Medicaid Proposed Rule Could Impact Nursing Home Provider Taxes and Supplemental Payments

On November 18, CMS published the Medicaid Fiscal Accountability Regulation (MFAR) Proposal on the Federal Register. This proposed rule would make significant changes to key parts of state Medicaid financing structures for nursing homes and hospitals.

For nursing homes, including Life Plan Communities (LPCs)/Continuing Care Retirement Communities (CCRCs) with nursing homes/health centers, the most significant proposed changes are to provider taxes and supplemental payments.

This article provides a summary of key provisions of the MFAR proposal as they relate to nursing homes.

Implications for Provider Taxes

Provider taxes would not be banned outright under the proposed rule. CMS is, however, proposing to set new criteria for which revenue generated by provider taxes would or would not receive federal matching funds, and state provider taxes would face new scrutiny under the proposed regulation. Current policy requires that provider taxes be broad-based and uniform (or, in other words, be applied to providers equally), and that if states want more targeted tax structures, like a bed tax, it must receive a CMS waiver to do so.

This process would not change under the proposed rule, and states would still be able to receive these waivers from CMS, but the considerations of what would be allowed under those waivers would change. Specifically, states would be disallowed from receiving federal funds for taxes that "impose undue burden" on the Medicaid program. Such "undue burdens", per the proposal, include:

1) Taxing providers that provide less Medicaid services at lower rates than those that provide relatively more Medicaid services.
2) Medicaid services, in general, being taxed more than non-Medicaid services (except when excluding Medicare/Medicaid revenue).
3) Not taxing, or taxing at a lower rate, groups of providers with no Medicaid services compared to other groups (e.g., those that take Medicaid).

In addition to these cases, the proposal also says that a tax would impose an undue burden if it "*excludes or imposes a lower tax rate on a taxpayer group defined based on any commonality that, considering the totality of the circumstances, CMS reasonably determines to be used as a proxy for the taxpayer group having no Medicaid activity or relatively lower Medicaid activity than any other taxpayer group*."

In other words, CMS would have significant latitude determining whether a provider tax and any provider tax exclusions or "discounts" would comply with the proposal if finalized. This could very well mean that exclusions or lower taxes for LPCs, for example, could be determined disallowable.

Further, current policy does not allow providers to be guaranteed to be held harmless under provider taxes. This means taxes can't be levied with the understanding that any funds a provider pays will eventually circle back to them. CMS proposes new language in MFAR that would allow CMS to more closely look at arrangements between providers, states and other relevant entities – including arrangements not in writing or legally enforceable – to determine if providers have "reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount." If CMS reaches that conclusion, provider taxes could be further jeopardized.

Finally, all provider taxes for which a state wants to receive federal matching funds would sunset every three years under the proposal. States could renew at the end of the three-year period but would need to get CMS' approval to do so.

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States would have three years to comply with the MFAR requirements once a rule is finalized.

Implications for Supplemental Payments and Upper Payment Limits

In addition to provider taxes, the MFAR proposal seeks to make revisions to Upper Payment Limit (UPL) demonstrations and supplemental payments.

For the most part, this affects state Medicaid agencies and imposes new reporting requirements, including payment amount by provider and the criteria and methodology used to calculate these payments.

The proposal also includes new requirements for how UPLs can be calculated and which data sources to use. The following approaches would be allowed under MFAR, with more detail on each in the proposal:

- Cost-based demonstrations: retrospective demonstration, prospective demonstration
- Payment-based demonstrations: retrospective payment-to-charge UPL demonstration, prospective payment-to-charge UPL demonstration, payment-based UPL demonstration

It would also limit the amount of time a state could have supplemental payment policies without federal review. If finalized, MFAR would sunset supplemental payments every three years. In order to continue payments beyond that time, CMS approval would be required.

Similar to the provider taxes, states would have three years to comply with these MFAR requirements.

Implications for Ownership Arrangements

The proposal also has the potential to put ownership transfers between private organizations and government entities under increased scrutiny.

Under current policy, UPLs are calculated by provider types (e.g., nursing homes) and ownership type. There are three categories: state government, nonstate government and private ownership. When supplemental payments are calculated, they are differentiated by these groups.

CMS asserts that private providers have been making arrangements with county and other nonstate governments to transfer ownership to the government entity while maintaining operational control of the facility. Doing so potentially allows the provider to receive a higher supplemental payment if the amount available in the nonstate government category, for instance, is higher than the private ownership category.

The proposed rule includes criteria CMS would use to determine which category a facility would fall into if there was a private-government ownership transfer, including who is responsible for the facility's operations.

Next Steps

LeadingAge is continuing to assess the potential impact of the MFAR proposal on its members and the residents they serve. Given the central role Medicaid plays in nursing home financing, it is important to make sure that any policy change would not have an adverse effect on a Medicaid enrollee's ability to receive the care they need, including in nursing homes.

We will work with our state partners and members to determine the implications of the proposal and provide feedback to CMS, including through comment letters. We will also develop resources for our members to educate them on the MFAR proposal and how they can participate in the rulemaking process.

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Notes on Reading This Document

- Yellow Highlights indicate the section title.
- Text in the Current Policy (left hand) column reflects current regulation as posted to the Federal Register.
- Red text in the Proposed Policy (right hand) column indicates proposed new regulatory language.
- Text with *italics* in the Proposed Policy column indicates proposed removed regulatory language.
- If a section of the proposed rule revises, but does not eliminate, current regulatory text, we show the proposed changes via *italics* on the left side and red text on the right side.
- Entirely new sections/parts are shown in red in singular columns.
- Editorial text from LeadingAge staff appears in green.

Navigating the Federal Register and the Code of Federal Regulations:

- Proposed rulemaking is posted on the Federal Register. You can find the MFAR proposed text here: https://www.federalregister.gov/documents/2019/11/18/2019-24763/medicaid-program-medicaid-fiscal-accontability-regulation
- Current federal regulation is posted to the Code of Federal Regulations. The proposed rule will **NOT** appear on the Code of Federal Regulations. Rulemaking only appears on the Code of Federal Regulations once it is finalized.
- The current regulatory language can be found at this web page: https://www.law.cornell.edu/cfr/text/42/chapter-IV/subchapter-C.
- To find a specific section, click the appropriate part number, subpart letter and finally the section number that appears after the period. For 430.42, for example, click Part 430, then Subpart C (which has the section 42 captured in the range in parentheses), and then section 42.

