the Federal share of the Medicaid program expenditures for these hospitals. Therefore, we believe the reduction of the UPL from 150 percent to 100 percent will be sufficient to maintain the fiscal integrity of the Medicaid Program and ensure that all facilities are treated equally under Federal Medicaid UPL regulations.

Comment: One commenter noted that the Congress, in passing BIPA, in effect required us to retain the 150 percent UPL for non-State government-owned or operated hospitals. The new proposed rule lowering the UPL is clearly contrary to the intent of the Congress in passing section 705 of BIPA because the Congress clearly wanted to provide a transition period for States down to the 150 percent UPL without causing economic dislocations to non-State government-owned hospitals.

Response: We do not agree that the statute at section 705(a) of BIPA requires that we retain the 150 percent UPL forever simply because it was in the October 10, 2000 proposed rule. Section 705 of BIPA required that we publish a rule based on the proposed rule, but did not remove agency discretion as to the

contents of the final rule except to the extent of requiring a transition period not specified in the proposed rule. We published that final rule, fulfilling those BIPA requirements. Section 705 of BIPA did not preclude the agency from revisiting and revising its rule.

Comment: Several commenters indicated that our timing could not be worse with this rule given the economic downturn, workforce downsizing, and Medicaid experiencing a financial deficit due to a rise in health care costs. One commenter expressed concern that this rule would make it difficult for hospitals to attract and keep quality workers.

Response: This rule allows States to pay hospitals up to 100 percent of the reasonable costs of serving Medicaid patients, based on a reasonable estimate of what Medicare would have paid for the services provided to Medicaid patients. Also, as noted in an earlier response, if the number or severity of Medicaid beneficiaries increases, for whatever reason, the payment that can be made consistent with the UPL will likewise increase commensurate with the reasonable cost of serving the Medicaid population in each State.

Comment: One commenter noted that President Bush wants more funding for the military, but, at the same time, is willing to slash the country's public health care system. The commenter viewed this policy as indicating a lack of compassion for the country's poor. Another commenter considers it irresponsible for the Department and the Administration to be considering a rule change that is sure to have inhumane and tragic results.

Response: This rule is not a statement of public policy on funding for this nation's health care system. This rule also does not intend to cut funds to care for the country's poor, but is intended to promote fiscal integrity and restore an appropriate balance between the Federal government and States with respect to funding the Medicaid program. Since the publication of the January 12, 2001 rule, many States have increased payments to non-State government-owned hospitals and requested hospitals transfer a portion of those payments back to the State, county, or local governments or used Federal monies to supplant State monies for these payments. Therefore, these enhanced payments are not being used by the hospital to provide additional services to Medicaid beneficiaries, but are being transferred back to the State government for purposes not necessarily related to providing Medicaid services to Medicaid beneficiaries.

Comment: One commenter recommended that we leave the 150 percent UPL intact for those States that transfer the Federal funds, through intergovernmental transfers, to the public hospitals and not back into the State general fund. Another commenter urged us to create an exception to the 100 percent UPL for those States that operate under cost-neutral waivers.

Response: Because of the administrative difficulty in identifying and tracking Federal funds once the State draws down the Federal share for Medicaid expenditures, it is unrealistic to consider implementing a regulation that permits the 150 percent UPL to remain for some States, but eliminates it for others. Furthermore, the reduction to a 100 percent UPL applies to all States, regardless of whether they operate under cost neutral waivers, except to the extent that the State is entitled to a transition period, discussed in detail below.

Comment: One commenter noted that the 150 percent limit should remain and that CMS has no basis for the exclusion of long term care facilities from consideration for a more flexible UPL. Additionally, this commenter requested that the 150 percent UPL be expanded to include Medicaid payments to nursing facilities.

Response: Modifying the upper payment limit for nursing home facilities is outside the scope of this rule and contrary to our intent to preserve the fiscal integrity of the Medicaid program. Therefore, we do not accept this comment.

