101

Association of Counties

March 15, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: CMS-2258-P: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of federal-State Financial Partnership, (Vol. 72, NO. 11), January 18, 2007

Dear Ms. Norwalk:

The New Hampshire Association of Counties would like to be on file as opposing this proposed rule for the following reasons:

1. The rule will impose new restrictions on how states fund their Medicaid program and restricts how states reimburse their governmentally nursing homes.
2. This rule will result in an inefficient cost-based reimbursement system that contains no incentives for efficient performance. Congress moved away from a Medicaid cost- based system 27 years ago.
3. The estimated cut in federal spending over five years amounts to a budget cut for safety-net nursing homes.
4. The rule restricts intergovernmental transfers and certified public expenditures thus restricting New Hampshire's ability to fund the non-federal share of Medicaid payments.
5. There is no authority in the statute for CMS to restrict IGTs to funds generated from tax revenue and inconsistent with historic CMS policy. We believe that CMS has inappropriately interpreted the federal statute.
6. The new restrictions would result in fewer dollars to pay for the needed care for the nation's most vulnerable people, the sick and frail elderly.
7. CMS has not provided sufficient and relative data to support a claim that state financing practices across the nation do not comport with the Medicaid statute. Without access to this data a meaningful review of the proposed changes is questionable.

The New Hampshire Association of Counties opposes this rule and urges CMS to withdraw this rule immediately. If these policy changes are implemented, the nation's health care safety net will unravel, and the health care services for the millions of our nation's most vulnerable people will be jeopardized.

Sincerely,

Cathy Stacey

Cathy Ann Stacey, President

cc: The Honorable Judd Gregg
The Honorable John E. Sununu
The Honorable Paul Hodes
The Honorable Carol Shea-Porter

102

March 15, 20007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: (CMS 2258-P) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal State Financial Partnership, (Vo. 72, NO. 11), January 18, 2006

Dear Ms. Norwalk:

I am writing in support of the Illinois Hospital Associations position on the proposed rule of the Centers for Medicare & Medicaid Services (CMS) identified above. Our opposition to this rule rests in the belief that the purposed changes would cause major disruptions to the Illinois Medicaid program, harming providers and beneficiaries alike.

For Illinois, the impact of the proposed rules would represent a serious financial impact to hospitals and nursing homes providing healthcare for thousands of low-income, elderly and disable people throughout the state. Illinois' Governor has stated that this action would mean "a serious financial blow of $623 million" to certain public hospitals in Illinois and to the state.

I join in urging CMS to permanently withdraw this rule. I understand that the most significant concerns of healthcare providers include: (l) the limitation on reimbursement of governmentally operated providers; (2) the restrictions on intergovernmental transfers and certified public expenditures; and (3) the absence of data or other factual support for CMS's estimate of savings.

I respectfully urge that CMS permanently withdraw this legislation.

Sincerely yours,

Sr. Ritamary Brown
Hosp. Sisters Health System
Springfield, IL

Oneidas bringing several hundred bags of corn to Washington's starving army at Valley Forge, after the colonists had consistently refused to aid them.

Oneida Tribe of Indians of Wisconsin
BUSINESS COMMITTEE

UGWA DEMOLUM YATEHE
Because of the help of this Oneida Chief in cementing a friendship between the six nations and the colony of Pennsylvania, a new nation, the United States was made possible.

P.O. Box 365 • Oneida, WI 54155
Telephone: 920-869-4364 • Fax: 920-869-4040

March 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

Subject: (CMS-2258-P) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (72 Federal Register 2236), January 18, 2007

Dear Ms. Norwalk:

My name is Gerald L. Danforth and I am the Chairman for the Oneida Tribe of Indians of Wisconsin. We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule published on January 18, 2007 at 72 Federal Register 2236. As currently written, we oppose the proposed rule and would like to offer suggested regulatory language that we believe will address tribal concerns consistent with existing CMS policy.

Statements made by the Acting Administrator, Deputy Administrator and other CMS officials during the most recent meeting of the Tribal Technical Advisory Committee made it clear that the it was CMS's intent that this proposed rule have no effect on the opportunity of Indian Tribes and Tribal organizations to participate in financing the non-Federal portion of medical assistance expenditures for the purpose of supporting certain Medicaid administrative services, as set forth in State Medicaid Director letters of October 18, 2005, as clarified by the letter of June 9, 2006. Unfortunately, we are convinced that, as written, the proposed rule would, in fact, negatively affect such participation. We discuss our concerns and offer proposed solutions below.

Criteria for Indian Tribes to Participate

The proposed rule attempts to make clear that Indian Tribes may participate by specifically referencing them in proposed section 433.50(a)(1). However, as currently proposed, an Indian Tribe would only be able to participate if it has "generally applicable taxing authority," a criteria applied to all units of government referenced here. Although in principle Indian Tribes do enjoy taxing authority, as with all other matters about Indian Tribes, the law is complex and fraught with exceptions. To impose this requirement will burden each State with trying to understand the specific status of each Indian Tribe and to make decisions about the taxing authority of the

Tribe – a complex matter often the subject of litigation between Indian Tribes and States. A requirement to make such determinations will almost certainly negatively affect the willingness of States to enter into cost sharing agreements with Indian Tribes since an error in the determination regarding this undefined term could have potentially negative effects for the State.

Since other provisions of the proposed rule address the limitations on the type of funds that may be used, other funds of the Indian Tribe, including funds transferred to the Tribe under a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, should be acceptable without regard to whether they derive from "generally applicable taxing authority." Accordingly, we propose the following amendment to the proposed language for section 433.50(a)(1)(i):

> (i) A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State ~~(including Indian tribes)~~ that has generally applicable taxing authority, and includes an Indian tribe as defined in section 4 of the Indian Self-Determination and Education Assistance Act, as amended, [25 U.S.C. 450b] .

Criteria for Tribal Organizations to Participate

We oppose this rule as currently written because we believe it will negatively affect the participation of tribal organizations to perform Medicaid State administrative activities. The CMS TTAG spent over two years working with CMS and Indian Health Service (IHS) resulting in an October 18, 2005, State Medicaid Director (SMD) letter clarifying that tribes and tribal organizations, under certain conditions, could certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services provided by such entities. However, the proposed rule does not reflect that the criteria approved by CMS recognizing tribal organizations as a unit of government eligible to incur expenditures of State plan administration eligible for Federal matching funds. As part of these comments, we have enclosed a copy of the SMD's letter of October 18, 2005, and clarifying SMD letter dated June 9, 2006. [1]

Under the proposed rule, participation will be available only if two conditions are satisfied:

(1) the unit that proposes to contribute the funds is eligible under the proposed amendment to 42 C.F.R. § 433.50(a)(1); and(2) the contribution is from an allowable source of funds under the newly proposed section 447.206.[2]

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[1] The October letter contained the incorrect footnote that said ISDEAA funds cannot be used for match. But the SMD letter dated June 9, 2006, corrected this error. "[T]he Indian Health Service has determined that ISDEAA funds may be used for certified public expenditures under such an arrangement [MAM] to obtain federal Medicaid matching funding.")

[2] The language in proposed 447.206(b) that provides an exception for IHS and tribal facilities from limits on the amounts of contributions uses language consistent with the October 18, 2005, State Medicaid Director Letter ("The limitation in paragraph (c) of this section does

Most tribal organizations will not meet the proposed standard for criteria (1). The basic participation requirement in proposed 433.50(a)(1) sets a new standard for the eligibility of the unit that will exclude many tribal organizations by imposing a requirement that there be "taxing authority" or "access [to] funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities, and deficits . . .." The new proposed rule at 433.50(a)(1) provides:

> (i) A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority.
>
> (ii) A health care provider may be considered a unit of government only when it is operated by a unit of government as demonstrated by a showing of the following:
>
> (A) The health care provider has generally applicable taxing authority; or
>
> (B) The health care provider is able to access funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities, and deficits, so that a contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues.

In the explanation of the proposed rule, the problem is exacerbated in the discussion of section 433.50. Many tribal organizations are not-for-profit entities. The explanation of the rule suggests that not-for-profit entities "cannot participate in the financing of the non-Federal share of Medicaid payments, whether by IGT or CPE, because such arrangements would be considered provider-related donations."

None of these criteria: taxing authority; governmental responsibility for expenses, liabilities and deficits; nor a prohibition on being a not-for-profit are limitations contained in the October 18, 2005 SMD letter. None of these criteria are consistent with the governmental status of tribal organizations carrying out programs of the IHS under the Indian Self-Determination and Education Assistance Act (ISDEAA), which is the basis of the State Medicaid Director letters.

The proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). Furthermore, we believe there is no authority in the statute for CMS to restrict cost sharing to funds generated from tax revenue. CMS has inexplicably attempted to use a provision in current law that *limits the Secretary's authority to regulate* cost sharing as the source of authority that *all* cost sharing must be made from state or local taxes. The proposed change is inconsistent with CMS policy as outlined in the October 18, 2005 and the June 9, 2006 SMD letters.

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not apply to Indian Health Service facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638").

Based on the comments made by Leslie Norwalk during the TTAG meeting February 22, 2007, it is clear that the proposed rule regarding conditions for inter-governmental transfers was not intended by the Department to overturn any part of the SMD letters of October 18, 2005, and June 9, 2006, regarding Tribal participation in MAM. This was further confirmed by Aaron Blight, Director Division of Financial Operations, CMSO, on a conference call held with the CMS TTAG policy subcommittee as well as the second day of the CMS TTAG meeting held on February 23.

We therefore suggest that the regulations be amended to include the criteria contained in the October 18, 2005 SMD letter as a new (C) to 433.50(a)(1)(ii), as follows:

> (C) The health care provider is an Indian Tribe or a Tribal organization (as those terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (ISDEAA); 25 U.S.C. 450b) and meets the following criteria:
>
> (1) If the entity is a Tribal organization, it is—
>
> (aa) carrying out health programs of the IHS, including health services which are eligible for reimbursement by Medicaid, under a contract or compact entered into between the Tribal organization and the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, and
>
> (bb) either the recognized governing body of an Indian tribe, or an entity which is formed solely by, wholly owned or comprised of, and exclusively controlled by Indian tribes.
>
> (2) The cost sharing expenditures which are certified by the Indian Tribe or Tribal organization are made with Tribal sources of revenue, including funds received under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, provided such funds may not include reimbursements or payments from Medicaid, whether such reimbursements or payments are made on the basis of an all-inclusive rate, encounter rate, fee-for-service, or some other method.

The caveat to paragraph (2) above regarding the source of payments was added to expressly address a new limitation that CMS proposed on February 23, 2007, with regard to approving the Washington State Medicaid Administrative Match Implementation Plan to exclude any "638 clinics that are reimbursed at the all-inclusive rate from participation in the tribal administrative claiming program." No such exclusion was ever contemplated by CMS when it sent the SMD letters referred to earlier. Such an exclusion would swallow the rule that allows Indian Tribes and Tribal organizations to participating in cost sharing.

This new requirement could be interpreted as undermining the commitment made in the SMD letters, which had no such limitation, notwithstanding hours of discussion among CMS, Tribal representatives, and IHS about how reimbursement for tribal health programs is calculated. There was an understanding that the all-inclusive rate does not include expenditures for the types

of activity covered by Administrative Match Agreements and therefore avoids duplication of costs. CMS well knows that most Indian Health Service and tribal clinics are reimbursed under an all-inclusive rate. We have to hope that instead this is another instance in which the individuals responding to Washington State were simply "out-of-the-loop" regarding the extensive discussions with the TTAG prior to the issuance of the SMD letter.

We appreciate the challenges that face a large bureaucracy like CMS in making sure that all of its employees are equally well informed. Given that this request to Washington State reflects yet another breakdown in internal communication, we believe that the caveat at the end of the (C)(2) is essential (or some other language that makes clear that the form of Medicaid reimbursement received by an Indian Tribe or Tribal organization will not disqualify it from participating in cost sharing).

We appreciate the opportunity to comment and appreciate thoughtful consideration of these comments.

Sincerely,

Gerald L. Danforth, Chairman
Oneida Tribe of Indians of Wisconsin

CC: National Indian Health Board

104

Boykin, Jibril O. (CMS/OSORA)

From: Staton, Alfreda R. (CMS/OSORA)
Sent: Tuesday, March 20, 2007 10:23 AM
To: Boykin, Jibril O. (CMS/OSORA)
Cc: Young, Sheila L. (CMS/OSORA); Nixon, Karen E. (CMS/OSORA); Bailey, Glenda G. (CMS/OSORA)
Subject: FW: Opposing CMS Proposed Rule

Please control.