§ 430.42 Disallowance of claims for FFP.	
This section covers communication between CMS and State Medicaid Agencies. Changes in this section are not policy-related. Rather, it replaces "registered or certified mail" with "electronic mail (email) or electronic system" throughout the section.	
§ 433.51 State share of financial participation.	
(a) Public Funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section. *(b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.* *(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.*	**(a)** State or local funds may be considered as the State's share in claiming Federal financial participation (FFP) if they meet the conditions specified in paragraphs (b) and (c) of this section. **(b)** State or local funds that may be considered as the State's share are any of the following: **(1)** State General Fund dollars appropriated by the State legislature directly to the State or local Medicaid agency. **(2)** Intergovernmental transfer of funds from units of government within a State (including Indian tribes), derived from State or local taxes (or funds appropriated to State university teaching hospitals), to the State Medicaid Agency and under its administrative control, except as provided in paragraph (d) of this section. **(3)** Certified Public Expenditures, which are certified by a unit of government within a State as representing expenditures eligible for FFP under this section, and which meet the requirements of § 447.206 of this chapter. **(c)** The State or local funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds. **(d)** State funds that are provided as an intergovernmental transfer from a unit of government within a State that are contingent upon the receipt of funds by, or are actually replaced in the accounts of, the transferring unit of government from funds from unallowable sources, would be considered to be a provider-related donation that is non-bona fide under §§ 433.52 and 433.54.
§ 433.52 General definitions.	
N/A- this is proposed added text.	**Medicaid activity** means any measure of the degree or amount of health care items or services related to the Medicaid program or utilized by Medicaid beneficiaries. Such a measure could include, but would not necessarily be limited to, Medicaid patient bed days, the percentage of an entity's net patient revenue attributable to Medicaid, Medicaid utilization, units of medical equipment sold to individuals utilizing Medicaid to pay for or supply such equipment or Medicaid member months covered by a health plan. **Net effect** means the overall impact of an arrangement, considering the actions of all of the entities participating in the arrangement, including all relevant financial transactions

	or transfers of value, in cash or in kind, among participating entities. The net effect of an arrangement is determined in consideration of the totality of the circumstances, including the reasonable expectations of the participating entities, and may include consideration of reciprocal actions without regard to whether the arrangement or a component of the arrangement is reduced to writing or is legally enforceable by any entity. **Non-Medicaid activity** means the degree or amount of health care items or services not related to the Medicaid program or utilized by Medicaid beneficiaries. Such a measure could include, but would not necessarily be limited to, non-Medicaid patient bed days, percentage of an entity's net patient revenue not attributable to Medicaid, the percentage of patients not utilizing Medicaid to pay for health care items or services, units of medical equipment sold to individuals not utilizing Medicaid funds to pay for or supply such equipment, or non-Medicaid member months covered by a health plan. **Parameters of a tax** means the grouping of individuals, entities, items or services, on which the State or unit of government imposes a tax. **Taxpayer group** means one or more entities grouped together based on one or more common characteristics for purposes of imposing a tax on a class of items or services specified under § 433.56.
Provider-related donation means a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a State or unit of local government by or on behalf of a health care provider, an entity related to such a health care provider, or an entity providing goods or services to the State for administration of the State's Medicaid plan. (1) Donations made by a health care provider to an organization, which in turn donates money to the State, may be considered to be a donation made indirectly to the State by a health care provider. (2) When an organization receives less than 25 percent of its revenues from providers and/or provider-related entities, its	**Provider-related donation** means a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a State or unit of local government by or on behalf of a health care provider, an entity related to such a health care provider, or an entity providing goods or services to the State for administration of the State's Medicaid plan. (1) Donations made by a health care provider to an organization, which in turn donates money to the State, may be considered to be a donation made indirectly to the State by a health care provider. (2) Any transfer of value where a health care provider or provider-related entity assumes an obligation previously held by a governmental entity and the governmental entity does not compensate the private entity at fair market value will be considered a donation made indirectly to the governmental entity. Such an assumption of obligation need not rise to the level of a legally enforceable obligation to be considered a donation, but will be considered by examining the totality of the circumstances and judging the arrangement's net effect. (3) When an organization receives less than 25 percent of its revenues from providers and/or provider-related entities, its donations will not generally be presumed to be provider-related donations. Under these circumstances, a

donations will not generally be presumed to be provider-related donations. Under these circumstances, a provider-related donation to an organization will not be considered a donation made indirectly to the State. However, if the donations from providers to an organization are subsequently determined to be indirect donations to the State or unit of local government for administration of the State's Medicaid program, then such donations will be considered to be *health care* related. (3) When the organization receives more than 25 percent of its revenue from donations from providers or provider-related entities, the organization always will be considered as acting on behalf of health care providers if it makes a donation to the State. The amount of the organization's donation to the State, in a State fiscal year, that will be considered *health care related*, will be based on the percentage of *donations the organization received from the providers during that period.*	provider-related donation to an organization will not be considered a donation made indirectly to the State. However, if the donations from a provider or entities related to a provider to an organization are subsequently determined to be indirect donations to the State or unit of local government for administration of the State's Medicaid program, then such donations will be considered to be provider-related donations. (4) When the organization receives more than 25 percent of its revenue from donations from providers or provider-related entities, the organization always will be considered as acting on behalf of health care providers if it makes a donation to the State. The amount of the organization's donation to the State, in a State fiscal year, that will be considered to be a provider-related donation will be based on the percentage of the organization's revenue during that period that was received as donations from providers or provider-related entities.
§ 433.54 Bona fide donations.	
(3) The State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to return any portion of the donation to the provider (or other parties responsible for the donation).	(3) The State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver, such that the provision of that payment, offset, or waiver directly or indirectly guarantees to return any portion of the donation to the provider (or other party or parties responsible for the donation). Such a guarantee will be found to exist where, considering the totality of the circumstances, the net effect of an arrangement between the State (or other unit of government) and the provider (or other party or parties responsible for the donation) results in a reasonable expectation that the provider, provider class, or a related entity will receive a return of all or a