Intergovernmental Transfers

Comment: One commenter pointed out that some States have used intergovernmental transfers (IGT) of funds to take advantage of the flexibility in past and current UPL rules to draw down excess Federal dollars. The commenter recommended that we should adopt rules that will prevent States from requiring hospitals to transfer a sizable portion of enhanced payments back to the State for other purposes. At the same time, the commenter pointed out that limiting a State's ability to finance its Medicaid program using IGT payments may result in reduced access to services for Medicaid beneficiaries. Other commenters noted that a regulation to require non-State government-owned or operated hospitals to retain their Medicaid funding would be more prudent.

Response: Under section 1903(w)(6)(A) of the Social Security Act, the Congress limited authority to regulate States' certain uses of IGTs. We

have clear authority to limit the State payment levels that are not consistent with efficiency, economy, and quality of care because they exceed the amount appropriate for the Medicaid services being furnished. These limits are a reasonable measure to protect the overall fiscal integrity of the Federal Medicaid program.

Comment: The proposed rule, by lowering the UPL to 100 percent of what reasonable Medicare payments would be, effectively eliminates the use of intergovernmental transfers and thus permits the Secretary to do indirectly what section 1903(w)(6) of the Act prohibits the Secretary from doing directly.

Response: We are not restricting the States' use of funds transferred or certified from units of government. This reduction in the UPL restricts the States' payment to non-State government-owned or operated hospitals. The State still maintains control as to what government funding sources it may use to make Medicaid payments.

Transition Periods

Comment: One commenter noted that the transition periods permitted under previous rules should be eliminated or reduced.

Response: We are retaining the transition periods outlined in previously published rules in this final rule. We continue to believe that States that have had longstanding reliance on these funds need time to find other funding sources to replace the money generated by the UPL payment mechanisms. However, we want to reiterate our position with regard to States that have had payment methodologies in effect that provide for payments to non-State government-owned or operated hospitals up to the 150 percent UPL. These States were not previously entitled to a transition period and regardless of the effective date of such payment methodologies, we are not establishing a new transition period during which these States may make payments in excess of the 100 percent UPL. We have modified the regulation text at §§ 447.272(e) and 447.321(e) to clarify that States with payment methodologies that provide for payments to non-State government-owned or operated hospitals up to the 150 percent UPL do not qualify for a transition period. Such States must reduce such payments to comply with the 100 percent UPL as of the effective date of this rule.

Comment: Several commenters pointed out that States have already factored Medicaid monies gained through the 150 percent UPL into their

State budgets for health care expenditures. Other commenters pointed out that at the very least States that relied on the final rule in developing their biennial budgets should be afforded a transition. Several commenters further noted that it is unfair to allow transition periods for some facilities to come into compliance with the 100 percent UPL, but not permit States that recently began using the 150 percent UPL to use similar transition periods. They believe it unfairly penalizes States that have more recently used the 150 percent UPL funds. Several commenters also noted that not allowing a transition period from the 150 percent UPL to the 100 percent UPL is arbitrary and capricious.

Response: Although we acknowledge that States may have established budgets based on the 150 percent UPL, the higher UPL has only been in effect since March 2001. The impact of the reduced funding available to public hospitals through the rule published on January 12, 2001 is mitigated by the transition periods contained in that rule, as well as those in the rule published on September 5, 2001. Furthermore, the transition periods contained in prior regulations apply equally to all States and all State payment methodologies. The transition periods are designed to mitigate the impact of the creation of new categories of providers subject to an aggregate 100 percent UPL. All States that meet the requirements of one or more transition periods will be able to reduce their payments gradually based on the schedules in the transition periods. However, as previously noted, the 150 percent UPL has only been in place since March 2001, and, therefore, States have not developed the same reasonable reliance on that higher UPL as they have on payments that were in place for several years. In the absence of any reasonable reliance on higher payment levels, we do not agree that additional modification of the transition periods is required.