>-----Original Message-----
>From: White, Jacquelyn Y. (CMS/OSORA)
>Sent: Tuesday, March 20, 2007 9:03 AM
>To: Shortt, Michelle R. (CMS/OSORA); Bailey, Glenda G. (CMS/OSORA);
>Nixon, Karen E. (CMS/OSORA); Staton, Alfreda R. (CMS/OSORA); Converse, Daniel J.
>(CMS/OSORA)
>Subject: FW: Opposing CMS Proposed Rule
>
>For regs and correspondence. Thanks.
>
>>-----Original Message-----
>>From: Norwalk, Leslie V. (CMS)
>>Sent: Monday, March 19, 2007 8:15 PM
>>To: White, Jacquelyn Y. (CMS/OSORA)
>>Subject: Fw: Opposing CMS Proposed Rule
>>
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>>--------------------------
>>Sent from my BlackBerry Wireless Handheld
>>
>>
>>-----Original Message-----
>>From: Moore, Elliott <MooreEG@msha.com>
>>To: Norwalk, Leslie V. (CMS)
>>CC: Legislator David Davis <rep.david.davis@legislature.state.tn.us>;
>>Tom_Ingram@alexander.senate.gov <Tom_Ingram@alexander.senate.gov>;
>>Lana_moore@alexander.senate.gov <Lana_moore@alexander.senate.gov>;
>>bridget_baird@corker.senate.gov <bridget_baird@corker.senate.gov>;
>>brenda.otterson@mail.house.gov <brenda.otterson@mail.house.gov>
>>Sent: Mon Mar 19 17:38:40 2007
>>Subject: Opposing CMS Proposed Rule
>>
>>March 19, 2007
>>
>>
>>
>>Leslie Norwalk
>>
>>Acting Administrator
>>
>>Centers for Medicare & Medicaid Services
>>
>>200 Independence Avenue, S.W., Room 445-G
>>
>>Washington, DC 20201
>>
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>>
>>Re: (CMS-2258-P) Medicaid Program; Cost Limit for Providers Operated
>>by Units of
>>
>>Government and Provisions to Ensure the Integrity of Federal-State
>>Financial

2007 MAR 20 AM 9:59

Timely to Leslie

>>
>>Partnership, (Vo. 72, NO. 11), January 18, 2006
>>
>>
>>
>>Dear Ms. Norwalk:
>>
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>>
>>Mountain States Health Alliance appreciates this opportunity to
>>comment on the Centers for Medicare & Medicaid Services' (CMS)
>>proposed rule. We oppose this rule and would like to highlight the
>>harm its proposed policy changes would cause to our hospitals and the patients we serve.
>>
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>>The rule represents a substantial departure from long-standing
>>Medicaid policy by imposing new restrictions on how states fund their
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>>CMS estimates that the rule will cut $3.9 billion in federal spending
>>over five years. This amounts to a budget cut for safety-net hospitals
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>>Medicaid programs that bypass the congressional approval process and
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>>
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>>
>>Our primary concerns are as follows: (1) the limitation on
>>reimbursement
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>>Sincerely
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>>
>>Elliott Moore
>>
>>Assistant Vice President
>>
>>Community and Government Relations
>>
>>Mountain States Health Alliance

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>>=== MSHA Communications Disclaimer === This message is from Mountain
>>States Health Alliance. The contents contained herein may contain
>>confidential information. If you are not the intended recipient, you
>>are hereby notified that any disclosure, copying, distribution,
>>printing or action taken on the contents is strictly prohibited. If
>>you have received this email in error, please notify the sender
>>immediately and delete this message.
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>>

105

Johnson, Sharon B. (CMS/OSORA)

From: Simon, Carlos (CMS/OSORA)
Sent: Tuesday, March 20, 2007 11:11 AM
To: Johnson, Sharon B. (CMS/OSORA)
Subject: FW: Opposing CMS Proposed Rule

>-----Original Message-----
>From: Shortt, Michelle R. (CMS/OSORA)
>Sent: Tuesday, March 20, 2007 9:52 AM
>To: Simon, Carlos (CMS/OSORA)
>Subject: FW: Opposing CMS Proposed Rule
>
>
>
>>-----Original Message-----
>>From: White, Jacquelyn Y. (CMS/OSORA)
>>Sent: Tuesday, March 20, 2007 9:03 AM
>>To: Shortt, Michelle R. (CMS/OSORA); Bailey, Glenda G.
>>(CMS/OSORA); Nixon, Karen E. (CMS/OSORA); Staton, Alfreda R.
>>(CMS/OSORA); Converse, Daniel J. (CMS/OSORA)
>>Subject: FW: Opposing CMS Proposed Rule
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>>For regs and correspondence. Thanks.
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>>>From: Norwalk, Leslie V. (CMS)
>>>Sent: Monday, March 19, 2007 8:15 PM
>>>To: White, Jacquelyn Y. (CMS/OSORA)
>>>Subject: Fw: Opposing CMS Proposed Rule
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>>>Sent from my BlackBerry Wireless Handheld
>>>
>>>
>>>-----Original Message-----
>>>From: Moore, Elliott <MooreEG@msha.com>
>>>To: Norwalk, Leslie V. (CMS)
>>>CC: Legislator David Davis <rep.david.davis@legislature.state.tn.us>;
>>>Tom_Ingram@alexander.senate.gov <Tom_Ingram@alexander.senate.gov>;
>>>Lana_moore@alexander.senate.gov <Lana_moore@alexander.senate.gov>;
>>>bridget_baird@corker.senate.gov <bridget_baird@corker.senate.gov>;
>>>brenda.otterson@mail.house.gov <brenda.otterson@mail.house.gov>
>>>Sent: Mon Mar 19 17:38:40 2007
>>>Subject: Opposing CMS Proposed Rule
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>>>March 19, 2007
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>>>Leslie Norwalk
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>>>Acting Administrator
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>>>Centers for Medicare & Medicaid Services
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>>>200 Independence Avenue, S.W., Room 445-G
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>>>Washington, DC 20201
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>>>Re: (CMS-2258-P) Medicaid Program; Cost Limit for Providers
>>Operated by
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>>>Government and Provisions to Ensure the Integrity of Federal-State
>>>Financial
>>>
>>>Partnership, (Vo. 72, N0. 11), January 18, 2006
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>>>Dear Ms. Norwalk:
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>>>Mountain States Health Alliance appreciates this opportunity
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>>>We oppose this rule and would like to highlight the harm its proposed
>>>policy changes would cause to our hospitals and the patients we serve.
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>>>The rule represents a substantial departure from
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>>>policy by imposing new restrictions on how states fund their Medicaid
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>>>These changes would cause major disruptions to our state Medicaid
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>>>Sincerely
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>>>
>>>Elliott Moore

>>>
>>>Assistant Vice President
>>>
>>>Community and Government Relations
>>>
>>>Mountain States Health Alliance
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>>>=== MSHA Communications Disclaimer === This message is from Mountain
>>>States Health Alliance. The contents contained herein may contain
>>>confidential information. If you are not the intended recipient, you
>>>are hereby notified that any disclosure, copying, distribution,
>>>printing or action taken on the contents is strictly prohibited. If
>>>you have received this email in error, please notify the sender
>>>immediately and delete this message.
>>>==========
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106

Hayes, Yolanda K. (CMS/OSORA)

From: Teeters, Margaret A. (CMS/OSORA)
Sent: Friday, March 09, 2007 1:24 PM
To: Hayes, Yolanda K. (CMS/OSORA)
Cc: Lafferty, Tiffany R. (CMS/OSORA); Braxton, Shawn L. (CMS/OSORA); Simon, Carlos (CMS/OSORA); Teeters, Margaret A. (CMS/OSORA)
Subject: FW: Public Comment on CMS-2258-P (Cost Limit for Providers Operated by Units of Government)

Importance: High

Yolanda,

Please log in the public comment below on CMS-2258-P (Cost Limit for Providers Operated by Units of Government).

Thank you--

Margie

>-----Original Message-----
>From: Lafferty, Tiffany R. (CMS/OSORA)
>Sent: Friday, March 09, 2007 1:19 PM
>To: Teeters, Margaret A. (CMS/OSORA); Braxton, Shawn L. (CMS/OSORA)
>Subject: FW: RightNow Service Notification
>
>Margie, The following is a public comment for CMS-2258-P that was
>received via the QPU web site.
>
>Shawn, per my voicemail, please let me know how I should respond to
>Erik to close out this response.
>
>Thanks!
>Tiffany
>
>>-----Original Message-----
>>From: Akelaitis, Erik J. (CMS/OSORA)
>>Sent: Friday, March 09, 2007 9:33 AM
>>To: Lafferty, Tiffany R. (CMS/OSORA)
>>Subject: FW: RightNow Service Notification
>>
>>Tiffany-
>>
>>We've received the feedback below via the RightNow tool. Can you
>>respond or forward it onto someone who can respond? If so, would you
>>forward me the response so that I can log it into the system?
>>
>>Thanks,
>>Erik
>>
>>>-----Original Message-----
>>>From: CMS Website Questions [mailto:cms@custhelp.com]
>>>Sent: Friday, March 09, 2007 7:55 AM
>>>To: Akelaitis, Erik J. (CMS/OSORA)
>>>Subject: RightNow Service Notification
>>>
>>>Incident Assigned Notification
>>>
>>>Generated By System, 03/09/2007 07:54 AM
>>>
>>>
>>>Click here to login

>>>http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/admin/launc
>>h.php?p_launch=1
>>>
>>>
>>>Reference #070309-000006
>>>--
>>>   Summary: March 8, 2007 Ms. Leslie Norwalk Acting
>>>   Administrator Centers for Medicare & ...
>>> Product Level 1: Regulations & Guidance
>>> Product Level 2: Policies
>>> Product Level 3: e-Rulemaking
>>>   Date Created: 03/09/2007 07:54 AM
>>>   Last Updated: 03/09/2007 07:54 AM
>>>   Status: Unresolved
>>>   Assigned: Erik Akelitis
>>>   State:
>>>
>>>
>>>Discussion Thread
>>>--
>>>Customer - 03/09/2007 07:54 AM
>>>March 8, 2007
>>>
>>>
>>>Ms. Leslie Norwalk
>>>Acting Administrator
>>>Centers for Medicare & Medicaid Services 200 Independence
>>Avenue, S.W.,
>>>Room 445-G Washington, DC 20201
>>>
>>>RE: (CMS-2258-P) Medicaid Program: Cost Limit for
>>>Providers Operated by Units of Government and Provisions to
>>Ensure the
>>>Integrity of Federal-State Financial Partnership, (Vo. 72, No. 11),
>>>January 18, 2006
>>>
>>>Dear Ms. Norwalk:
>>>
>>>I am the Chief Executive Officer of Sampson Regional Medical Center.
>>>We are a 146-bed rural community hospital in Clinton, North
>>Carolina.
>>>We appreciate the opportunity to comment on the CMS proposed rule.
>>>Sampson Regional Medical Center opposes this rule. I would like to
>>>highlight the impact of this rule and its severe detriment to our
>>>hospital and ultimately the patients we serve.
>>>
>>>Please allow me to briefly describe the demographics of our hospital
>>>setting. We are the sole hospital for Sampson County, North Carolina
>>>serving approximately 80,000 people.
>>>Sampson County is the largest county geographically in the state of
>>>North Carolina (slightly larger than the state of Rhode Island).
>>>Revenue from the Medicaid program accounts for twenty percent
>>(20%) of
>>>gross revenue. We are currently paid, on average, twenty-three cents
>>>(23¢) for every dollar billed to the Medicaid program. Our
>>hospital is
>>>clearly a "poster-child" for a safety net hospital. Over the last
>>>three
>>>(3) years, the hospital's operating margin has averaged less than one
>>>percent (1%). The impact of the rule currently proposed by CMS will
>>>eliminate approximately 1.4 million dollars in reimbursement to our
>>>hospital. This will create an environment of a negative operating
>>>margin and negative cash flow. If this happens, the
>>leadership of our
>>>rural community hospital will have to strategically determine which
>>>vital patient care services we should curtail in order to keep the
>>>hospital doors open.