	portion of the donation. The net effect of such an arrangement may result in the return of all or a portion of the donation, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party to the arrangement.
§ 433.55 Health care-related taxes defined.	
(c) A tax is considered to be health care related if the tax is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to *other* individuals or entities.	(c) A tax is considered to be health care-related if the tax is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to individuals or entities that are providers or payers of any health care items or services that are not subject to the tax, or other individuals or entities that are subject to the tax. In determining whether differential treatment exists, consideration will be given to the parameters of the tax, as well as the totality of the circumstances relevant to which individuals, entities, items, or services are subject and not subject to the tax, and the tax rate applicable to each. Differential treatment includes, but is not limited to: (1) Tax programs in which some individuals or entities providing or paying for health care items or services are selectively incorporated, but others are excluded. Selective incorporation means that the State or other unit of government includes some, but not all, health care-related items or services and these items or services are not reasonably related to the other items or services being taxed. Reasonably related means that there exists a logical or thematic connection between the items or services being taxed. Examples of such a connection include, but are not limited to, industry, such as electronics; geographical area, such as city or county; net revenue volume; or number of employees. For example, if the State imposes a tax on all telecommunication services and inpatient hospital services, this would constitute differential treatment as inpatient hospital services are selectively incorporated. However, if the State imposes a tax on revenue from all professional services, which includes medical professional service revenue, this alone would not constitute differential treatment. (2) Differential treatment of individuals or entities providing or paying for health care items or services included in the tax, and other entities also included in the tax. For example, if the State taxes all businesses in the State, but places a higher tax rate on hospitals and nursing facilities than on other businesses, this would result in differential treatment.
§ 433.56 Classes of health care services and providers defined.	

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N/A- this is proposed added text.	(19) Services of health insurers (other than services of managed care organizations as specified in paragraph (a)(8) of this section);
§ 433.68 Permissible health care-related taxes.	
(e) Generally redistributive. A tax will be considered to be generally redistributive if it meets the requirements of this paragraph. If the State *desires* waiver of only the broad-based tax requirement, it must demonstrate compliance with paragraph (e)(1) of this section. If the State desires waiver of the uniform tax requirement, whether or not the tax is broad-based, it must demonstrate compliance with paragraph (e)(2) of this section.	(e) Generally redistributive. A tax will be considered to be generally redistributive if it meets the requirements of this paragraph (e). If the State requests waiver of only the broad-based tax requirement, it must demonstrate compliance with paragraphs (e)(1) and (3) of this section. If the State requests waiver of the uniform tax requirement, whether or not the tax is broad-based, it must demonstrate compliance with paragraphs (e)(2) and (3) of this section. (ed: section (e)(3) below applies to both types of waivers.)
N/A- this is proposed added text.	(3) **Requirement to avoid imposing undue burden on health care items or services reimbursed by Medicaid, as well as providers of such items or services.** This paragraph (e)(3) applies on a per class basis (note: class here refers to provider type, like nursing homes, hospitals, etc). A tax must not impose undue burden on health care items or services paid for by Medicaid or on providers of such items and services that are reimbursed by Medicaid. A tax is considered to impose undue burden under this paragraph if taxpayers are divided into taxpayer groups and any one or more of the following conditions apply: (i) The tax excludes or places a lower tax rate on any taxpayer group defined by its level of Medicaid activity than on any other taxpayer group defined by its relatively higher level of Medicaid activity. (ii) Within each taxpayer group, the tax rate imposed on any Medicaid activity is higher than the tax rate imposed on any non-Medicaid activity (except as a result of excluding from taxation Medicare or Medicaid revenue or payments as described in paragraph (d) of this section). (iii) The tax excludes or imposes a lower tax rate on a taxpayer group with no Medicaid activity than on any other taxpayer group, unless all

	entities in the taxpayer group with no Medicaid activity meet at least one of the following: (A) Furnish no services within the class in the State. (B) Do not charge any payer for services within the class. (C) Are Federal provider of services within the meaning of § 411.6 of this chapter. (D) Are a unit of government. (iv) The tax excludes or imposes a lower tax rate on a taxpayer group defined based on any commonality that, considering the totality of the circumstances, CMS reasonably determines to be used as a proxy for the taxpayer group having no Medicaid activity or relatively lower Medicaid activity than any other taxpayer group.
(f) Hold harmless. A taxpayer will be considered to be held harmless under a tax program if any of the following conditions applies: (3) The State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount.	Changes proposed to paragraph (f)(3) of this section. Other text in this section is not proposed to be changed and can be found here: https://www.law.cornell.edu/cfr/text/42/433.68 **(f) Hold harmless.** A taxpayer will be considered to be held harmless under a tax program if any of the following conditions applies: (3) The State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount. A direct guarantee will be found to exist where, considering the totality of the circumstances, the net effect of an arrangement between the State (or other unit of government) and the taxpayer results in a reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount. The net effect of such an arrangement may result in the return of all or any portion of the tax amount, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party to the arrangement.
§ 433.72 Waiver provisions applicable to health care-related taxes.	
(c) ***Effective date.*** A waiver will be effective: **(1)** The date of enactment of the tax for programs in existence prior to August 13, 1993 or; **(2)** For tax programs commencing on or after August 13, 1993, on the first day in the	**(c)** ***Effective date.*** A waiver will be effective: **(1)** The date of enactment of the tax for programs in existence prior to August 13, 1993 or; **(2)** For tax programs commencing on or after August 13, 1993, on the first day in the quarter in which the waiver is received by CMS.