Comment: One commenter requested that we clarify our intention in applying the 100 percent UPL to States that qualify for a transition period.

Response: For States that qualify for the 5 and 8 year transition periods, the maximum amount allowable during each transition period will be based on a percentage of the 100 percent UPL during each year. For example, during the 8-year transition period, for State FY 2006, a State may pay up to the 100 percent UPL for State FY 2006, plus 55 percent of the State's excess payment above 100 percent during the base year. Had we not published this rule, the State would be able to pay up to the 150

percent UPL for State FY 2006, plus 55 percent of the State's excess payment above 150 percent during the base year. For States that qualify for the 2-year transition period, payments must be reduced to the 100 percent UPL as of October 1, 2002.

Reporting Requirements

Comment: One commenter pointed out that the 150 percent UPL was put in place less than one year ago. When the higher UPL was established, we also created requirements for States to report to us how they were spending Medicaid funds under the 150 percent UPL. The commenter recommended that we delay implementing a reduction in the 150 percent UPL until we have evaluated those reports. Another commenter recommended that we allow more time to evaluate the effects of the January 12, 2001 final rule to allow a more balanced response to any legitimate concerns that might be found to exist.

Response: Our reporting requirements are not sufficiently detailed to allow us to evaluate State spending in the manner suggested by the commenters. Regardless, our decision to reduce the UPL for public hospitals to 100 percent is not based on the reporting requirements associated with the higher UPL. Based on a number of detailed reports by the OIG, it has become clear that Federal funding being claimed for excessive payments was not always being used by the public hospitals themselves; instead a portion of the Federal funding was being used to substitute for State funding. This is clearly inappropriate in the context of a joint Federal-State program and we do not see any reason to delay reducing the UPL to a level that would limit these abuses.

Comment: One commenter suggested that if additional reporting is required, the staffing for preparing the data and reports should be eligible for enhanced Federal match at 90 percent due to the extensive additional workload. Another commenter urged that the reporting requirements be strengthened to include the level of IGTs or other funds provided by or on behalf of health care providers in UPL arrangements.

Response: We have evaluated the impact of the reporting requirements in the regulatory impact section below. As noted in a previous comment, we are decreasing the reporting requirements in this regulation. As we also previously noted, this rule does not address the States' abilities to transfer funds. Accordingly, such a reporting requirement would have no bearing on the intent of this final rule.

Impact on State Plan Amendments

Commenter: One commenter has asked what effect this final rule will have on those 150 percent UPL State plans submitted before publication of the proposed rule, but which have not been approved.

Response: We reviewed and approved numerous State plans submitted before we issued the proposed rule that permitted 150 percent UPL payments. These amendments were reviewed based upon the current regulation in effect at the time of review. Unless these amendments qualify for a transition period, however, as of the effective date of this rule, no payments may be made that exceed the revised UPL. The requirements contained in this regulation will not take effect until 60 days after the publication of the regulation and, at that time, we will disapprove any pending amendments that would provide for payments that exceed the UPL in effect. Any new State plan amendments submitted on or after the effective date will be disapproved to the extent that payments would exceed the revised UPL.

Commenter: One commenter stated that States with already approved State plans that allow UPL payments up to 150 percent should be exempted from the proposed rule.

Response: We can not legally exempt from this rule States with approved State plan amendments supporting a higher UPL. We will handle all States equally with respect to the UPL. We can and have allowed States that qualify for transition periods to continue to have those transition periods at a lower level of Federal funding.

Miscellaneous

Comment: Several commenters indicated that we should consider the number of proposals the OIG has made including requiring annual audits of UPL calculations; providing definitive guidance on calculating the UPL that is uniform to all States; and requiring States to demonstrate that the enhanced payments are actually made available to the facilities and that these payments are for approved Medicaid services only. Another commenter indicated that we have an obligation to analyze the problem much more thoroughly and exercise our already broad authority to control the UPL problem using more appropriate methods targeted to the situation. For example, we could issue guidelines to clarify how States are actually calculating their upper payment limits and that Medicaid payments are reasonable and are being retained by the provider. Other

commenters suggested alternatives to issuing a final rule. For example, we could reinstate the previous practice of requiring States to submit assurances that the UPL has not been exceeded.