>>>
>>>This rule represents a substantial departure from long-standing
>>>Medicaid policy by imposing new restrictions on how states fund their
>>>Medicaid program. This rule further restricts how states reimburse
>>>hospitals; clearly, these changes will cause major
>>disruptions to North
>>>Carolina's Medicaid program and ultimately harm providers and
>>patients
>>>sponsored by the Medicaid program. In making its proposal, CMS fails
>>>to provide data that supports the need for the proposed restrictions
>>>and the dramatic reductions.
>>>
>>>Our hospital, as does the North Carolina Hospital Association
>>and other
>>>public hospitals in our state, believes that this drastic budget cut
>>>for safety net hospitals bypasses the congressional approval process
>>>and comes on the heels of vocal congressional opposition to CMS' plan
>>>to regulate in this area. Last year, 300 members of the House of
>>>Representatives and 55 United States Senators signed letters to HHS
>>>Secretary Mike Leavitt opposing this end run around Congress to
>>>restrict Medicaid payment. Currently, the House of
>>Representatives and
>>>the United States Senate are again voicing this opposition.
>>>As I write this letter, I am aware of 226 House members and
>>43 Senators
>>>who have signed letters opposing this rule moving forward.
>>>
>>>My recommendation in this matter is very straightforward. I strongly
>>>urge CMS to promptly withdraw this rule. My concerns lie in four (4)
>>>areas:
>>>
>>>· The Limitation on Reimbursement of Governmentally
>>>(Public) Operative Providers
>>>
>>>This rule proposed to limit reimbursement for government hospitals to
>>>the cost of providing services to Medicaid patients, and restricts
>>>states from making supplemental payments to these safety net
>>hospitals
>>>through Medicaid Upper Payment Limit (UPL) programs. Nearly 27 years
>>>ago, Congress moved away from cost-based reimbursement for
>>the Medicaid
>>>program, arguing that the reasonable cost-based reimbursement formula
>>>contained no incentives for efficient performance.
>>>Since then, hospital reimbursement systems have evolved following the
>>>model of the Medicare program and its use of prospective payment
>>>systems. These reimbursement systems are intended to improve
>>>efficiency by rewarding hospitals that can keep costs below
>>the amount
>>>paid. Many state Medicaid programs have adopted this method of
>>>hospital reimbursement, yet COS is proposing to resurrect a
>>cost-based
>>>limit that Congress long ago declared less efficient.
>>>
>>>In proposing a cost-based reimbursement system for government
>>>hospitals, CMS also fails to define allowable costs. We are very
>>>concerned that, in CMS' zeal to reduce federal Medicaid spending,
>>>important costs such as graduate medical education and physician
>>>on-call services or clinic services would not be recognized and
>>>therefore would no longer be reimbursed.
>>>
>>>CMS also fails to explain why it is changing its position
>>regarding the
>>>flexibility afforded to states under the UPL program. CMS, in 2o02
>>>court documents, described the UPL concept as setting
>>aggregate payment
>>>amounts for specifically defined categories of health care providers
>>>and specifically defined groups of providers, but leaving to

>>the states
>>>considerable flexibility to allocate payment rates within those
>>>categories. Those documents further note the flexibility to allow
>>>states to direct higher Medicaid payment to hospitals facing stressed
>>>financial circumstances. CMS reinforced this concept of state
>>>flexibility in its 2002 UPL final rule. But CMS, in this current
>>>proposed rule, is disregarding without explanation its previous
>>>decisions that grant states flexibility under the UPL system
>>to address
>>>the special needs of hospitals through supplemental payments.
>>>
>>>· The Narrowing of The Definition of The Public Hospital
>>>
>>>The proposed rule puts forward a new and restrictive definition of
>>>"unit of government", such as a public hospital.
>>> Public hospitals that meet this new definition must demonstrate they
>>>are operated by a unit of government or are an integral part
>>of a unit
>>>of government that has taxing authority. Hospitals that do not meet
>>>this new definition would not be allowed to certify expenditures to
>>>state Medicaid programs. Contrary to CMS' assertion, the statutory
>>>definition of "unit of government" does not require "generally
>>>applicable taxing authority." This new restrictive
>>definition would no
>>>longer permit many public hospitals that operate under public benefit
>>>corporations or many state universities from helps states
>>finance their
>>>share of Medicaid funding.
>>>There is no basis in federal statute that supports this
>>proposed change
>>>in definition.
>>>
>>>· The Restrictions on Intergovernmental Transfers and
>>>Certified Public Expenditures
>>>
>>>The proposed rule imposes significant new restrictions on a state's
>>>ability to fund the non-federal share of Medicaid payments through
>>>intergovernmental transfers (IGTs) and certificated public
>>expenditures
>>>(CPEs). There is no authority in the statute for CMS to
>>restrict IGTs
>>>to funds generated from tax revenue. CMS has inexplicably
>>attempted to
>>>use a provision in current law that limits the Secretary's
>>authority to
>>>regulate IGTs as the source of authority that all IGTs must be made
>>>from state or local taxes. Not only is the proposed change
>>>inconsistent with historic CMS policy, but it is another instance in
>>>which CMS has inappropriately interpreted the federal statute.
>>>
>>>CPEs are restricted as well, so only hospitals that meet the new
>>>definition of public hospital and are reimbursed on a cost
>>basis would
>>>be eligible to use CPEs to help states fund their programs. These
>>>restrictions would result in fewer dollars available to pay
>>for needed
>>>care for the nation's most vulnerable people.
>>>
>>>· The Absence of Data or Other Factual Support for CMS's
>>>Estimate of Program Savings
>>>
>>>CMS is required to examine relevant data to support to need to change
>>>current policy. The proposed rule estimates that the policy changes
>>>will result in $3.87 billion in spending cuts over the next five (5)
>>>years. But CMS fails to provide any relevant data or facts
>>to support
>>>this conclusion. CMS claims to have examined Medicaid financing

>>>arrangements across the country and has identified state financing
>>>practices that do not comport with the Medicaid statute.
>>CMS, however,
>>>provides no information on which states or how many states are
>>>employing questionable financing practices. The public,
>>without access
>>>to such data, has not been given the opportunity to
>>meaningfully review
>>>CMS' proposed changes, calling into question CMS' adherence to
>>>administrative procedure.
>>>
>>>We oppose the rule and strongly urge that CMS permanently
>>withdraw it.
>>>If these policy changes are implemented, our hospital's health care
>>>safety net will unravel and healthcare services for millions of our
>>>nation's most vulnerable people will be jeopardized.
>>>
>>>
>>>Sincerely,
>>>
>>>
>>>
>>>Larry H. Chewning
>>>Chief Executive Officer
>>>
>>>
>>>LHC/cb
>>>
>>>Cc: Senator Elizabeth Dole
>>> Senator Richard Burr
>>> Congressman Bob Etheridge
>>> Congressman Mike McIntyre
>>>
>>>Auto-Response - 03/09/2007 07:54 AM
>>>Title: Who is the Administrator and what is the mailing address?
>>>Link:
>>>http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/pop
>>up_adp.php?p_faqid=49&p_created=1000473025
>>>
>>>Title: Which DESI drugs do not satisfy the definition of a
>>Part D drug?
>>>Link:
>>>http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/pop
>>up_adp.php?p_faqid=8053&p_created=1165343011
>>>
>>>Title: How Do I Submit a Request for a National Coverage
>>Determination?
>>>Link:
>>>http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/pop
>>up_adp.php?p_faqid=2653&p_created=1079984847
>>>
>>>Title: I am a provider who has been adversely impacted by Hurricane
>>>Katrina, and I am unable to restart full operations.
>>> Can I maintain my existing provider agreement and retain my provider
>>>number while my facility is closed? Can I relocate, an
>>>Link:
>>>http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/pop
>>up_adp.php?p_faqid=6499&p_created=1136421392
>>>
>>>Title: Are oral anti-cancer agents with no indications other than
>>>cancer treatment eligible for reimbursement as Part D drugs, since
>>>the CMS Part D formulary guidance requires "all or substantially" of
>>>the antineoplastic classes?
>>>Link:
>>>http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/pop
>>up_adp.php?p_faqid=8054&p_created=1165343523
>>>

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INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

March 12, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-2258-P (Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership)

Dear Ms. Norwalk:

On behalf of the State of Indiana, I am writing to express my concerns regarding the proposed rule CMS-2258-P (Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership) published in the *Federal Register* on January 18, 2007. If implemented as proposed, the rules could reduce the availability of health care services to the uninsured and increase cost shifting to small business.

Indiana recognizes the importance of a strong state-federal partnership in the Medicaid program; however, we believe that the policies proposed in the rule represent fundamental policy changes that would limit the use of long-standing, legitimate state funding mechanisms. The proposed rule would impose a cost limit for public health care providers and alter the definition of a "unit of government." Both of these proposals would reduce funding options for states and are likely to substantially reduce services for Medicaid patients and the uninsured in Indiana.

Limiting public provider reimbursement to cost would reward inefficiencies and prevent states from bringing cost-effective market principles into their Medicaid programs. Cost limits would impede a state's ability to utilize prospective payment systems that create incentives for efficient, cost conscious care. Prospective payment systems, which are used in the Medicare program, pay

providers a predetermined fixed price that depends on patient resource needs but is independent of the amount of services actually provided. Since the payment is independent of service provision, providers are given an incentive to provide cost-effective care and are not rewarded for high costs. Inefficient provision of health care services drives up costs, both for the uninsured and for small business struggling to provide coverage to their employees.

The proposed rule also unfairly discriminates against one type of provider by applying the cost reimbursement limitation only to public providers. This proposal would allow states to pay private providers rates that the federal government deems excessive for public providers, even though the needs of public providers are often significantly greater. Public providers typically provide a disproportionate share of care to the uninsured and offer critical community-wide services such as trauma care and first response services. At the same time, public providers' payer mix is often markedly different from private providers, with higher uncompensated care costs and a greater reliance on Medicaid revenues to fund operations. Limiting Medicaid reimbursement to public providers has the potential to greatly reduce their primary source of funding.

We also believe that the proposed change in the definition of "unit of government" oversteps statutory authority by defining what subunits of state government may contribute to and what financing sources states may utilize in financing the non-federal share of Medicaid. This discretion has been left to state governments since Medicaid was created in 1965 and represents a fundamental right of states to determine which of its entities are governmental and which are not. The new definition undermines the efforts of states and local governments to deliver a core governmental function of ensuring access to health care in the most efficient and effective manner by preventing them from organizing themselves as they deem necessary.

An abrupt change in the definition of unit of government has the potential to disrupt the delivery of health care services by altering the existing financing structure for public agencies. A transition period to the new definition would enable the state to realign the flow of certain tax monies from public agencies to the state. As this process could take as long as three years, we believe it is important to give states time to properly implement the change.

The requirements that intergovernmental transfers (IGTs) be derived only from tax revenues and that such funds be specifically appropriated ignores the much broader nature of public funding and budgeting. States, local governments and governmental providers derive their funding from a variety of sources, not just taxes, and such funds are no less public due to their source or specific category of appropriation. Limiting IGTs to tax revenues and dictating how states budget the non-federal share of their programs will deprive states of long-standing funding sources and leave them with significant budget gaps that are likely to lead to reductions in Medicaid services for vulnerable populations.

We find cause for further concern in the rule's prohibition on a state's use of taxes that support indigent care as a source of funding for the state share of Medicaid spending. As public providers often care for a disproportionate share of uninsured patients, many of whom share

characteristics of the Medicaid population, we believe that it is appropriate to use taxes that support indigent care toward the non-federal share of Medicaid. States should be left to their own discretion to determine which taxes may be used as the non-federal source for Medicaid match.

Last year, 300 members of the House and 55 Senators wrote to the Bush Administration to express their concern about the impact of this proposed regulation and to urge the President not to move ahead with it. Despite these objections, the proposed rule is slated to take effect on September 1, 2007. On behalf of the State of Indiana, I urge you to consider the devastating impact that this rule will have on the safety net in our state and work with Congress to strengthen, rather than deplete, the resources of the Medicaid program.

Sincerely,

Anne W. Murphy
Chief of Staff
Indiana Family and Social Services Administration

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Ted Strickland
Governor

Helen E. Jones-Kelley
Director

30 East Broad Street Columbus, Ohio 43215-3414
jfs.ohio.gov

February 15, 2007

Office of Strategic Operations and
Regulatory Affairs
Division of Regulations Development
ATTN: Melissa Musotto [CMS-2238-P]
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room C4-26-05
7500 Security Boulevard
Baltimore MD 21244-1850

Office of Information and Regulatory
Affairs
Office of Management and Budget
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New Executive Office Building
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CMS Desk Officer, CMS-2238-P
Katherine_astrich@omb.eop.gov
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Comments on the Collection of Information Requirements
For the Proposed Rule Concerning the Medicaid Program: Prescription Drugs
CMS-2238-P

Dear Ms. Musotto and Ms. Astrich:

Thank you for the opportunity to comment on collection of information requirements reported in the proposed rules regarding the Medicaid prescription drug program changes outlined in sections 6001 (a)-(d), 6002, and 6003 of the Deficit Reduction Act of 2005 (DRA). Within the Ohio Department of Job and Family Services, the Office of Ohio Health Plans administers Ohio Medicaid and the Medicare Premium Assistance Program. These programs cover 1.7 million Ohioans each month.

Preserving access to prescription drugs for Medicaid recipients should be a priority for the Centers for Medicare and Medicaid Services (CMS). The Ohio Medicaid program is concerned that the information collection requirements outlined in this Notice of Proposed Rulemaking (NPRM) are understated.

Ohio Medicaid is particularly concerned that the requirement that physicians bill using National Drug Code (NDC) in addition to Healthcare Common Procedure Coding System (HCPCS) code for physician-administered drugs will create a new billing procedure that is used only for Medicaid, creating an administrative burden that many physicians may not be able to carry. This causes Medicaid patients to be treated differently than other patients in the practice, and physicians may choose to not accept Medicaid patients. We believe that this will create a barrier to access.

Section III: Collection of Information Requirements

FFP: Conditions Relating to Physician-Administered Drugs. (447.520)

Ohio Medicaid disagrees with the estimates that CMS has proposed for the time for physician office staff, hospital outpatient departments, and other entities to bill using both NDC and HCPCS. The estimate of 15 seconds, or nine cents per claim, significantly discounts the time and funds that will be required for these providers to learn the requirements, train staff, and implement the procedures. In addition to the individual administering the drug, the entire billing staff will need to be trained to include NDC on the claim. While the ongoing effort may be small, the initial training will be intensive for both providers and for Medicaid programs.