quarter in which the waiver is received by CMS.	**(3)** For waivers approved on or after [final rule effective date] a waiver will cease being effective 3 years from the date that the waiver was approved by CMS. **(4)** For waivers approved before [final rule effective date] a waiver will cease to be effective [3 years from final rule effective date]. **(d)** Ongoing compliance with waiver conditions. For a State to continue to receive tax revenue (within specified limitations) without a reduction in FFP under a waiver approved under paragraph (b) of this section, the State must meet all of the following requirements: **(1)** Ensure that the tax program for which CMS approved the waiver under paragraph (b) of this section continues to meet the waiver conditions identified in paragraphs (b)(1) through (3) of this section at all times during which the waiver is in effect. **(2)** Request and receive approval for a new waiver, subject to effective date requirements in paragraph (c) of this section, if either of the following tax program modifications occurs: **(i)** The State or other unit of government imposing the tax modifies the tax in a non-uniform manner, meaning the change in tax or tax rate does not apply in an equal dollar amount or percentage change to all taxpayers. **(ii)** The State or other unit of government imposing the tax modifies the criteria for defining the taxpayer group or groups subject to the tax.
§ 433.316 When discovery of overpayment occurs and its significance.	
Changes here are specific to disproportionate share hospitals	
§ 447.201 State plan requirements.	
(a) A State plan must provide that the requirements in this subpart are met. **(b)** The plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program.	**(a)** A State plan must provide that the requirements in this subpart are met. **(b)** The plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program. **(c)** The plan must provide for no variation in fee-for-service payment for a Medicaid service on the basis of a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration project, or FMAP rate available for services provided to an individual in the beneficiary's eligibility category.
§ 447.206 Payments funded by certified public expenditures made to providers that are units of government. This is proposed added text.	
(a) Scope. This section applies only to payments made to providers that are State government providers or non-State government providers, as defined in § 447.286, where such payments to such providers are funded by a certified public expenditure, as specified in § 433.51(b)(3) of this chapter.	

(b) General rules.

(1) Payments are limited to reimbursement not in excess of the provider's actual, incurred cost of providing covered services to Medicaid beneficiaries using reasonable cost allocation methods as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, to Medicare cost principles specified in part 413 of this chapter.

(2) The State must establish and implement documentation and audit protocols, which must include an annual cost report to be submitted by the State government provider or non-State government provider to the State agency that documents the provider's costs incurred in furnishing services to beneficiaries during the provider's fiscal year.

(3) Only the certified amount of the expenditure may be claimed for Federal financial participation.

(4) The certifying entity of the certified public expenditure must receive and retain the full amount of Federal financial participation associated with the payment, consistent with the cost identification protocols in the Medicaid State plan and in accordance with § 447.207.

(c) Other criteria for the use of certified public expenditures.

(1) A State must implement processes by which all claims for medical assistance are processed through Medicaid management information systems in a manner that identifies the specific Medicaid services provided to specific enrollees.

(2) The most recently filed cost reports as specified in paragraph (b)(2) of this section must be used to develop interim payments rates, which may be trended by an applicable health care-related index.

(3) Final settlement must be performed annually by reconciling any interim payments to the finalized cost report for the State plan rate year in which any interim payment rates were made, and final settlement must be made no more than 24 months from the cost report year end, except under circumstances identified in 45 CFR 95.19.

(4) If the final settlement establishes that the provider received an overpayment, the Federal share in recovered overpayment amounts must be credited to the Federal Government, in accordance with part 433, subpart F, of this chapter.

(d) State plan requirements. If certified public expenditures are used as a source of non-Federal share under the State plan, the State plan must specify cost protocols in the service payment methodology applicable to the certifying provider that meet all of the following:

(1) Identify allowable cost, using either of the following:

(i) A Medicare cost report, as described in part 413 of this chapter.

(ii) A State-developed Medicaid cost report prepared in accordance with the cost principles in 45 CFR part 75 and 2 CFR part 200.

(2) Define an interim rate methodology for interim payments to providers for services furnished.

(3) Describe an attestation process by which the certifying entity will attest that the costs are accurate and consistent with 45 CFR part 75 and 2 CFR part 200.

(4) Include, as necessary, a list of the covered Medicaid services being furnished by each provider certifying a certified public expenditure.

(5) Define a reconciliation and final settlement process consistent with paragraphs (c)(3) and (4) of this section.

§ 447.207 Retention of payments.

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This is proposed added text.	
(a) Payments. Payment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved State plan (or the approved provisions of a waiver or demonstration, if applicable). The Secretary will determine compliance with this paragraph (a) by examining any associated transactions that are related to the provider's total computable Medicaid payment to ensure that the State's claimed expenditure, which serves as the basis for Federal financial participation, is consistent with the State's net expenditure, and that the full amount of the non-Federal share of the payment has been satisfied. Associated transactions may include, but are not necessarily limited to, the payment of an administrative fee to the State for processing provider payments or, in the case of a non-State government provider, for processing intergovernmental transfers. In no event may such administrative fees be calculated based on the amount a provider receives through Medicaid payments or amounts a unit of government contributes through an intergovernmental transfer as funds for the State share of Medicaid service payments.	
§ 447.252 State plan requirements.	
(a) The plan must provide that the requirements of this subpart are met. **(b)** The plan must specify comprehensively the methods and standards used by the agency to set payment rates in a manner consistent with § 430.10 of this chapter. **(c)** If the agency chooses to apply the cost limits established under Medicare (see § 413.30 of this chapter) on an individual provider basis, the plan must specify this requirement.	**(a)** The plan must provide that the requirements of this subpart are met. **(b)** The plan must specify comprehensively the methods and standards used by the agency to set payment rates in a manner consistent with § 430.10 of this chapter. **(c)** If the agency chooses to apply the cost limits established under Medicare (see § 413.30 of this chapter) on an individual provider basis, the plan must specify this requirement. **(d)** CMS may approve a supplemental payment, as defined in § 447.286, provided for under the State plan or a State plan amendment (SPA) for a period not to exceed 3 years. A State whose supplemental payment approval period has expired or is expiring may request a SPA to renew the supplemental payment for a subsequent period not to exceed 3 years, consistent the requirements of this section. For any State plan or SPA that provides or would provide for a supplemental payment, the plan or plan amendment must specify all of the following: **(1)** An explanation of how the State plan or SPA will result in payments that are consistent with section 1902(a)(30)(A) of the Act, including that provision's standards with respect to efficiency, economy, quality of care, and access, along with the stated purpose and intended effects of the supplemental payment, for example, with respect to the Medicaid program, providers, and beneficiaries. **(2)** The criteria to determine which providers are eligible to receive the supplemental payment. **(3)** A comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including all of the following:

	(i) The amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment. **(ii)** If applicable, the specific criteria with respect to Medicaid service, utilization, or cost data from the proposed State plan rate year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment. **(iii)** The timing of the supplemental payment to each eligible provider. **(iv)** An assurance that the total Medicaid payment to an inpatient hospital provider, including the supplemental payment, will not exceed the upper limits specified in § 447.271. **(v)** If not already submitted, an upper payment limit demonstration as required by § 447.272 and described in § 447.288. **(4)** The duration of the supplemental payment authority (not to exceed 3 years). **(5)** A monitoring plan to ensure that the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the effects of the supplemental payment on the Medicaid program, for example, with respect to providers and beneficiaries. **(6)** For a SPA proposing to renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period, for example, with respect to providers and beneficiaries, and including an analysis of the impact of the supplemental payment on compliance with section 1902(a)(30)(A) of the Act. **(e)** The authority for State plan provisions that authorize supplemental payments that are approved as of [effective date of the final rule], are limited as follows— **(1)** For State plan provisions approved 3 or more years prior to [effective date of the final rule], the State plan authority will expire [date that is 2 calendar years following the effective date of the final rule]. **(2)** For State plan provisions approved less than 3 years prior to [effective date of the final rule], the State plan authority will expire [date that is 3 calendar years following the effective date of the final rule].
§ 447.272 Inpatient services: Application of upper payment limits.	

(a) Scope. This section applies to rates set by the agency to pay for inpatient services furnished by hospitals, NFs, and ICFs/IID within one of the following categories: ***(1)*** *State government-owned or operated facilities (that is, all facilities that are either owned or operated by the State).* ***(2)*** *Non-State government-owned or operated facilities (that is, all government facilities that are neither owned nor operated by the State).* ***(3)*** *Privately-owned and operated facilities.*	**(a)** Scope. This section applies to rates set by the agency to pay for inpatient services furnished by hospitals, NFs, and ICFs/IID within one of the following categories: **(1)** State government provider as defined using the criteria set forth in § 447.286. **(2)** Non-State government provider as defined using the criteria set forth at § 447.286. **(3)** Private provider as defined in § 447.286. (Changes to definitions are found in section 447.286 below)
(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.*	**(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, or allowed costs established in accordance with the cost principles as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, Medicare cost principles specified in part 413 of this chapter. Data elements, methodology parameters, and acceptable upper payment limit demonstration methodologies are specified in § 447.288(b).
Subpart D—Payments for Services (note: this an entirely new section- all text will appear as proposed in singular columns below).	
§ 447.284 Basis and purpose. **(a)** This subpart sets forth additional requirements for supplemental payments made under the State plan and implements sections 1902(a)(6) and (a)(30) of the Act. **(b)** The reporting requirements in this subpart are applicable to supplemental payments to which an upper payment limit applies under § 447.272 or § 447.321.	
§ 447.286 Definitions. For purposes of this subpart— **Base payment** means a payment, other than a supplemental payment, made to a provider in accordance with the payment methodology authorized in the State plan or that is paid to the provider through its participation with a Medicaid managed care organization. Base payments are documented at the beneficiary level in MSIS or T-MSIS and include all payments made to a provider for specific Medicaid services rendered to individual Medicaid beneficiaries, including any payment adjustments, add-ons, or other additional payments	

received by the provider that can be attributed to a particular service provided to the beneficiary, such as payment adjustments made to account for a higher level of care or complexity of services provided to the beneficiary.

Non-State government provider means a health care provider, as defined in § 433.52 of this chapter, including those defined in § 447.251, that is a unit of local government in a State, including a city, county, special purpose district, or other governmental unit in the State that is not the State, which has access to and exercises administrative control over State funds appropriated to it by the legislature or local tax revenue, including the ability to dispense such funds. In determining whether an entity is a non-State government provider, CMS will consider the totality of the circumstances, including, but not limited to, the following:

(1) The identity and character of any entity or entities other than the provider that share responsibilities of ownership or operation of the provider, and including the nature of any relationship among such entities and the relationship between such entity or entities and the provider. In determining whether an entity shares responsibilities of ownership or operation of the provider, our consideration would include, but would not be limited to, whether the entity:

(i) Has the immediate authority for making decisions regarding the operation of the provider;

(ii) Bears the legal responsibility for risk from losses from operations of the provider;

(iii) Has immediate authority for the disposition of revenue from operations of the provider;

(iv) Has immediate authority with regard to hiring, retention, payment, and dismissal of personnel performing functions related to the operation of the provider;

(v) Bears legal responsibility for payment of taxes on provider revenues and real property, if any are assessed; or

(vi) Bears the responsibility of paying any medical malpractice premiums or other premiums to insure the real property or operations, activities, or assets of the provider.

(2) In determining whether a relevant entity is a unit of a non-State government, we would consider the character of the entity which would include, but would not be limited to, whether the entity:

(i) Is described in its communications to other entities as a unit of non-State government, or otherwise.

(ii) Is characterized as a unit of non-State government by the State solely for the purposes of Medicaid financing and payments, and not for other purposes (for example, taxation).

(iii) Has access to and exercises administrative control over State funds appropriated to it by the legislature and/or local tax revenue, including the ability to expend such appropriated or tax revenue funds, based on its characterization as a governmental entity.

Private provider means a health care provider, as defined in § 433.52 of this chapter, including those defined in § 447.251 of this chapter, that is not a State government provider or a non-State government provider.