Response: We want to curtail unnecessary spending in a way that results in the least amount of burden administratively on the States and the Federal government. The quickest way to reduce unnecessary spending is to stop the funding stream soon after the States begin to rely on it. In addition, we are considering increasing our oversight activities with respect to evaluating States' enhanced payments. The majority of the State plan proposals submitted since the effective date of the January 12, 2001 rule required hospitals to either fund the State's share of the costs of the 150 percent UPL payment or transfer part of the UPL payment back to the State or local government. In our view, the 100 percent UPL is adequate reimbursement as long as the States allow hospitals to retain the Medicaid payment. Furthermore, we do not see how creating a requirement that States submit assurances would result in the savings anticipated in this final rule.

Comment: One commenter suggested that abuses of the system be corrected on a case-by-case basis instead of by imposition of a broad based policy.

Response: We feel strongly that the problem being corrected in this rule is of national importance and is most appropriately addressed by this rule, rather than pursuing abuses based on other authorities on a case-by-case basis. As noted earlier, we want to limit any unnecessary spending that would result in burdensome administrative proceedings for the States and the Federal government. To track and evaluate each case of possible abuse would also require additional resources not currently available.

Comment: One commenter suggested that we have not met the requirements of the Administrative Procedure Act (APA) in publishing this rule. The commenter noted that relevant case law regarding the APA permits an agency to change a regulation if it can demonstrate good cause for making the change and can clearly explain the reasons for its departure from its prior stance. The commenter noted that before the January 12, 2001 rule took effect, the President announced a proposal to modify this UPL. The commenter believes we cannot articulate a reasonable basis for our policy reversal and, as a result, we cannot meet the requirements of the APA.

Response: We disagree. In publishing this rule, we have adhered to the law. In publishing this rule, we have based

our actions on a review of the OIG reports pertaining to UPL payments as well as our own review of the new State plan amendments submitted after the January 2001 rule took effect and our further analysis of the requirements of the Medicaid statute. This additional information and analysis underlay the President's proposal to modify the UPL, and the proposal has been promulgated using full notice and comment procedures. Therefore, this regulatory action to modify the UPL does not violate the APA.

Comment: One commenter stated that in attempting to implement the proposed regulation immediately, we are violating rulemaking requirements for the effective date of a regulation. In addition, the commenter believes that we are attempting to evade the rulemaking requirements contained in Executive Order 12866 by failing to make a serious effort to evaluate existing law and regulations.

Response: We have not implemented these proposed regulations to date, nor do we have any intention of so doing until the effective date stated in this rule. This effective date is consistent with all requirements of law. Furthermore the results intended to be achieved by this rule are fully consistent with the Medicaid statute and we believe are necessary to ensure the fiscal integrity of the Medicaid program. The Medicaid statute contains a formula for the Federal and State shares of expenditures; as explained above, the 150 percent UPL has been a means for States to effectively claim a higher Federal share than warranted. The payments that States are permitted to make to hospitals consistent with the revised UPL are sufficient to pay the full reasonable costs to hospitals of serving the Medicaid population, and will assure access to those hospitals for Medicaid beneficiaries. The revised UPL will assure that payments will be consistent with "efficiency, economy and quality of care" as required by section 1902(a)(30)(A) of the Social Security Act. The Medicaid statute has specific provisions for the additional payments to assist disproportionate share hospitals but does not contemplate other general assistance to hospitals, or use of excessive payments as mechanisms to finance general State obligations. In section VI below, we set forth our full regulatory impact analysis.

IV. Provisions of the Final Regulations

We are adopting the provisions of the regulations text in the November 23, 2001 proposed rule as final. In response to comments, we have modified §§ 447.272(e) and 447.321(e) to clarify

that States with payment methodologies that provide for payments to non-State government-owned or operated hospitals up to the 150 percent of the UPL do not qualify for a transition period.