We are also concerned with CMS's position that no state will need to apply for a hardship waiver for this provision. Ohio's Medicaid Management Information System (MMIS) became operational in 1986, and it will be virtually impossible to implement the inclusion of the NDC in the existing claims payment system. We are in process of contracting for a new Medicaid Information Technology System (MITS) and plan to include this functionality in the new system. However, this system will not be operational until at least 2009. Ohio Medicaid asks that CMS reconsider its position that it will not accept hardship waiver requests from any state. We also believe that the estimate for the time that it would take a state agency to apply for a hardship waiver is not accurate. Five hours is not enough time for a state to gather the information, synthesize it into the format required by CMS, and gain approval of the request from all stakeholders that would need to be involved.

Recommendations:

* CMS should reconsider the financial impact on providers that bill for drugs administered in the provider setting.
* CMS should accept and approve hardship waiver requests from those states that will be unable to implement the procedure due to technology limitations or provider resistance to the change.

Ohio Medicaid looks forward to working with CMS on the implementation of the Deficit Reduction Act changes to the Medicaid pharmacy program. Preserving access to prescription drugs for Medicaid consumers is a priority. Please consider these recommendations before issuing final regulations. If you have any questions, please do not hesitate to contact me at (614) 466-4443.

Respectfully Submitted,

Cristal A. Thomas
State Medicaid Director

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ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
Administration
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Telephone: 907-729-1900
Facsimile: 907-729-1901

March 19, 2007

Ms. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Central Building, Mail Stop C5-11-24
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: (CMS-2258-P) MEDICAID PROGRAM; COST LIMIT FOR PROVIDERS OPERATED BY UNITS OF GOVERNMENT AND PROVISIONS TO ENSURE THE INTEGRITY OF FEDERAL-STATE FINANCIAL PARTNERSHIP, (72 FEDERAL REGISTER 2236), JANUARY 18, 2007

Dear Ms. Norwalk:

I appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule published on January 18, 2007 at 72 Federal Register 2236. As currently written, I oppose the proposed rule and would like to offer suggested regulatory language that we believe will address tribal concerns consistent with existing CMS policy.

Statements made by the Acting Administrator, Deputy Administrator and other CMS officials during the most recent meeting of the Tribal Technical Advisory Committee (TTAG) made it clear that the it was CMS's intent that this proposed rule have no effect on the opportunity of Indian Tribes and Tribal organizations to participate in financing the non-Federal portion of medical assistance expenditures for the purpose of supporting certain Medicaid administrative services, as set forth in State Medicaid Director letters of October 18, 2005, as clarified by the letter of June 9, 2006. Unfortunately, I am convinced that, as written, the proposed rule would, in fact, negatively affect such participation. We discuss our concerns and offer proposed solutions below.

Criteria for Indian Tribes to Participate

The proposed rule attempts to make clear that Indian Tribes may participate by specifically referencing them in proposed section 433.50(a)(1). However, as currently proposed, an Indian Tribe would only be able to participate if it has "generally applicable taxing authority," a criteria applied to all units of government referenced here. Although in principle Indian Tribes do enjoy taxing authority, as with all other matters about Indian Tribes, the law is complex and fraught with exceptions. To impose this requirement will burden each State with trying to understand the specific status of each Indian Tribe and to make decisions about the taxing authority of the Tribe – a complex matter often the subject of litigation between Indian Tribes and States. A requirement to make such determinations will almost certainly negatively affect the willingness of States to enter into cost sharing agreements with Indian Tribes since an error in the determination regarding this undefined term could have potentially negative effects for the State.

Since other provisions of the proposed rule address the limitations on the type of funds that may be used, other funds of the Indian Tribe, including funds transferred to the Tribe under a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, should be acceptable without regard to whether they derive from "generally applicable taxing authority." Accordingly, we propose the following amendment to the proposed language for section 433.50(a)(1)(i):

> (i) A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State ~~(including Indian tribes)~~ that has generally applicable taxing authority, and includes an Indian tribe as defined in section 4 of the Indian Self-Determination and Education Assistance Act, as amended, [25 U.S.C. 450b] .

Criteria for Tribal Organizations to Participate

On behalf of the Alaska Native Tribal Health Consortium, I oppose this rule as currently written because we believe it will negatively affect the participation of tribal organizations to perform Medicaid State administrative activities. The CMS TTAG spent over two years working with CMS and Indian Health Service (IHS) resulting in an October 18, 2005, State Medicaid Director (SMD) letter clarifying that tribes and tribal organizations, under certain conditions, could certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services provided by such entities. However, the proposed rule does not reflect that the criteria approved by CMS recognizing tribal organizations as a unit of government eligible to incur expenditures of State plan administration eligible for Federal matching funds. As part of these comments, we have enclosed a copy of the SMD's letter of October 18, 2005, and clarifying SMD letter dated June 9, 2006. [1]

Under the proposed rule, participation will be available only if two conditions are satisfied:

(1) the unit that proposes to contribute the funds is eligible under the proposed amendment to 42 C.F.R. § 433.50(a)(1); and
(2) the contribution is from an allowable source of funds under the newly proposed section 447.206.[2]

Most tribal organizations will not meet the proposed standard for criteria (1). The basic participation requirement in proposed 433.50(a)(1) sets a new standard for the eligibility of the unit that will exclude many tribal organizations by imposing a requirement that there be "taxing authority" or "access [to] funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities, and deficits" The new proposed rule at 433.50(a)(1) provides:

> (i) A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority.
>
> (ii) A health care provider may be considered a unit of government only when it is operated by a unit of government as demonstrated by a showing of the following:
>
> (A) The health care provider has generally applicable taxing authority; or
>
> (B) The health care provider is able to access funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities, and deficits, so that a contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues.

---

[1] The October letter contained the incorrect footnote that said ISDEAA funds cannot be used for match. But the SMD letter dated June 9, 2006, corrected this error. "[T]he Indian Health Service has determined that ISDEAA funds may be used for certified public expenditures under such an arrangement [MAM] to obtain federal Medicaid matching funding.")

2/ The language in proposed 447.206(b) that provides an exception for IHS and tribal facilities from limits on the amounts of contributions uses language consistent with the October 18, 2005, State Medicaid Director Letter ("The limitation in paragraph (c) of this section does not apply to Indian Health Service facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638").

In the explanation of the proposed rule, the problem is exacerbated in the discussion of section 433.50. Many tribal organizations are not-for-profit entities. The explanation of the rule suggests that not-for-profit entities "cannot participate in the financing of the non-Federal share of Medicaid payments, whether by IGT or CPE, because such arrangements would be considered provider-related donations."

None of these criteria: taxing authority; governmental responsibility for expenses, liabilities and deficits; nor a prohibition on being a not-for-profit are limitations contained in the October 18, 2005 SMD letter. None of these criteria are consistent with the governmental status of tribal organizations carrying out programs of the IHS under the Indian Self-Determination and Education Assistance Act (ISDEAA), which is the basis of the State Medicaid Director letters.

The proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through intergovernmental transfers (IGT's) and certified public expenditures (CPE's). Furthermore, I believe there is no authority in the statute for CMS to restrict cost sharing to funds generated from tax revenue. CMS has inexplicably attempted to use a provision in current law that *limits the Secretary's authority to regulate* cost sharing as the source of authority that *all* cost sharing must be made from state or local taxes. The proposed change is inconsistent with CMS policy as outlined in the October 18, 2005 and the June 9, 2006 SMD letters.

Based on your comments made during the TTAG meeting on February 22, 2007, it is clear that the proposed rule regarding conditions for inter-governmental transfers was not intended by the Department to overturn any part of the SMD letters of October 18, 2005, and June 9, 2006, regarding Tribal participation in MAM. This was further confirmed by Aaron Blight, Director Division of Financial Operations, CMSO, on a conference call held with the CMS TTAG policy subcommittee as well as the second day of the CMS TTAG meeting held on February 23.

We therefore suggest that the regulations be amended to include the criteria contained in the October 18, 2005 SMD letter as a new (C) to 433.50(a)(1)(ii), as follows:

> (C) The health care provider is an Indian Tribe or a Tribal organization (as those terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (ISDEAA); 25 U.S.C. 450b) and meets the following criteria:
>
> (1) If the entity is a Tribal organization, it is—
>
> (aa) carrying out health programs of the IHS, including health services which are eligible for reimbursement by Medicaid, under a contract or compact entered into between the Tribal organization and the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, and
>
> (bb) either the recognized governing body of an Indian tribe, or an entity which is formed solely by, wholly owned or comprised of, and exclusively controlled by Indian tribes.
>
> (2) The cost sharing expenditures which are certified by the Indian Tribe or Tribal organization are made with Tribal sources of revenue, including funds received under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, provided such funds may not include reimbursements or payments from Medicaid, whether such reimbursements or payments are made on the basis of an all-inclusive rate, encounter rate, fee-for-service, or some other method.

The caveat to paragraph (2) above regarding the source of payments was added to expressly address a new limitation that CMS proposed on February 23, 2007, with regard to approving the Washington State Medicaid Administrative Match Implementation Plan to exclude any "638 clinics that are reimbursed at the all-inclusive rate from participation in the tribal administrative claiming program." No such exclusion was

ever contemplated by CMS when it sent the SMD letters referred to earlier. Such exclusion would swallow the rule that allows Indian Tribes and Tribal organizations to participating in cost sharing.

This new requirement could be interpreted as undermining the commitment made in the SMD letters, which had no such limitation, notwithstanding hours of discussion among CMS, Tribal representatives, and IHS about how reimbursement for tribal health programs is calculated. There was an understanding that the all-inclusive rate does not include expenditures for the types of activity covered by Administrative Match Agreements and therefore avoids duplication of costs. CMS well knows that most Indian Health Service and tribal clinics are reimbursed under an all-inclusive rate. We have to hope that instead this is another instance in which the individuals responding to Washington State were simply "out-of-the-loop" regarding the extensive discussions with the TTAG prior to the issuance of the SMD letter.

I appreciate the challenges that face a large bureaucracy like CMS in making sure that all of its employees are equally well informed. Given that this request to Washington State reflects yet another breakdown in internal communication, I believe that the caveat at the end of the (C)(2) is essential (or some other language that makes clear that the form of Medicaid reimbursement received by an Indian Tribe or Tribal organization will not disqualify it from participating in cost sharing).

I appreciate the opportunity to comment and appreciate thoughtful consideration of these comments.

Sincerely,

Don Kashevaroff
Chairman and President

Attachments (2)

CC: Paul Sherry, Chief Executive Officer, Alaska Native Tribal Health Consortium
Valerie Davidson, Senior Director of Legal and Intergovernmental Affairs, Alaska Native Tribal Health Consortium, and Chairman, Tribal Technical Advisory Committee
Stacy Bohlen, Executive Director, National Indian Health Board, 101 Constitution Avenue, N.W., Suite 8-B02; Washington, DC 20001

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

June 9, 2006 **SMDL#06-014**

Dear State Medicaid Director:

On October 18, 2005 The Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director (SMD) letter containing guidance for participation by Tribal organizations in arrangements that use certified public expenditures by a "unit of government" to fulfill the non- federal matching requirements for administrative activities under the Medicaid program. The letter set forth criteria under which a Tribal organization may be considered as a unit of government that can certify expenditures as the non-Federal share of Medicaid administration claims. The letter contained the following footnote:

"Federal funds may not be used to meet State matching requirements, except as authorized by Federal law. Although Federal HHS funds awarded under ISDEAA [the Indian Self-Determination and Education Assistance Act, or Pub.L. 93-638] may be used to meet Tribal matching requirements, that authority does not include State matching requirements. As a result, Tribal expenditures certified for this purpose must be funded through non-ISDEAA sources."

Although the footnote correctly states the applicable principles of law, after further review, we have determined that the conclusion in the last sentence would not apply when the full financial benefit and responsibility has been assigned to the tribal organization. The Indian Health Service (IHS) and CMS are issuing this joint SMD letter to clarify that footnote.

When a State assigns to a tribal organization the full right to the federal matching share, without any diminution, along with the full responsibility for establishing the non-federal share through certified public expenditures, the State effectively drops out of the financial equation. What remains is a funding arrangement under which federal matching funds are directly available to the tribal organization based on the tribal organization's expenditures. This is effectively a tribal matching obligation, rather than a contribution to a larger State matching obligation.

Based on this analysis that such an arrangement effectively results in a tribal matching obligation, the Indian Health Service (HIS) has determined that ISDEAA funds may be used for certified public expenditures under such an arrangement to obtain federal Medicaid matching funding. The net required contribution by the Tribal organization cannot exceed the non-Federal share of such expenditures; thus the State must pass through to the Tribal organization the full amount of Federal Medicaid matching funding received based on the certified expenditures.