State government provider means a health care provider, as defined in § 433.52 of this chapter, including those defined in § 447.251 of this chapter, that is a unit of State government or a State university teaching hospital, which has access to and exercises administrative control over State-appropriated funds from the legislature or State tax revenue, including the ability to dispense such funds. In determining whether a provider is a State government provider, CMS will consider the totality of the circumstances, including, but not limited to, the following:

(1) The identity and character of any entity or entities other than the provider that share responsibilities of ownership or operation of the provider, and including the nature of any relationship among such entities and the relationship between such entity or entities and the provider. In determining whether an entity shares responsibilities of ownership or operation of the provider, our consideration would include, but would not be limited to, whether the entity:

(i) Has the immediate authority for making decisions regarding the operation of the provider;

(ii) Bears the legal responsibility for risk from losses and litigation from operations of the provider;

(iii) Has immediate authority for the disposition of revenue and profit from operations of the provider;

(iv) Has immediate authority with regard to acquisition, retention, payment, and dismissal of personnel performing functions related to the operation of the provider;

(v) Bears legal responsibility for payment of taxes on provider revenues and real property, if any are assessed; or

(vi) Bears the responsibility of paying any medical malpractice premiums or other premiums to insure the real property or operations, activities, or assets of the provider;

(2) In determining whether a relevant entity is a unit of a State government, we would consider the character of the entity which would include, but would not be limited to, whether the entity:

(i) Is described in its communications to other entities as a unit of State government, or otherwise;

(ii) Is characterized as a unit of State government by the State solely for the purposes of Medicaid financing and payments, and not for other purposes (for example, taxation); and

(iii) Has access to and exercises administrative control over State funds appropriated to it by the legislature and/or local tax revenue, including the ability to expend such appropriated or tax revenue funds, based on its characterization as a governmental entity.

Supplemental payment means a Medicaid payment to a provider that is in addition to the base payments to the provider, other than disproportionate share hospital (DSH) payments under subpart E of this part, made under State plan authority or demonstration authority. Supplemental payments cannot be attributed to a particular provider claim for specific services provided to an individual beneficiary and are often made to the provider in a lump sum.

§ 447.288 Reporting requirements for upper payment limit demonstrations and supplemental payments.

(a) **Upper payment limit demonstration reporting requirements**. Beginning October 1, [first year following the year the final rule takes effect] and annually thereafter, by October 1 of each year, in accordance with the requirements of this section and in the manner and format specified by the Secretary, each State must submit a demonstration of compliance with the applicable upper payment limit for each of the following services for which the State makes payment:

(1) Inpatient hospital, as specified in § 447.272.

(2) Outpatient hospital, as specified in § 447.321.

(3) Nursing facility, as specified in § 447.272.

(4) Intermediate care facility for individuals with intellectual disabilities (ICF/IID), as specified in § 447.272.

(5) Institution for mental diseases (IMD), as specified in § 447.272.

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(b) **Upper payment limit demonstration standards.** When demonstrating the upper payment limit (UPL), States must use the data sources identified in paragraph (b)(1) of this section, adhere to the data standards specified in paragraph (b)(2) of this section, and use the acceptable methods of demonstrating the UPL specified in paragraph (b)(3) of this section.

(1) **UPL methodology data sources**. The data sources identified in this paragraph (b)(1) are as follows:

(i) **Medicare cost demonstrations**. Medicare cost demonstrations use cost and charge data for all providers, from either a Medicare cost report or a State-developed cost report which uses either Medicare cost reporting principles specified in part 413 of this chapter or the cost allocation requirements specified in 45 CFR part 75. Cost and charge data must:

(A) Include only data with dates of service that are no more than 2 years prior to the dates of service covered by the upper payment limit demonstration;

(B) Represent costs and charges specifically related to the service subject to the UPL demonstration; and

(C) Include either Medicare costs and Medicare charges, or total provider costs and total provider charges, to develop a cost-to-charge ratio as described in paragraph (b)(3)(i) of this section. The selection must be consistently applied for all providers within the provider category subject to the upper payment limit.

(ii) **Medicare payment demonstrations**. Medicare payment demonstrations use Medicare payment and charge data for all providers from Medicare cost reports; Medicare payment systems for the specific provider type specified in subchapter B of this chapter, as applicable; or imputed provider payments, specified in paragraph (b)(3)(ii)(C) of this section. When using Medicare payment and charge data, the data must:

(A) Include only data with dates of service that are no more than 2 years prior to the dates of service covered by the upper payment limit demonstration;

(B) Include only Medicare payment and charges, or Medicare payment and Medicare census data, specifically related to the service subject to the UPL demonstration; and

(C) Use either gross Medicare payments and Medicare charges, which includes deductibles and co-insurance in but excludes reimbursable bad debt from the Medicare payment, or net Medicare payments and Medicare charges, which excludes deductibles and coinsurance from and includes reimbursable bad debt in the Medicare payment, as reported on a Medicare cost report. The selection must be consistently applied for all providers within the provider category subject to the upper payment limit.

(iii) **Medicaid charge data and Medicaid census data** from a State's Medicaid billing system for services provided during the same dates of service as the Medicare cost or Medicare payment data, as specified in paragraph (b)(1)(i) or (ii) of this section, as applicable.

(iv) **Medicaid payment data** from a State's Medicaid billing system for services provided during the same dates of service as the Medicare cost or Medicare payment data, as specified in paragraph (b)(1)(i) or (ii) of this section, as applicable, or from the most recent State plan rate year for which a full 12 months of data are available. Such Medicaid payment data must:

(A) Include only data with dates of service that are no more than 2 years prior to the dates of service covered by the upper payment limit demonstration;

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(B) Include all actual payments and all projected base and supplemental payments, excluding any payments made for services for which Medicaid is not the primary payer, expected to made during the time period covered by the upper payment limit demonstration to the providers within the provider category, as applicable, during the State plan rate year; and

(C) Only be trended to account for changes in relevant Medicaid State plan payments, except as provided in paragraph (b)(2)(i) of this section.

(2) **UPL methodology data standards**. The data standards specified in this paragraph (b)(2) are as follows:

(i) Projected changes in Medicaid enrollment and utilization must be reflected in the demonstration. At a minimum, the demonstration must be adjusted to account for projected changes in Medicaid enrollment and utilization to reflect programmatic changes, such as reasonable utilization changes due to managed care enrollment projections.