V. Collection of Information Requirements

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

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

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

Section 447.272 Inpatient Services: Application of Upper Payment Limits

Under paragraph (f), *Reporting requirements for payments during the transition periods*, States that are eligible for a transition period described in § 447.272(e), and that make payments that exceed the limit under § 447.272(b) must report annually the following information to CMS:

(1) The total Medicaid payments made to each facility for services furnished during the entire State fiscal year.

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

We estimate that there would be 57 reports filed the first year and that they would take 8 hours, for a total of 456 hours. The number of reports and corresponding burden would decrease each year.

Section 447.321 Outpatient Hospital and Clinic Services: Application of Upper Payment Limits

Under paragraph (f), *Reporting requirements for payments during the transition periods*, States that are

eligible for a transition period described in § 447.321(e), and that make payments that exceed the limit under § 447.321(b), would have to report annually the following information to CMS:

(1) The total Medicaid payments made to each facility for services furnished during the entire State fiscal year.

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

We estimate that there would be 31 reports filed the first year under this section and that it would take 8 hours to complete one report, for a total of 248 hours. The number of reports and corresponding burden would decrease over the next 8 years.

The particular information collection requirements contained in these two sections were published in the January 12, 2001 final rule. We are revising these requirements by eliminating the reporting requirement that States report hospital expenditures up to the 150 percent UPL, consistent with its elimination in this final rule. This would reduce the reporting burden by 31 reports (for the 31 States noted in section VI.B of this final rule) and 248 hours of burden.

We submitted an emergency request for approval of the information collection requirements associated with the January 12, 2001 final rule to OMB for review of the requirements in §§ 447.272 and 447.321. These sections have been approved by OMB under OMB number 0938-0855 through May 2002 and are now in effect. We plan to submit a revised request for approval to OMB shortly that incorporates the elimination of the reporting requirement that States report hospital expenditures up to 150 percent of the UPL. This change will not become effective until approved by OMB.

VI. Regulatory Impact Analysis

A. Introduction

We have examined the impact of this final rule as required by Executive Order (EO) 12866, the Unfunded Mandates Reform Act of 1995, and the Regulatory Flexibility Act (RFA) (Pub. L. 96-354). EO 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects

(\$100 million or more in any one year). We consider this a major rule and provide an analysis below.

B. Overall Impact

We have identified approximately 31 States with State plan amendments that may provide for payments to non-State government-owned or operated hospitals for inpatient or outpatient services in excess of the 100 percent UPL. These plans currently account for approximately \$3 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. In addition, we expect that, absent rulemaking, additional States would submit amendments to increase spending above the 100 percent UPL in the future. Estimates of these increased costs, both current and future, are included in the President's FY 2002 Medicaid budget baseline. Based on these budget estimates, we estimate that removing the higher UPL for non-State government-owned or operated hospitals reduces potential Federal costs by about \$9 billion over fiscal years 2002 through 2006.

C. Impact on Small Entities and Rural Hospitals

The RFA 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 other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$5 million to \$25 million (see 65 FR 69432) or less annually. For purposes of the RFA, all hospitals 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 number of small entities, including small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

The purpose of this rule is to promote fiscal integrity to the Medicaid program and restore an appropriate balance between the Federal government and States with respect to funding the Medicaid program. This rule is necessary because, as the OIG

concluded in a report dated September 11, 2001, States' use of intergovernmental transfers as part of enhanced payment programs was a financing mechanism designed to maximize Federal Medicaid reimbursements, thus effectively avoiding Federal/State matching requirements.