It is important to note that ISDEAA funds may only be used to fund activities permissible under the ISDEAA. This includes activities authorized under the Snyder Act, 25 U.S.C. 13, and the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. §1601 et seq. Thus, any Medicaid administrative activities that are funded with ISDEAA funds must also be permissible activities under the Snyder Act or the IHCIA.

The October 18, 2005 State Medicaid Director letter also contained four criteria for recognition of Tribal organization expenditures as the non-Federal share of Medicaid administration claims. The fourth criterion, stating that expenditures for allowable administrative activities which are certified by the Tribal organizations must be made with Tribal sources of revenue other than Medicaid revenues or ISDEAA funds is amended to delete the reference to ISDEAA funds, which may now be used as outlined in this letter. Additionally, a fifth criterion is hereby added. The fourth and fifth criteria now read as follows:

4. Expenditures for allowable Medicaid administrative activities which are certified by the Tribal organization are made with funds derived from Tribal sources of revenue other than Medicaid revenues.

5. Expenditures made with funds derived from ISDEAA agreements may be certified by the Tribal organization only to the extent that the State passes the entire amount of Federal Medicaid matching funding to the Tribal organization.

Tribes, as well as Tribal organizations, which certify Medicaid administration expenditures made with funds derived from ISDEAA agreements, must receive the full amount of Federal Medicaid matching funding.

If you have questions regarding this matter, please contact Ed Gendron at CMS on 410-786-1064 or Carl Harper at HIS on 301-443-3216.

Sincerely,

/s/
Dr. Charles Grim, D.D.S.,M.H.S.A.
Director
Indian Health Service

/s/
Dennis G. Smith
Director
Center for Medicaid and State Operations

Cc:

CMS Regional Administrators

CMS Associate Regional Administrators
For Medicaid and State Operations

Martha Roberty
Director, Health Policy Unit
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Joy Wilson
Director, Health Committee
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Chairperson
CMS Tribal Technical Advisory Group

HIS Area Directors

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

SMDL #05-004

October 18, 2005

Dear State Medicaid Director:

A number of States and Tribal organizations have asked whether expenditures that are certified by Tribal organizations can be used to fulfill State matching requirements for administrative activities under the Medicaid program. In considering this question, the Centers for Medicare & Medicaid Services (CMS) took into account the fact that Tribal organizations may have governmental responsibilities when operating on behalf of Tribal governments. Additionally, CMS considered the possible occurrence of duplicate payment when the same entity is paid under an agreement to perform Medicaid State administrative activities and as a provider for Medicaid services. This letter describes CMS' policy regarding the conditions under which Tribal organizations can certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services directly provided by such entities.

Pursuant to Federal law, the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, as amended, permits Indian Tribes to directly operate health programs that furnish covered Medicaid services under a contract or compact with the Indian Health Service (IHS). Several States have contracted with Tribes to perform certain allowable Medicaid administrative functions and, as units of government, the Tribes certify actual expenditures related to these activities to the State. The activities performed include, among other things, outreach and application assistance for Medicaid enrollment and activities that ensure appropriate utilization of Medicaid services by Medicaid beneficiaries. The contract language ensures that expenditures certified for administrative costs do not duplicate, in whole or in part, claims made for the costs of direct patient care. The State uses the certified expenditures in its Federal financial participation (FFP) claims for State Medicaid administration activities.[1]

Section 1903(w)(6)(A) of the Social Security Act (the Act) specifies that the Secretary may not restrict a State's use of funds where such funds are derived from State or local taxes (or funds appropriated to State teaching hospitals) transferred from, or certified by, units of government within a State as the non-Federal share of Medicaid expenditures, regardless of whether the unit of government is also a health care provider under the State plan, unless the transferred funds are derived from donations or taxes that would not otherwise be recognized as the non-Federal share. Under this provision, only certified public expenditures from units of government are protected.

[1] Federal funds may not be used to meet State matching requirements, except as authorized by Federal law. Although Federal IHS funds awarded under ISDEAA may be used to meet Tribal matching requirements, that authority does not include State matching requirements. As a result, Tribal expenditures certified for this purpose must be funded through non-ISDEAA sources.

Regulations at 42 CFR section 433.51 permit certified public expenditures from public agencies, specifically including Indian Tribes, to be used as the non-Federal share of expenditures. However, these regulations do not address Tribal organizations.

It is not the intent of this letter to expand the scope of transactions protected under section 1903(w)(6)(A) of the Act or the regulations at 42 CFR section 433.51. However, it is CMS' position that when federally recognized Indian Tribes coalesce for a common purpose, that collective effort should be afforded the same rights, privileges, protections, and exemptions as the individual Tribes themselves.[2] This status extends to Tribal organizations formed solely by, wholly owned by or comprised of, and exclusively controlled by Indian Tribes, as currently defined in section 4(e) of ISDEAA. This section defines "Indian Tribe" to mean any Indian Tribe, band, nation, or other organized group or community, including any Alaska Native village or a regional or village corporation as defined in, or established pursuant to, the Alaska Native Claims Settlement Act, which are recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Some Indian Tribes, either alone or jointly with other Indian Tribes, operate health programs indirectly through separate Tribal organizations. The organizational structure of the Tribal organizations, as well as the designation of authority and responsibilities by the Tribes to the Tribal organizations, varies among Tribes and Tribal organizations. When the IHS enters into an ISDEAA contract or compact with a Tribal organization, the IHS engages in a detailed process of certifying that the Tribal organization meets the ISDEAA statutory requirements. The governing body of the Tribal organization must be composed solely of members of Indian Tribes. Each Tribe represented by the Tribal organization must have passed a resolution authorizing the Tribal organization to act on its behalf. ISDEAA requires that the contracting or compacting Tribal organization compute its costs in accordance with the cost principles for State, local, and Indian Tribal governments contained in the Office of Management and Budget (OMB) Circular A-87. Additionally, ISDEAA requires that the Tribal organization comply with the provisions of the Single Audit Act (31 U.S.C., Chapter 75). Therefore, reliance on the IHS certification process for approval of ISDEAA contracts and compacts will prevent duplication of some of the efforts necessary to determine—by CMS standards—whether an entity is a unit of government.

Some Tribal organizations that receive IHS funding do not operate solely on behalf of Tribal governments. A Tribal organization that is not formed wholly by Indian Tribes, as discussed above, may be authorized to act on behalf of Tribal governments, may receive IHS grant funds on behalf of such governments, and may be accorded the rights of such governments for many purposes. However, unless a Tribal organization is either the recognized governing body of an Indian Tribe, or an entity which is formed solely by, wholly owned by or comprised of, and

[2] See Dille v. Council of Energy Resource Tribes, 801 F.2d 373 (10th Cir. 1986).

exclusively controlled by Indian Tribes, as defined above, it is not a unit of government for Medicaid purposes.

Because of the variations in the organization, nature, function, responsibilities, and fiscal arrangements between Tribes and Tribal organizations, CMS has developed a set of criteria for use in analyzing whether a Tribal organization is acting as a unit of government and incurs expenditures of State plan administration that are eligible for Federal matching funds. All of these criteria must be met for recognition of certified public expenditures for administration of the State plan by a Tribal organization. If you choose to enter into a contractual arrangement for certification of expenditures for Medicaid administrative activities by a Tribal organization which meets the criteria set forth below, please ensure that your agreements are structured such that you do not contract out any Medicaid administrative functions that Federal or State law and regulations require that the State government itself perform. Assure that the activities covered by the contract are not already being offered or provided by other entities or through other programs and will not otherwise be paid for as a Medicaid administrative cost. In addition, if the Tribal organization is also a direct provider of health care services, the contract language must ensure that activities that are integral parts or extensions of direct medical services, such as patient follow-up, patient assessment, patient education, or counseling, are not included in the claims for Medicaid administration. Finally, the costs of any subcontracts by the Tribal organization to non-governmental entities are not to be included in the FFP claims for which certification is made.

CRITERIA FOR RECOGNITION OF TRIBAL ORGANIZATION EXPENDITURES AS THE NON-FEDERAL SHARE OF MEDICAID ADMINISTRATION CLAIMS:

1. The Tribal organization is carrying out health programs of the IHS, including health services which are eligible for reimbursement by Medicaid, under a contract or compact entered into between the Tribal organization and the IHS pursuant to the ISDEAA (P.L. 93-638), as amended.

2. The Tribal organization is either the recognized governing body of an Indian Tribe, or an entity which is formed solely by, wholly owned by or comprised of, and exclusively controlled by Indian Tribes, as defined in Section 4 of the ISDEAA (P.L. 93-638), as amended.

3. The Tribal organization has contracted with the State Medicaid agency to perform specified State Medicaid administrative activities and certify as public expenditures only its actual costs (computed in accordance with applicable provisions of OMB Circular A-87) of allowable administrative activities performed pursuant to its contract with the State Medicaid agency.

4. The expenditures for allowable administrative activities which are certified by the Tribal organization are made with Tribal sources of revenue other than Medicaid revenues or ISDEAA funds.

Attached is a list of Tribal organizations with current ISDEAA Title I contracts or Title V compacts that have been identified by IHS as meeting the criteria listed above (Attachment A). This list is subject to change as new Tribal organizations contract or compact with IHS on a yearly basis. In addition to the attached list of Tribal organizations, for those Tribal organizations which are the recognized governing body of an Indian Tribe, please refer to the Department of the Interior's list of federally Recognized Tribes. The most recent listing, a copy of which is attached (Attachment B), was published on December 5, 2003, in the *Federal Register* (67 *Fed. Reg.* 68180). Proof of current ISDEAA contractor status should be included in the agreement approval process established by each State.

Prior to claiming FFP for expenditures for which a Tribal organization certifies the funds, the State must submit a written statement to the jurisdictional CMS regional office, certifying that the State reviewed the organization and that it meets all of the criteria specified in this letter. Please note that the source of funds used by Tribal organizations to represent expenditures eligible for FFP must be documented to CMS upon its request.

If you have questions regarding this matter, please contact Mr. Ed Gendron at (410) 786-1064.

Sincerely,

/s/

Dennis G. Smith
Director

Attachments

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Sandy Bourne
Legislative Director
American Legislative Exchange Council

Lynne Flynn
Director for Health Policy
Council of State Governments

Dr. Charles W. Grim, D.D.S., M.H.S.A.
Director
Indian Health Service

H. Sally Smith
Chairperson
National Indian Health Board

Valerie Davidson
Chairperson
CMS Tribal Technical Advisory Group

Attachment A

Title I Contractors
Tribal Organizations

Title I Tribal Organizations*

Alamo Navajo School Board, Inc.
Albuquerque Area Indian Health Board
All Indian Pueblo Council, Inc.
California Rural Indian Health Board (CRIHB)
Central Valley Indian Health, Inc.
Chapa-De Indian Health Program, Inc.
Consolidated Tribal Health Project, Inc.
Cook Inlet Tribal Council, Inc.
Eight Northern Indian Pueblo Council
Fairbanks Native Association
Feather River Tribal Health, Inc.
Great Lakes Inter-Tribal Council
Healing Lodge of Seven Nations
Indian Health Council
Lake County Tribal Health Consortium, Inc.
Mariposa, Amador, Calaveras, Tuolumne (MACT)
Indian Health Board, Inc.
Northern Valley Indian Health
NW Portland Area Indian Health Board
Ramah Navajo School Board, Inc.
Sierra Tribal Consortium
Sonoma County Indian Health
Southern Indian Health Council
South Puget Intertribal Planning Agency
Toiyabe Indian Health Project
Ukpeagvik Inupiat Corporation
United Indian Health Services
United South and Eastern Tribes, Inc.
United Tribes Technical College
Valdez Native Tribe

*** This list will be updated periodically.**

Title V Compactors
Tribal Organizations

Title V Tribal Organizations*

Alaska Native Tribal Health Consortium (ANTHC)
Aleutian Pribilof Islands Association, Inc.
Arctic Slope Native Association, Ltd.
Bristol Bay Area Health Corporation
Chugachmiut
Copper River Native Association
Council of Athabascan Tribal Governments
Eastern Aleutian Tribes, Inc.
Ketchikan Indian Community
Kodiak Area Native Association
Maniilaq Association
Metlakatla Indian Community
Miami Health Consortium
Mount Sanford Tribal Consortium
Native Village of Eklutna
Northeastern Tribal Health System
Norton Sound Health Corporation
Riverside-San Bernadino County Indian Health, Inc.
Seldovia Village Tribe
Southcentral Foundation
SouthEast Alaska Regional Health Consortium (SEARHC)
Tanana Chiefs Conference, Inc.
Yakutat Tlingit Tribe
Yukon-Kuskokwim Health Corporation

* This list is updated periodically.

Federal Register

Friday,
December 5, 2003

Part III

Department of the Interior

Bureau of Indian Affairs

Indian Entities Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs; Notice

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Indian Entities Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: Notice is hereby given of the current list of 562 tribal entities recognized and eligible for funding and services from the Bureau of Indian Affairs by virtue of their status as Indian tribes. This notice is published pursuant to section 104 of the Act of November 2, 1994 (Pub. L. 103–454; 108 Stat. 4791, 4792).