(ii) Medicare cost or payment data may be projected using Medicare trend factors appropriate to the service and demonstration methodology, with such trend factors being uniformly applied to all providers within a provider category.

(iii) When calculating the aggregate upper payment limit using a cost-based demonstration as described in paragraph (b)(3)(i) of this section, the State may include the cost of health care-related taxes paid by each provider in the provider category that is reasonably allocated to Medicaid as an adjustment to the upper payment limit, to the extent that such costs were not already included in the cost-based UPL.

(iv) Medicaid payment data described in paragraph (b)(1)(iv) of this section that is included in the upper payment limit demonstration must only include payments made for the applicable Medicaid services under the specific Medicaid service type at issue in the upper payment limit.

(3) **Acceptable UPL demonstration methods**. The State must demonstration compliance with an applicable UPL using a method described in this paragraph (b)(3).

(i) **Cost-based demonstrations**. Cost-based demonstration data sources are identified in paragraphs (b)(1)(i), (iii), and (iv) of this section and data standards defined in paragraph (b)(2) of this section. To make a cost-based demonstration of compliance with an applicable upper payment limit, Medicaid covered charges are multiplied by a cost-to-charge ratio developed for the period covered by the upper payment limit demonstration. The State may use a ratio of Medicare costs to Medicare charges, or total provider costs to total provider charges in developing the cost-to-charge ratio, but the selection must be applied consistently to each provider within a provider type identified in paragraph (a) of this section. The product of Medicaid covered charges and the cost-to-charge ratio for each provider is summed to determine the aggregate upper payment limit. The demonstration must show that Medicaid payments will not exceed this aggregate upper payment limit for the demonstration period. This methodology may only be used for services where a provider applies uniform charges to all payers. This demonstration may use one of the following demonstration types:

(A) **A retrospective demonstration** showing that aggregate Medicaid payments paid to the providers within the provider category during the prior State plan rate year did not exceed the costs incurred by the providers furnishing Medicaid services within the prior State plan rate year period.

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(B) **A retrospective demonstration** showing that prospective Medicaid payments would not exceed the estimated cost of furnishing the services for the upcoming State plan rate year period.

(ii) **Payment-based demonstrations**. Payment-based demonstration data sources are identified in paragraphs (b)(1)(ii), (iii), and (iv) of this section and data standards defined in paragraph (b)(2) of this section. To make a payment-based demonstration of compliance with an applicable UPL, the State may use one of the following demonstration types:

(A) A retrospective payment-to-charge UPL demonstration where Medicaid covered charges are multiplied by a ratio of Medicare payments to Medicare charges developed for the period covered by the UPL demonstration. The product of Medicaid covered charges and the Medicare payment-to-charge ratio for each provider is summed to determine the aggregate UPL. The demonstration must show that Medicaid payments did not exceed this aggregate UPL;

(B) A prospective payment-to-charge UPL demonstration where Medicaid covered charges are multiplied by a ratio of Medicare payments to Medicare charges developed for the period covered by the UPL demonstration. The product of Medicaid covered charges and the Medicare payment-to-charge ratio for each provider is summed to determine the aggregate UPL. The demonstration must show that proposed Medicaid payments would not exceed this aggregate UPL within the next State plan rate year immediately following the demonstration period; or

(C) A payment-based UPL demonstration using an imputed Medicare per diem payment rate determined by dividing total Medicare prospective payments paid to the provider by the provider's total Medicare patient days, which are derived from the provider's Medicare census data. Each provider's imputed Medicare per diem payment rate is multiplied by the total number of Medicaid patient days for the provider for the period. The products of this operation for each provider are summed to determine the aggregate UPL. The demonstration must show that Medicaid payments are not excess of the aggregate UPL, calculated on either a retrospective or prospective basis, consistent with the methodology described in paragraph (b)(3)(ii)(A) or (B) of this section, as applicable.

(c) **Supplemental payment reporting requirements**.

(1) At the time the State submits its quarterly CMS-64 under § 430.30(c) of this chapter, the State must report all of the following information for each supplemental payment included on the CMS-64 on a supplemental report to accompany the CMS-64:

(i) The State plan amendment transaction number or demonstration authority number which authorizes the supplemental payment.

(ii) A listing of each provider that received a supplemental payment under Start Printed Page 63783the SPA or demonstration authority, and for each provider, under each authority listed in paragraph (a) of this section:

(A) The provider's legal name.

(B) The physical address of the location or facility where services are provided, including street address, city, State, and ZIP code.

(C) The National Provider Identifier (NPI).

(D) The Medicaid identification number.

(E) The employer identification number (EIN).

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(F) The service type for which the reported payment was made.
(G) The provider specialty type (if applicable, for example, critical access hospital (CAH), pediatric hospital, or teaching hospital).
(H) The provider category (that is, State government provider, Non-state government provider, or Private provider).
(iii) The specific amount of the supplemental payment made to the provider, including:
(A) The total supplemental payment made to the provider authorized under the specified State plan, as applicable.
(B) The total Medicaid supplemental payment made to the provider under the specified demonstration authority, as applicable.
(2) Not later than 60 days after the end of the State fiscal year, each State must annually report aggregate and provider-level information on base and supplemental payments made under State plan and demonstration authority, as applicable, by service type. This reporting must include all of the following:
(i) The SPA transaction number or demonstration authority number which authorizes the supplemental payment, as applicable.
(ii) A listing of each provider that received a supplemental payment under each authority listed in paragraph (a) of this section by:
(A) The provider's legal name.
(B) The physical address of the location or facility where services are provided, including street address, city, State, and ZIP code.
(C) The NPI.
(D) The Medicaid identification number.
(E) The EIN.
(F) The service type for which the reported payment was made.
(G) The provider specialty type (if applicable, for example, CAH, pediatric hospital, or teaching hospital).
(H) The provider category (that is, State government provider, non-State government provider, or Private provider).
(I) The State reporting period (State fiscal year start and end dates).
(iii) The specific amount of Medicaid payments made to each provider, including, as applicable:
(A) The total fee-for-service base payments made to the provider authorized under the State plan.
(B) The total Medicaid payments made to the provider under demonstration authority.
(C) The total amount received from Medicaid beneficiary cost-sharing requirements, donations, and any other funds received from third parties to support the provision of Medicaid services.
(D) The total supplemental payment made to the provider authorized under the specified State plan.
(E) The total Medicaid supplemental payment made to the provider under the specified demonstration authority.
(F) The total Medicaid payments made to the provider as reported under paragraphs (c)(2)(iii)(A) through (E) of this section.
(G) The total disproportionate share hospital (DSH) payments made to the provider.