We believe the UPL in this final rule may potentially have a significant impact on small entities, including rural hospitals. Nationwide, we believe there are approximately 1,275 non-State government-owned or operated hospitals that could potentially be affected by this rule. We included facilities in all 50 States in this estimate because although not every State is currently making enhanced payments to non-State government-owned or operated hospitals, this rule will prevent new proposals from all States in the future. We believe that the 100 percent payment limit permits States to set fair and appropriate rates to non-State government-owned or operated hospitals for services provided to Medicaid beneficiaries. Even if States were paying rates to public hospitals to help subsidize the cost of care to non-Medicaid eligible individuals, the impact of this final rule will be mitigated due to several factors:

- First, if these hospitals are treating large numbers of indigent patients, they should be eligible to qualify as a disproportionate share hospital. Under both the Medicaid and Medicare program, supplemental funding is available to assist hospitals that serve a disproportionate share of indigent patients. In Federal fiscal year 2000, the Federal government provided more than \$8.4 billion in financial assistance to safety net hospitals through the Medicaid DSH program. As noted previously, the Congress provided additional funding to public safety net hospitals by increasing the hospital-specific DSH limits from 100 percent to 175 percent of a hospital's reasonable costs of treating the uninsured and Medicaid beneficiaries for a period of two fiscal years beginning after September 30, 2002.

- Second, payment methodologies in excess of the January 12, 2001 final rule may qualify for one of the transition periods described in §§ 447.272(e) and 447.321(e). State payment methodologies that qualify for one of the transition periods would continue to qualify under this final rule; the only difference is that payments to non-State government-owned or operated hospitals must be reduced over the transition period to a 100 percent UPL rather than a 150 percent UPL.

Currently, we believe that two States qualify for the 8-year transition period, four States for the 5-year transition period, and two States for the 2-year transition period. From 2002 through 2006, these States will require approximately \$2.9 billion because of the transition periods allowed for in the rule.

- Third, the OIG issued a report on September 11, 2001 stating that the higher UPL for non-State government-owned or operated hospitals has not been adequately supported through an analysis of these hospitals' financial operations. To the extent that States now pay providers efficient rates that are retained by these providers, we do not believe States will be able to further reduce these rates.

We received comments on the impact analysis stating that we did not adequately consider the impact on these entities and that in fact monies paid under the 150 percent UPL were in fact retained by these facilities. The commenters also noted that the OIG did not specifically look at the 150 percent UPL. In addition, commenters noted that CMS did not effectively analyze the effects of the 150 percent UPL before issuing this new rule.

We believe that the OIG reports confirmed our subsequent analysis that States did not use these excess funds as part of the proper State and Federal match for the Medicaid program for any facilities, including non-State government-owned and operated hospitals. In fact, the OIG concluded that even in those cases where UPL enhanced payments were retained by public hospitals, these hospitals would instead return the majority of any Medicaid DSH payments to their State via intergovernmental transfers. States appear to have been replacing DSH payments with UPL enhanced payments, even though Medicaid DSH payments are specifically intended to help hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients.

D. Other Alternatives Considered

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

1. Maintain a Higher Upper Limit for Non-State Government-Owned or Operated Facilities

Under this option, we would set the upper payment limit for non-State government-owned or operated hospitals at a level between 100 percent and 150 percent. There are several reasons for not pursuing this option. As we have stated earlier, we believe that payments above the 100 percent UPL have resulted in excessive payments to these hospitals that have either been returned to the State via intergovernmental transfers or used to replace DSH funding returned to the State. The information available to date indicates that States are combining higher payments to public hospitals with intergovernmental transfers to effectively raise their Federal match rate. Furthermore, both the Medicaid and Medicare program include disproportionate share programs that are intended to assist facilities in providing care and services to indigent patients.

2. "Grandfathering" Existing Arrangements

Under this option, we would not approve any new plan amendments after the effective date of the final rule but would allow those that have been approved to continue operating. This would permit States that are currently making excessive payments to non-State government-owned or operated hospitals to continue making those payments indefinitely. However, allowing some States to permanently continue making excessive payments solely because they were approved before this rule is published and effective would be inconsistent with our responsibility to administer the Medicaid program in an equitable manner.