FOR FURTHER INFORMATION CONTACT: Daisy West, Bureau of Indian Affairs, Division of Tribal Government Services, MS–320-MIB, 1849 C Street, NW., Washington, DC 20240. Telephone number: (202) 513–7641.

SUPPLEMENTARY INFORMATION: This notice is published in exercise of authority delegated to the Assistant Secretary—Indian Affairs under 25 U.S.C. 2 and 9 and 209 DM 8.

Published below is a list of federally acknowledged tribes in the contiguous 48 states and in Alaska. The list is updated from the notice published on July 12, 2002 (67 FR 46328).

Several tribes have made changes to their tribal name. To aid in identifying tribal name changes, the tribe's former name is included with the new tribal name. We will continue to list the tribe's former name for several years before dropping the former name from the list. We have also made several corrections. To aid in identifying corrections, the tribe's previously listed name is included with the tribal name.

The listed entities are acknowledged to have the immunities and privileges available to other federally acknowledged Indian tribes by virtue of their government-to-government relationship with the United States as well as the responsibilities, powers, limitations and obligations of such tribes. We have continued the practice of listing the Alaska Native entities separately solely for the purpose of facilitating identification of them and reference to them given the large number of complex Native names.

Dated: November 21, 2003.

Aurene M. Martin,

Principal Deputy Assistant Secretary—Indian Affairs.

Indian Tribal Entities Within the Contiguous 48 States Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs

Absentee-Shawnee Tribe of Indians of Oklahoma
Agua Caliente Band of Cahuilla Indians of the Agua Caliente Indian Reservation, California
Ak Chin Indian Community of the Maricopa (Ak Chin) Indian Reservation, Arizona
Alabama-Coushatta Tribes of Texas
Alabama-Quassarte Tribal Town, Oklahoma
Alturas Indian Rancheria, California
Apache Tribe of Oklahoma
Arapahoe Tribe of the Wind River Reservation, Wyoming
Aroostook Band of Micmac Indians of Maine
Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana
Augustine Band of Cahuilla Mission Indians of the Augustine Reservation, California
Bad River Band of the Lake Superior Tribe of Chippewa Indians of the Bad River Reservation, Wisconsin
Bay Mills Indian Community, Michigan
Bear River Band of the Rohnerville Rancheria, California
Berry Creek Rancheria of Maidu Indians of California
Big Lagoon Rancheria, California
Big Pine Band of Owens Valley Paiute Shoshone Indians of the Big Pine Reservation, California
Big Sandy Rancheria of Mono Indians of California
Big Valley Band of Pomo Indians of the Big Valley Rancheria, California
Blackfeet Tribe of the Blackfeet Indian Reservation of Montana
Blue Lake Rancheria, California
Bridgeport Paiute Indian Colony of California
Buena Vista Rancheria of Me-Wuk Indians of California
Burns Paiute Tribe of the Burns Paiute Indian Colony of Oregon
Cabazon Band of Mission Indians, California (previously listed as the Cabazon Band of Cahuilla Mission Indians of the Cabazon Reservation)
Cachil DeHe Band of Wintun Indians of the Colusa Indian Community of the Colusa Rancheria, California
Caddo Nation of Oklahoma (formerly the Caddo Indian Tribe of Oklahoma)
Cahuilla Band of Mission Indians of the Cahuilla Reservation, California
Cahto Indian Tribe of the Laytonville Rancheria, California
California Valley Miwok Tribe, California (formerly the Sheep Ranch Rancheria of Me-Wuk Indians of California)
Campo Band of Diegueno Mission Indians of the Campo Indian Reservation, California
Capitan Grande Band of Diegueno Mission Indians of California:
Barona Group of Capitan Grande Band of Mission Indians of the Barona Reservation, California
Viejas (Baron Long) Group of Capitan Grande Band of Mission Indians of the Viejas Reservation, California
Catawba Indian Nation (aka Catawba Tribe of South Carolina)
Cayuga Nation of New York
Cedarville Rancheria, California
Chemehuevi Indian Tribe of the Chemehuevi Reservation, California
Cher-Ae Heights Indian Community of the Trinidad Rancheria, California
Cherokee Nation, Oklahoma
Cheyenne-Arapaho Tribes of Oklahoma
Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota
Chickasaw Nation, Oklahoma
Chicken Ranch Rancheria of Me-Wuk Indians of California
Chippewa-Cree Indians of the Rocky Boy's Reservation, Montana
Chitimacha Tribe of Louisiana
Choctaw Nation of Oklahoma
Citizen Potawatomi Nation, Oklahoma
Cloverdale Rancheria of Pomo Indians of California
Cocopah Tribe of Arizona
Coeur D'Alene Tribe of the Coeur D'Alene Reservation, Idaho
Cold Springs Rancheria of Mono Indians of California
Colorado River Indian Tribes of the Colorado River Indian Reservation, Arizona and California
Comanche Nation, Oklahoma (formerly the Comanche Indian Tribe)
Confederated Salish & Kootenai Tribes of the Flathead Reservation, Montana
Confederated Tribes of the Chehalis Reservation, Washington
Confederated Tribes of the Colville Reservation, Washington
Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians of Oregon
Confederated Tribes of the Goshute Reservation, Nevada and Utah
Confederated Tribes of the Grand Ronde Community of Oregon
Confederated Tribes of the Siletz Reservation, Oregon
Confederated Tribes of the Umatilla Reservation, Oregon
Confederated Tribes of the Warm Springs Reservation of Oregon
Confederated Tribes and Bands of the Yakama Nation, Washington (formerly

the Confederated Tribes and Bands of the Yakama Indian Nation of the Yakama Reservation)
Coquille Tribe of Oregon
Cortina Indian Rancheria of Wintun Indians of California
Coushatta Tribe of Louisiana
Cow Creek Band of Umpqua Indians of Oregon
Cowlitz Indian Tribe, Washington
Coyote Valley Band of Pomo Indians of California
Crow Tribe of Montana
Crow Creek Sioux Tribe of the Crow Creek Reservation, South Dakota
Death Valley Timbi-Sha Shoshone Band of California
Delaware Nation, Oklahoma (formerly the Delaware Tribe of Western Oklahoma)
Delaware Tribe of Indians, Oklahoma
Dry Creek Rancheria of Pomo Indians of California
Duckwater Shoshone Tribe of the Duckwater Reservation, Nevada
Eastern Band of Cherokee Indians of North Carolina
Eastern Shawnee Tribe of Oklahoma
Elem Indian Colony of Pomo Indians of the Sulphur Bank Rancheria, California
Elk Valley Rancheria, California
Ely Shoshone Tribe of Nevada
Enterprise Rancheria of Maidu Indians of California
Ewiiaapaayp Band of Kumeyaay Indians, California (formerly the Cuyapaipe Community of Diegueno Mission Indians of the Cuyapaipe Reservation)
Federated Indians of Graton Rancheria, California (formerly the Graton Rancheria)
Flandreau Santee Sioux Tribe of South Dakota
Forest County Potawatomi Community, Wisconsin
Fort Belknap Indian Community of the Fort Belknap Reservation of Montana
Fort Bidwell Indian Community of the Fort Bidwell Reservation of California
Fort Independence Indian Community of Paiute Indians of the Fort Independence Reservation, California
Fort McDermitt Paiute and Shoshone Tribes of the Fort McDermitt Indian Reservation, Nevada and Oregon
Fort McDowell Yavapai Nation, Arizona (formerly the Fort McDowell Mohave-Apache Community of the Fort McDowell Indian Reservation)
Fort Mojave Indian Tribe of Arizona, California & Nevada
Fort Sill Apache Tribe of Oklahoma
Gila River Indian Community of the Gila River Indian Reservation, Arizona
Grand Traverse Band of Ottawa and Chippewa Indians, Michigan
Greenville Rancheria of Maidu Indians of California
Grindstone Indian Rancheria of Wintun-Wailaki Indians of California
Guidiville Rancheria of California
Hannahville Indian Community, Michigan
Havasupai Tribe of the Havasupai Reservation, Arizona
Ho-Chunk Nation of Wisconsin (formerly the Wisconsin Winnebago Tribe)
Hoh Indian Tribe of the Hoh Indian Reservation, Washington
Hoopa Valley Tribe, California
Hopi Tribe of Arizona
Hopland Band of Pomo Indians of the Hopland Rancheria, California
Houlton Band of Maliseet Indians of Maine
Hualapai Indian Tribe of the Hualapai Indian Reservation, Arizona
Huron Potawatomi, Inc., Michigan
Inaja Band of Diegueno Mission Indians of the Inaja and Cosmit Reservation, California
Ione Band of Miwok Indians of California
Iowa Tribe of Kansas and Nebraska
Iowa Tribe of Oklahoma
Jackson Rancheria of Me-Wuk Indians of California
Jamestown S'Klallam Tribe of Washington
Jamul Indian Village of California
Jena Band of Choctaw Indians, Louisiana
Jicarilla Apache Nation, New Mexico (formerly the Jicarilla Apache Tribe of the Jicarilla Apache Indian Reservation)
Kaibab Band of Paiute Indians of the Kaibab Indian Reservation, Arizona
Kalispel Indian Community of the Kalispel Reservation, Washington
Karuk Tribe of California
Kashia Band of Pomo Indians of the Stewarts Point Rancheria, California
Kaw Nation, Oklahoma
Keweenaw Bay Indian Community, Michigan
Kialegee Tribal Town, Oklahoma
Kickapoo Tribe of Indians of the Kickapoo Reservation in Kansas
Kickapoo Tribe of Oklahoma
Kickapoo Traditional Tribe of Texas
Kiowa Indian Tribe of Oklahoma
Klamath Indian Tribe of Oregon
Kootenai Tribe of Idaho
La Jolla Band of Luiseno Mission Indians of the La Jolla Reservation, California
La Posta Band of Diegueno Mission Indians of the La Posta Indian Reservation, California
Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wisconsin
Lac du Flambeau Band of Lake Superior Chippewa Indians of the Lac du Flambeau Reservation of Wisconsin
Lac Vieux Desert Band of Lake Superior Chippewa Indians, Michigan
Las Vegas Tribe of Paiute Indians of the Las Vegas Indian Colony, Nevada
Little River Band of Ottawa Indians, Michigan
Little Traverse Bay Bands of Odawa Indians, Michigan
Lower Lake Rancheria, California
Los Coyotes Band of Cahuilla & Cupeno Indians of the Los Coyotes Reservation, California (formerly the Los Coyotes Band of Cahuilla Mission Indians of the Los Coyotes Reservation)
Lovelock Paiute Tribe of the Lovelock Indian Colony, Nevada
Lower Brule Sioux Tribe of the Lower Brule Reservation, South Dakota
Lower Elwha Tribal Community of the Lower Elwha Reservation, Washington
Lower Sioux Indian Community in the State of Minnesota
Lummi Tribe of the Lummi Reservation, Washington
Lytton Rancheria of California
Makah Indian Tribe of the Makah Indian Reservation, Washington
Manchester Band of Pomo Indians of the Manchester-Point Arena Rancheria, California
Manzanita Band of Diegueno Mission Indians of the Manzanita Reservation, California
Mashantucket Pequot Tribe of Connecticut
Match-e-be-nash-she-wish Band of Pottawatomi Indians of Michigan
Mechoopda Indian Tribe of Chico Rancheria, California
Menominee Indian Tribe of Wisconsin
Mesa Grande Band of Diegueno Mission Indians of the Mesa Grande Reservation, California
Mescalero Apache Tribe of the Mescalero Reservation, New Mexico
Miami Tribe of Oklahoma
Miccosukee Tribe of Indians of Florida
Middletown Rancheria of Pomo Indians of California
Minnesota Chippewa Tribe, Minnesota (Six component reservations: Bois Forte Band (Nett Lake); Fond du Lac Band; Grand Portage Band; Leech Lake Band; Mille Lacs Band; White Earth Band)
Mississippi Band of Choctaw Indians, Mississippi
Moapa Band of Paiute Indians of the Moapa River Indian Reservation, Nevada
Modoc Tribe of Oklahoma
Mohegan Indian Tribe of Connecticut
Mooretown Rancheria of Maidu Indians of California
Morongo Band of Cahuilla Mission Indians of the Morongo Reservation, California