(H) The Medicaid units of care furnished by the provider, as specified by the Secretary (for example, on a provider-specific basis, total Medicaid discharges, days of care, or any other unit of measurement as specified by the Secretary).

(3) Not later than 60 days after the end of the State fiscal year, each State must annually report aggregate and provider-level information on each provider contributing to the State or any unit of local government any funds that are used as a source of non-Federal share for any Medicaid supplemental payment, by:

(i) The service type for which the reported payment was made.
(ii) The provider specialty type (if applicable, for example, CAH, pediatric hospital, or teaching hospital).
(iii) The provider's legal name.
(iv) The physical address of the location or facility where services are provided, including street address, city, State, and ZIP code.
(v) The NPI.
(vi) The Medicaid identification number.
(vii) The EIN.
(viii) The provider category (that is, State government, non-State government, or private).
(ix) The total fee-for-service base payments made to the provider authorized under the State plan.
(x) The total fee-for-service supplemental payments made to the provider authorized under the State plan.
(xi) The total Medicaid payments made to the provider under demonstration authority.
(xii) The total DSH payments made to the provider.
(xiii) The total of each health care-related tax collected from the provider by any State authority or unit of local government.
(xiv) The total of any costs certified as a certified public expenditures (CPE) by the provider.
(xv) The total amount contributed by the provider to the State or a unit of local government in the form of an intergovernmental transfers (IGT).
(xvi) The total of provider-related donations made by the provider or by entities related to a health care provider, including in-cash and in-kind donations, to the State or a unit of local government, including State university teaching hospitals.
(xvii) The total funds contributed by the provider reported in paragraphs (c)(3)(xiii) through (xvi) of this section.

§ 447.290 Failure to report required information.

(a) The State must maintain the underlying information supporting base and supplemental payments, including the information required to be reported under § 447.288, consistent with the requirements of § 433.32 of this chapter, and must provide such information for Federal review upon request to facilitate program reviews or Department of Health and Human Services' Office of Inspector General (OIG) audits conducted under §§ 430.32 and 430.33 of this chapter.

(b) If a State fails to timely, completely and accurately report information required under § 447.288, CMS may reduce future grant awards through deferral in accordance with § 430.40 of this chapter, by the amount of Federal financial participation (FFP) CMS estimates is attributable to payments made to the provider or providers as to which the State has not reported properly, until such time as the State complies with the reporting requirements. CMS may defer FFP if a State submits the required report but the report fails to comply with

applicable requirements. Otherwise allowable FFP for expenditures deferred in accordance with this section will be released when CMS determines that the State has complied with all reporting requirements under § 447.288.	
§ 447.297 Limitations on aggregate payments for disproportionate share hospitals beginning October 1, 1992.	
This section focuses entirely on DSH payments.	
§ 447.299 Reporting requirements.	
This section focuses entirely on DSH payments.	
§ 447.302 State plan requirements.	
A State plan must provide that the requirements of this subpart are met.	(a) The plan must provide that the requirements of this subpart are met. (b) The plan must specify comprehensively the methods and standards used by the agency to set payment rates. (c) CMS may approve a supplemental payment, as defined in § 447.286, provided for under the State plan or a State plan amendment for a period not to exceed 3 years. A State whose supplemental payment approval period has expired or is expiring may request a State plan amendment to renew the supplemental payment for a subsequent period not to exceed 3 years, consistent the requirements of this section. For any State plan or State plan amendment that provides or would provide for a supplemental payment, the plan or plan amendment must specify all of the following: (1) An explanation of how the State plan or State plan amendment will result in payments that are consistent with section 1902(a)(30)(A) of the Act, including that provision's standards with respect to efficiency, economy, quality of care, and access along with the stated purpose and intended effects of the supplemental payment, for example, with respect to the Medicaid program, providers and beneficiaries. (2) The criteria to determine which providers are eligible to receive the supplemental payment. (3) A comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including all of the following: (i) The amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment. (ii) If applicable, the specific criteria with respect to Medicaid service, utilization, or cost data from the proposed State plan payment year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment. (iii) The timing of the supplemental payment to each eligible provider. (iv) An assurance that the total Medicaid payment to other inpatient and outpatient facilities, including the supplemental payment, will not exceed the upper limits specified in § 447.325. (v) If not already submitted, an upper payment limit demonstration as required by § 447.321 and described in § 447.288. (4) The duration of the supplemental payment authority (not to exceed 3 years).

	(5) A monitoring plan to ensure that the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the effects of the supplemental payment on the Medicaid program, for example, with respect to providers and beneficiaries. (6) For a SPA proposing to amend or renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period, for Start Printed Page 63785example, with respect to providers and beneficiaries, and including an analysis of the impact of the supplemental payment on compliance with section 1902(a)(30)(A) of the Act. (d) The authority for State plan provisions that authorize supplemental payments that are approved as of [effective date of the final rule], is limited as follows— (1) For State plan provisions approved 3 or more years prior to [effective date of the final rule], the State plan authority will expire [date that is 2 calendar years following the effective date of the final rule]. (2) For State plan provisions approved less than 3 years prior to [effective date of the final rule], the State plan authority will expire [date that is 3 calendar years following the effective date of the final rule].
§ 447.321 Outpatient hospital services: Application of upper payment limits.	
This section focuses entirely on outpatient hospital services.	
§ 447.406 Medicaid practitioner supplemental payment.	
This section focuses entirely on physician services.	
§ 455.301 Definitions.	
This section is specific to DSHs.	
§ 457.609 Process and calculation of State allotments for a fiscal year after FY 2008.	
This section focuses entirely on CHIP.	