3. Create a Facility-Specific Upper Payment Limit

Under this option, Medicaid spending would be limited to a provider-specific application of Medicare payment principles. FFP would not be available on the amount of Medicaid service payments in excess of what a provider would have been paid using Medicare payment principles. These limits would be applied to all hospitals, or just to public hospitals where the incentives for overpayment are significant. While a facility-specific limitation may be the most effective method to ensure State service payments are consistent with economy and efficiency, implementation of such an option would require significant additional

reporting and recordkeeping requirements to verify compliance.

We believe that the transition periods provided to States in the January 12, 2001 rule, the 2-year increase in the DSH payment limit for public safety net hospitals enacted by the Congress, and the elimination of any reporting requirements on hospitals, should minimize the significant economic impact on small entities.

E. The Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires 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 private sector, of \$110 million. Because this final rule does not mandate any new spending requirements or costs, but rather limits aggregate payments to a group of hospitals, we do not believe it has 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. We do not believe this final rule in any way imposes substantial direct compliance costs on State and local governments or preempts or supersedes State or local law. However, we realize the reform of upper payment limits is an issue in which some States are very interested. Therefore, in addition to providing States with an opportunity to comment on the proposed rule, we have tried to afford States ample opportunities to express their interest and concerns as we have moved forward in developing reforms.

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 reasons set forth in the preamble, the Centers for Medicare and Medicaid

Services amends 42 CFR, chapter IV, part 447 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. Amend § 447.272 as follows:
 - a. Revise paragraph (b).
 - b. Remove paragraph (c)(1).
 - c. Redesignate paragraph (c)(2) as (c)(1).
 - d. Redesignate paragraph (c)(3) as (c)(2).
 - e. Revise paragraph (d).
 - f. Revise paragraph (e)(1)(ii).
 - g. Redesignate paragraph (e)(2)(iii) as (e)(2)(iv).
 - h. Redesignate paragraph (e)(2)(ii)(C)(8) as paragraph (e)(2)(iii).
 - i. Add paragraph (e)(2)(v).
 - j. Revise paragraph (f).

The addition and revisions read as follows:

§ 447.272 Inpatient services: Application of upper payment limits.

* * * * *

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

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

* * * * *

(d) *Compliance dates.* Except as permitted under paragraph (e) of this section, a State must comply with the upper payment limit described in paragraph (b)(1) of this section by one of the following dates:

- (1) *For non-State government-owned or operated hospitals*—March 19, 2002.
- (2) *For all other facilities*—March 13, 2001.

(e) *Transition periods*—* * *

(1) * * *

(ii) *UPL* stands for the upper payment limit described in paragraph (b)(1) of this section for the referenced year.

* * * * *

(2) *General rules.* * * *

(v) A State with an approved State plan amendment payment provision that makes payments up to 150 percent of the UPL described in paragraph (b)(1) of this section to providers described in

paragraph (a)(2) of this section does not qualify for a transition period.

(f) *Reporting requirements for payments during the transition periods.* States that are eligible for a transition period described in paragraph (e) of this section, and that make payments that exceed the upper payment limit under paragraph (b)(1) of this section, must report annually the following information to CMS:

(1) The total Medicaid payments made to each facility for services furnished during the entire State fiscal year.

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

3. Amend § 447.321 as follows:

a. Revise paragraphs (b) through (d).

b. Revise paragraph (e)(1)(ii).

c. Redesignate paragraph (e)(2)(iii) as (e)(2)(iv).

d. Redesignate paragraph

(e)(2)(ii)(C)(8) as paragraph (e)(2)(iii).

e. Add paragraph (e)(2)(v).

f. Revise paragraph (f).

The addition and revisions read as follows:

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

* * * * *

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

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

(c) *Exception—Indian Health Services and tribal facilities.* The limitation in paragraph (b) of this section does not apply to Indian Health Services facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

(d) *Compliance dates.* Except as permitted under paragraph (e) of this section, a State must comply with the upper payment limit described in paragraph (b)(1) of this section by one of the following dates:

(1) *For non-State government-owned or operated hospitals*—March 19, 2002.