Muckleshoot Indian Tribe of the Muckleshoot Reservation, Washington
Muscogee (Creek) Nation, Oklahoma
Narragansett Indian Tribe of Rhode Island
Navajo Nation, Arizona, New Mexico & Utah
Nez Perce Tribe of Idaho
Nisqually Indian Tribe of the Nisqually Reservation, Washington
Nooksack Indian Tribe of Washington
Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, Montana
Northfork Rancheria of Mono Indians of California
Northwestern Band of Shoshoni Nation of Utah (Washakie)
Oglala Sioux Tribe of the Pine Ridge Reservation, South Dakota
Omaha Tribe of Nebraska
Oneida Nation of New York
Oneida Tribe of Indians of Wisconsin
Onondaga Nation of New York
Osage Tribe, Oklahoma
Ottawa Tribe of Oklahoma
Otoe-Missouria Tribe of Indians, Oklahoma
Paiute Indian Tribe of Utah (Cedar City Band of Paiutes, Kanosh Band of Paiutes, Koosharem Band of Paiutes, Indian Peaks Band of Paiutes, and Shivwits Band of Paiutes)
Paiute-Shoshone Indians of the Bishop Community of the Bishop Colony, California
Paiute-Shoshone Tribe of the Fallon Reservation and Colony, Nevada
Paiute-Shoshone Indians of the Lone Pine Community of the Lone Pine Reservation, California
Pala Band of Luiseno Mission Indians of the Pala Reservation, California
Pascua Yaqui Tribe of Arizona
Paskenta Band of Nomlaki Indians of California
Passamaquoddy Tribe of Maine
Pauma Band of Luiseno Mission Indians of the Pauma & Yuima Reservation, California
Pawnee Nation of Oklahoma
Pechanga Band of Luiseno Mission Indians of the Pechanga Reservation, California
Penobscot Tribe of Maine
Peoria Tribe of Indians of Oklahoma
Picayune Rancheria of Chukchansi Indians of California
Pinoleville Rancheria of Pomo Indians of California
Pit River Tribe, California (includes XL Ranch, Big Bend, Likely, Lookout, Montgomery Creek and Roaring Creek Rancherias)
Poarch Band of Creek Indians of Alabama
Pokagon Band of Potawatomi Indians, Michigan and Indiana
Ponca Tribe of Indians of Oklahoma
Ponca Tribe of Nebraska
Port Gamble Indian Community of the Port Gamble Reservation, Washington
Potter Valley Rancheria of Pomo Indians of California
Prairie Band of Potawatomi Nation, Kansas (formerly the Prairie Band of Potawatomi Indians)
Prairie Island Indian Community in the State of Minnesota
Pueblo of Acoma, New Mexico
Pueblo of Cochiti, New Mexico
Pueblo of Jemez, New Mexico
Pueblo of Isleta, New Mexico
Pueblo of Laguna, New Mexico
Pueblo of Nambe, New Mexico
Pueblo of Picuris, New Mexico
Pueblo of Pojoaque, New Mexico
Pueblo of San Felipe, New Mexico
Pueblo of San Juan, New Mexico
Pueblo of San Ildefonso, New Mexico
Pueblo of Sandia, New Mexico
Pueblo of Santa Ana, New Mexico
Pueblo of Santa Clara, New Mexico
Pueblo of Santo Domingo, New Mexico
Pueblo of Taos, New Mexico
Pueblo of Tesuque, New Mexico
Pueblo of Zia, New Mexico
Puyallup Tribe of the Puyallup Reservation, Washington
Pyramid Lake Paiute Tribe of the Pyramid Lake Reservation, Nevada
Quapaw Tribe of Indians, Oklahoma
Quartz Valley Indian Community of the Quartz Valley Reservation of California
Quechan Tribe of the Fort Yuma Indian Reservation, California & Arizona
Quileute Tribe of the Quileute Reservation, Washington
Quinault Tribe of the Quinault Reservation, Washington
Ramona Band or Village of Cahuilla Mission Indians of California
Red Cliff Band of Lake Superior Chippewa Indians of Wisconsin
Red Lake Band of Chippewa Indians, Minnesota
Redding Rancheria, California
Redwood Valley Rancheria of Pomo Indians of California
Reno-Sparks Indian Colony, Nevada
Resighini Rancheria, California (formerly the Coast Indian Community of Yurok Indians of the Resighini Rancheria)
Rincon Band of Luiseno Mission Indians of the Rincon Reservation, California
Robinson Rancheria of Pomo Indians of California
Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota
Round Valley Indian Tribes of the Round Valley Reservation, California (formerly the Covelo Indian Community)
Rumsey Indian Rancheria of Wintun Indians of California
Sac & Fox Tribe of the Mississippi in Iowa
Sac & Fox Nation of Missouri in Kansas and Nebraska
Sac & Fox Nation, Oklahoma
Saginaw Chippewa Indian Tribe of Michigan
St. Croix Chippewa Indians of Wisconsin
St. Regis Band of Mohawk Indians of New York
Salt River Pima-Maricopa Indian Community of the Salt River Reservation, Arizona
Samish Indian Tribe, Washington
San Carlos Apache Tribe of the San Carlos Reservation, Arizona
San Juan Southern Paiute Tribe of Arizona
San Manual Band of Serrano Mission Indians of the San Manual Reservation, California
San Pasqual Band of Diegueno Mission Indians of California
Santa Rosa Indian Community of the Santa Rosa Rancheria, California
Santa Rosa Band of Cahuilla Mission Indians of the Santa Rosa Reservation, California
Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation, California
Santa Ysabel Band of Diegueno Mission Indians of the Santa Ysabel Reservation, California
Santee Sioux Nation, Nebraska (formerly the Santee Sioux Tribe of the Santee Reservation of Nebraska)
Sauk-Suiattle Indian Tribe of Washington
Sault Ste. Marie Tribe of Chippewa Indians of Michigan
Scotts Valley Band of Pomo Indians of California
Seminole Nation of Oklahoma
Seminole Tribe of Florida, Dania, Big Cypress, Brighton, Hollywood & Tampa Reservations
Seneca Nation of New York
Seneca-Cayuga Tribe of Oklahoma
Shakopee Mdewakanton Sioux Community of Minnesota
Shawnee Tribe, Oklahoma
Sherwood Valley Rancheria of Pomo Indians of California
Shingle Springs Band of Miwok Indians, Shingle Springs Rancheria (Verona Tract), California
Shoalwater Bay Tribe of the Shoalwater Bay Indian Reservation, Washington
Shoshone Tribe of the Wind River Reservation, Wyoming
Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho
Shoshone-Paiute Tribes of the Duck Valley Reservation, Nevada
Sisseton-Wahpeton Oyate of the Lake Traverse Reservation, South Dakota (formerly the Sisseton-Wahpeton

Sioux Tribe of the Lake Traverse Reservation)
Skokomish Indian Tribe of the Skokomish Reservation, Washington
Skull Valley Band of Goshute Indians of Utah
Smith River Rancheria, California
Snoqualmie Tribe, Washington
Soboba Band of Luiseno Indians, California (formerly the Soboba Band of Luiseno Mission Indians of the Soboba Reservation)
Sokaogon Chippewa Community, Wisconsin
Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado
Spirit Lake Tribe, North Dakota
Spokane Tribe of the Spokane Reservation, Washington
Squaxin Island Tribe of the Squaxin Island Reservation, Washington
Standing Rock Sioux Tribe of North & South Dakota
Stockbridge Munsee Community, Wisconsin
Stillaguamish Tribe of Washington
Summit Lake Paiute Tribe of Nevada
Suquamish Indian Tribe of the Port Madison Reservation, Washington
Susanville Indian Rancheria, California
Swinomish Indians of the Swinomish Reservation, Washington
Sycuan Band of Diegueno Mission Indians of California
Table Bluff Reservation—Wiyot Tribe, California
Table Mountain Rancheria of California
Te-Moak Tribe of Western Shoshone Indians of Nevada (Four constituent bands: Battle Mountain Band; Elko Band; South Fork Band and Wells Band)
Thlopthlocco Tribal Town, Oklahoma
Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota
Tohono O'odham Nation of Arizona
Tonawanda Band of Seneca Indians of New York
Tonkawa Tribe of Indians of Oklahoma
Tonto Apache Tribe of Arizona
Torres-Martinez Band of Cahuilla Mission Indians of California
Tule River Indian Tribe of the Tule River Reservation, California
Tulalip Tribes of the Tulalip Reservation, Washington
Tunica-Biloxi Indian Tribe of Louisiana
Tuolumne Band of Me-Wuk Indians of the Tuolumne Rancheria of California
Turtle Mountain Band of Chippewa Indians of North Dakota
Tuscarora Nation of New York
Twenty-Nine Palms Band of Mission Indians of California
United Auburn Indian Community of the Auburn Rancheria of California
United Keetoowah Band of Cherokee Indians in Oklahoma
Upper Lake Band of Pomo Indians of Upper Lake Rancheria of California
Upper Sioux Community, Minnesota
Upper Skagit Indian Tribe of Washington
Ute Indian Tribe of the Uintah & Ouray Reservation, Utah
Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah
Utu Utu Gwaitu Paiute Tribe of the Benton Paiute Reservation, California
Walker River Paiute Tribe of the Walker River Reservation, Nevada
Wampanoag Tribe of Gay Head (Aquinnah) of Massachusetts
Washoe Tribe of Nevada & California (Carson Colony, Dresslerville Colony, Woodfords Community, Stewart Community, & Washoe Ranches)
White Mountain Apache Tribe of the Fort Apache Reservation, Arizona
Wichita and Affiliated Tribes (Wichita, Keechi, Waco & Tawakonie), Oklahoma
Winnebago Tribe of Nebraska
Winnemucca Indian Colony of Nevada
Wyandotte Nation, Oklahoma (formerly the Wyandotte Tribe of Oklahoma)
Yankton Sioux Tribe of South Dakota
Yavapai-Apache Nation of the Camp Verde Indian Reservation, Arizona
Yavapai-Prescott Tribe of the Yavapai Reservation, Arizona
Yerington Paiute Tribe of the Yerington Colony & Campbell Ranch, Nevada
Yomba Shoshone Tribe of the Yomba Reservation, Nevada
Ysleta Del Sur Pueblo of Texas
Yurok Tribe of the Yurok Reservation, California
Zuni Tribe of the Zuni Reservation, New Mexico

Native Entities Within the State of Alaska Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs

Native Village of Afognak (formerly the Village of Afognak)
Agdaagux Tribe of King Cove
Native Village of Akhiok
Akiachak Native Community
Akiak Native Community
Native Village of Akutan
Village of Alakanuk
Alatna Village
Native Village of Aleknagik
Algaaciq Native Village (St. Mary's)
Allakaket Village
Native Village of Ambler
Village of Anaktuvuk Pass
Yupiit of Andreafski
Angoon Community Association
Village of Aniak
Anvik Village
Arctic Village (See Native Village of Venetie Tribal Government)
Asa'carsarmiut Tribe (formerly the Native Village of Mountain Village)
Native Village of Atka
Village of Atmautluak
Atqasuk Village (Atkasook)
Native Village of Barrow Inupiat Traditional Government
Beaver Village
Native Village of Belkofski
Village of Bill Moore's Slough
Birch Creek Tribe
Native Village of Brevig Mission
Native Village of Buckland
Native Village of Cantwell
Native Village of Chanega (aka Chenega)
Chalkyitsik Village
Cheesh-Na Tribe (formerly the Native Village of Chistochina)
Village of Chefornak
Chevak Native Village
Chickaloon Native Village
Native Village of Chignik
Native Village of Chignik Lagoon
Chignik Lake Village
Chilkat Indian Village (Klukwan)
Chilkoot Indian Association (Haines)
Chinik Eskimo Community (Golovin)
Native Village of Chitina
Native Village of Chuathbaluk (Russian Mission, Kuskokwim)
Chuloonawick Native Village
Circle Native Community
Village of Clarks Point
Native Village of Council
Craig Community Association
Village of Crooked Creek
Curyung Tribal Council (formerly the Native Village of Dillingham)
Native Village of Deering
Native Village of Diomede (aka Inalik)
Village of Dot Lake
Douglas Indian Association
Native Village of Eagle
Native Village of Eek
Egegik Village
Eklutna Native Village
Native Village of Ekuk
Ekwok Village
Native Village of Elim
Emmonak Village
Evansville Village (aka Bettles Field)
Native Village of Eyak (Cordova)
Native Village of False Pass
Native Village of Fort Yukon
Native Village of Gakona
Galena Village (aka Louden Village)
Native Village of Gambell
Native Village of Georgetown
Native Village of Goodnews Bay
Organized Village of Grayling (aka Holikachuk)
Gulkana Village
Native Village of Hamilton
Healy Lake Village
Holy Cross Village
Hoonah Indian Association
Native Village of Hooper Bay
Hughes Village
Huslia Village
Hydaburg Cooperative Association
Igiugig Village
Village of Iliamna