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

(e) *Transition periods*—* * *

(1) * * *

(ii) *UPL* stands for the upper payment limit described in paragraph (b)(1) of this section for the referenced year.

* * * * *

(2) *General rules.* * * *

(v) A State with an approved State plan amendment payment provision that makes payments up to 150 percent of the UPL described in paragraph (b)(1) of this section to providers described in paragraph (a)(2) of this section does not qualify for a transition period.

(f) *Reporting requirements for payments during the transition periods.* States that are eligible for a transition period described in paragraph (e) of this section, and that make payments that exceed the limit under paragraph (b)(1) of this section, must report annually the following information to CMS:

(1) The total Medicaid payments made to each facility for services furnished during the entire State fiscal year.

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

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

Dated: January 14, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: January 15, 2002.

Tommy G. Thompson,

Secretary.

[FR Doc. 02-1482 Filed 1-17-02; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF TRANSPORTATION

Research and Special Programs Administration

49 CFR Part 199

[Docket RSPA-97-2995; Notice 9]

Pipeline Drug Testing; Random Testing Rate

AGENCY: Research and Special Programs Administration (RSPA), DOT.

ACTION: Notice of random drug testing rate.

SUMMARY: Each year, a minimum percentage of covered pipeline employees must be randomly tested for prohibited drugs. The percentage, either 50 percent or 25 percent, depends on the positive rate of random testing reported to RSPA in the previous year. In accordance with applicable standards, we have determined that the

positive rate of random testing reported this year for testing in calendar year 2000 was less than 1.0 percent.

Therefore, in calendar year 2002, the minimum annual percentage rate for random drug testing is 25 percent of covered employees.

DATES: Effective January 1, 2002, through December 31, 2002, at least 25 percent of covered employees must be randomly drug tested.

FOR FURTHER INFORMATION CONTACT: L. M. Furrow by phone at 202-366-4559, by fax at 202-366-4566, by mail at U.S. Department of Transportation, 400 Seventh Street, SW., Washington, DC 20590, or by e-mail at buck.furrow@rspa.dot.gov.

SUPPLEMENTARY INFORMATION: Operators of gas, hazardous liquid, and carbon dioxide pipelines and operators of liquefied natural gas facilities must annually submit Management Information System (MIS) reports of drug testing done in the previous calendar year (49 CFR 199.119(a)). One of the uses of this information is to calculate the minimum annual percentage rate at which operators must randomly drug test all covered employees during the next calendar year (49 CFR 199.105(c)(2)). If the minimum annual percentage rate for random drug testing is 50 percent, we may lower the rate to 25 percent if we determine that the positive rate reported for random tests for two consecutive calendar years is less than 1.0 percent (49 CFR 199.105(c)(3)). If the minimum annual percentage rate is 25 percent, we will increase the rate to 50 percent if we determine that the positive rate reported for random tests for any calendar year is equal to or greater than 1.0 percent (49 CFR 199.105(c)(4)). Part 199 defines "positive rate" as "the number of positive results for random drug tests * * * plus the number of refusals of random tests * * *, divided by the total number of random drug tests * * * plus the number of refusals of random tests. * * *"

Through calendar year 1996, the minimum annual percentage rate for random drug testing in the pipeline industry was 50 percent of covered employees. Based on MIS reports of random testing done in 1994 and 1995, we lowered the minimum rate from 50 to 25 percent for calendar year 1997 (61 FR 60206—November 27, 1996). The minimum rate remained at 25 percent in calendar years 1998 (62 FR 59297—Nov. 3, 1997); 1999 (63 FR 58324—Oct. 30, 1998); 2000 (64 FR 66788—Nov. 30, 1999), and 2001 (65 FR 81409—Dec. 26, 2000).