Inupiat Community of the Arctic Slope
Iqurmuit Traditional Council (formerly the Native Village of Russian Mission)
Ivanoff Bay Village
Kaguyak Village
Organized Village of Kake
Kaktovik Village (aka Barter Island)
Village of Kalskag
Village of Kaltag
Native Village of Kanatak
Native Village of Karluk
Organized Village of Kasaan
Native Village of Kasigluk
Kenaitze Indian Tribe
Ketchikan Indian Corporation
Native Village of Kiana
King Island Native Community
King Salmon Tribe
Native Village of Kipnuk
Native Village of Kivalina
Klawock Cooperative Association
Native Village of Kluti Kaah (aka Copper Center)
Knik Tribe
Native Village of Kobuk
Kokhanok Village
Native Village of Kongiganak
Village of Kotlik
Native Village of Kotzebue
Native Village of Koyuk
Koyukuk Native Village
Organized Village of Kwethluk
Native Village of Kwigillingok
Native Village of Kwinhagak (aka Quinhagak)
Native Village of Larsen Bay
Levelock Village
Lesnoi Village (aka Woody Island)
Lime Village
Village of Lower Kalskag
Manley Hot Springs Village
Manokotak Village
Native Village of Marshall (aka Fortuna Ledge)
Native Village of Mary's Igloo
McGrath Native Village
Native Village of Mekoryuk
Mentasta Traditional Council
Metlakatla Indian Community, Annette Island Reserve
Native Village of Minto
Naknek Native Village
Native Village of Nanwalek (aka English Bay)
Native Village of Napaimute
Native Village of Napakiak
Native Village of Napaskiak
Native Village of Nelson Lagoon
Nenana Native Association
New Koliganek Village Council (formerly the Koliganek Village)
New Stuyahok Village
Newhalen Village
Newtok Village
Native Village of Nightmute
Nikolai Village
Native Village of Nikolski
Ninilchik Village
Native Village of Noatak
Nome Eskimo Community
Nondalton Village
Noorvik Native Community
Northway Village
Native Village of Nuiqsut (aka Nooiksut)
Nulato Village
Nunakauyarmiut Tribe (formerly the Native Village of Toksook Bay)
Native Village of Nunapitchuk
Village of Ohogamiut
Village of Old Harbor
Orutsararmuit Native Village (aka Bethel)
Oscarville Traditional Village
Native Village of Ouzinkie
Native Village of Paimiut
Pauloff Harbor Village
Pedro Bay Village
Native Village of Perryville
Petersburg Indian Association
Native Village of Pilot Point
Pilot Station Traditional Village
Native Village of Pitka's Point
Platinum Traditional Village
Native Village of Point Hope
Native Village of Point Lay
Native Village of Port Graham
Native Village of Port Heiden
Native Village of Port Lions
Portage Creek Village (aka Ohgsenakale)
Pribilof Islands Aleut Communities of St. Paul & St. George Islands
Qagan Tayagungin Tribe of Sand Point Village
Qawalangin Tribe of Unalaska
Rampart Village
Village of Red Devil
Native Village of Ruby
Saint George Island (See Pribilof Islands Aleut Communities of St. Paul & St. George Islands)
Native Village of Saint Michael
Saint Paul Island (See Pribilof Islands Aleut Communities of St. Paul & St. George Islands)
Village of Salamatoff
Native Village of Savoonga
Organized Village of Saxman
Native Village of Scammon Bay
Native Village of Selawik
Seldovia Village Tribe
Shageluk Native Village
Native Village of Shaktoolik
Native Village of Sheldon's Point
Native Village of Shishmaref
Shoonaq' Tribe of Kodiak
Native Village of Shungnak
Sitka Tribe of Alaska
Skagway Village
Village of Sleetmute
Village of Solomon
South Naknek Village
Stebbins Community Association
Native Village of Stevens
Village of Stony River
Takotna Village
Native Village of Tanacross
Native Village of Tanana
Native Village of Tatitlek
Native Village of Tazlina
Telida Village
Native Village of Teller
Native Village of Tetlin
Central Council of the Tlingit & Haida Indian Tribes
Traditional Village of Togiak
Tuluksak Native Community
Native Village of Tuntutuliak
Native Village of Tununak
Twin Hills Village
Native Village of Tyonek
Ugashik Village
Umkumiute Native Village
Native Village of Unalakleet
Native Village of Unga
Village of Venetie (See Native Village of Venetie Tribal Government)
Native Village of Venetie Tribal Government (Arctic Village and Village of Venetie)
Village of Wainwright
Native Village of Wales
Native Village of White Mountain
Wrangell Cooperative Association
Yakutat Tlingit Tribe

[FR Doc. 03–30244 Filed 12–4–03; 8:45 am]
BILLING CODE 4310–4J–P

- *www.regulations.gov:* Follow the on-line instruction for submitting comments.
- *E-mail: schrock.roy@epa.gov.*
- *Fax:* 215–814–3002.
- *Mail:* Mr. Roy Schrock, Remedial Project Manager (3HS22), U.S. EPA, Region 3, 1650 Arch Street, Philadelphia, Pennsylvania 19103–2029.
- *Hand Delivery:* 1650 Arch Street, Philadelphia, Pennsylvania 19103–2029. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–HQ–SFUND–1989–0008. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *www.regulations.gov* or e-mail. The *www.regulations.gov* Web site is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *www.regulations.gov,* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: All documents in the docket are listed in the *www.regulations.gov* index. Although listed in the index, some information is not publicly available, e.g., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in *www.regulations.gov* or in hard copy at the EPA's Region III, Regional Center for Environmental Information (RCEI) 2nd floor, 1650 Arch Street, Philadelphia, Pennsylvania, 19103–1029, (215) 814–5254 OR (800) 553–2509 Monday through Friday 8 a.m. to 5 p.m. excluding legal holidays.

FOR FURTHER INFORMATION CONTACT: Mr. Roy Schrock, Remedial Project Manager (3HS22), U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103–2029; telephone number: 1–800–553–2509 or (215) 814–3210; fax number: 215–814–3002; e-mail address: *schrock.roy@epa.gov.*

SUPPLEMENTARY INFORMATION: For additional information, see the Direct Final Notice of Deletion which is located in the Rules Section of this **Federal Register**.

Information Respositories: Repositories have been established to provide detailed information concerning this decision at the following address:

U.S. EPA Region III, Regional Center for Environmental Information (RCEI), 2nd floor, 1650 Arch Street, Philadelphia, Pennsylvania, 19103–2029, (215) 814–5254 or (800) 553–2509 Monday through Friday 8 a.m. to 5 p.m.

West Cocalico Township Municipal Building, 156B, West Main Street, Reinholds, Pennsylvania 17569, Monday through Friday 8 a.m. to 4:30 p.m.

List of Subjects in 40 CFR Part 300

Environmental protection, Air pollution control, Chemicals, Hazardous waste, Hazardous substances, Intergovernmental relation, Penalties, Reporting and recordkeeping requirements, Superfund, Water pollution control, Water supply.

Authority: 33 U.S.C. 1321(c)(2); 42 U.S.C. 9601–9657; E.O.12777, 56 FR 54757, 3 CFR, 1991 Comp., p. 351; E.O. 12580, 52 FR 2923; 3 CFR, 1987 Comp., p. 193.

Dated: November 16, 2006.

Donald Welsh,

Regional Administrator, Region III.

[FR Doc. E7–534 Filed 1–17–07; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 433, 447, and 457

[CMS–2258–P]

RIN 0938–A057

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

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

ACTION: Proposed rule.

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

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on March 19, 2007.

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

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

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link "Submit electronic comments on CMS regulations with an open comment period." (Attachments

should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2258–P, P.O. Box 8017, Baltimore, MD 21244–8017.

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

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2258–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

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

FOR FURTHER INFORMATION CONTACT: Aaron Blight, (410) 786–9560.

SUPPLEMENTARY INFORMATION:

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

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

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

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

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

Since the summer of 2003, we have reviewed and processed over 1,000 State plan amendments related to State payments to providers. Of these, approximately 10 percent have been disapproved by the Centers for Medicare & Medicaid Services (CMS) or withdrawn by the States. Through examination of these State plan amendments and their associated funding arrangements, we have developed a greater understanding of how to ensure that payment and financing arrangements comply with statutory intent. As recently articulated by the U.S. Court of Appeals for the Ninth Circuit, "[t]he statutory text makes clear that the Secretary has the authority—indeed, the obligation—to ensure that each of the statutory prerequisites is satisfied before approving a Medicaid State plan amendment." We believe that this proposed rule strengthens accountability to ensure that statutory requirements within the Medicaid program are met in accordance with sections 1902, 1903, and 1905 of the Act.

Sections 1902(a)(2), 1903(a) and 1905(b) of the Act require States to share in the cost of medical assistance and in the cost of administering the State plan. Under section 1905(b) of the Act, the Federal medical assistance percentage (FMAP) is defined as "100 per centum less the State percentage," and section 1903(a) of the Act requires Federal reimbursement to the State of the FMAP of expenditures for medical assistance under the plan (and 50 percent of expenditures necessary for the proper and efficient administration of the plan). Section 1902(a)(2) of the Act and implementing regulations at 42 CFR 433.50(a)(1) require States to share in the cost of medical assistance expenditures but permit the State to delegate some responsibility for the non-Federal share of medical assistance expenditures to units of local government under some circumstances.

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

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

taxes that would not otherwise be recognized as the non-Federal share under this section.

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

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

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

Intergovernmental Transfer (IGT)

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

At section 1903(w)(6)(A) of the Act, the Medicaid statute provides that units of government within a State may transfer State and/or local tax revenue to the Medicaid agency for use as the non-Federal share of Medicaid payments. Because this provision does not override the definition of an expenditure as a net outlay, as discussed below, claimed expenditures must be net of any redirection or assignment from a health care provider to any State or local governmental entity that makes IGTs to the Medicaid agency. Generally, for the State to receive Federal matching on a claimed Medicaid payment where a governmentally operated health care provider has transferred the non-Federal share, the State must be able to demonstrate: (1) That the source of the transferred funds is State or local tax revenue (which must be supported by consistent treatment on the provider's financial records); and (2) that the provider retains the full Medicaid payment and is not required to repay, or in fact does not repay, all or any portion of the Medicaid payment to the State or local tax revenue account.

Under section 1903(a)(1) of the Act, the Federal government pays a share of State expenditures for medical assistance. Consistent with Office of Management and Budget (OMB) Circular A–87, an expenditure must be net of all "applicable credits" which include discounts, rebates, and refunds. Since the summer of 2003, we have examined Medicaid State financing arrangements across the country, and we have identified numerous instances in which health care providers did not retain the full amount of their Medicaid payments but were required to refund or return a portion of the payments received, either directly or indirectly. Failure by the provider to retain the full amount of reimbursement is inappropriate and inconsistent with statutory construction that the Federal government pay only its proportional cost for the delivery of Medicaid services. When a State claims Federal reimbursement in excess of net payments to providers, the FMAP rate has effectively been increased. To the extent that these State practices have come to light through the State plan amendment process, we have systematically required the States to eliminate these financing arrangements.

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

We have found instances in which the State or local government has used the funds returned by the health care provider for costs outside the Medicaid program or to help draw additional Federal dollars for other Medicaid program costs. The Government Accountability Office (GAO) and the Department of Health and Human Services Office of Inspector General (OIG) have reviewed these practices and shared our concerns that they are not consistent with Medicaid financing requirements. The net effect of this re-direction of Medicaid payments is that the Federal government incurs a greater level of Medicaid program costs, which is inconsistent with the FMAP. This is because the claimed expenditure, which is matched by the Federal government according to the FMAP rate, is actually greater than the net expenditure, effectively producing an increase in the FMAP rate.

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

Examples of limited congressional authorization of Federal financing for non-Medicaid populations and public health activities include the following. The Congress authorized disproportionate share hospital (DSH) payments to assist hospitals that serve a disproportionate share of low income patients which may include hospitals that furnish significant amounts of inpatient hospital services and outpatient hospital services to individuals with no source of third party coverage (that is, the uninsured). Under section 4723 of the Balanced Budget Act of 1997, the Congress also provided direct funding to the States to offset expenditures on behalf of aliens. Additional funding for payments to eligible providers for emergency health services to undocumented aliens was also provided by Congress under section 1011 of the Medicare Modernization Act. The Congress has periodically, and as recently as the Deficit Reduction Act of 2005 (DRA, Pub. L. 109–171, enacted on February 8, 2006), adjusted FMAPs for certain States and certain activities such as an enhanced FMAP to create incentives for States to assist individuals in institutions return to their homes. These examples are

provided to illustrate that the Congress has previously authorized limited Federal financing of non-Medicaid populations and public health activities, but has not to date authorized wider use of Federal Medicaid funding for these purposes.

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

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

Certified Public Expenditure (CPE)

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

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

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

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

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

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

As part of the review of proposed State plan amendments and focused financial reviews, we have examined CPE arrangements in many States that include various service categories within the Medicaid program. We note that currently there are a variety of practices used by State and local governments in submitting a CPE as the basis of matching FFP for the provision of Medicaid services. Different practices often make it difficult to (1) Align claimed expenditures with specific services covered under the State plan or identifiable administrative activities; (2) properly identify the actual cost to the governmental entity of providing services to Medicaid recipients or performing administrative activities; and (3) audit and review Medicaid claims to ensure that Medicaid payments are appropriately made. Further, we find that in many instances State Medicaid agencies do not currently review the CPE submitted by another unit of government to confirm that the CPE properly reflects the actual expenditure by the unit of government for providing Medicaid services or performing administrative activities. These circumstances do not serve to advance or promote the fiscal integrity of the Medicaid program. By establishing minimum standards for the documentation supporting CPEs, we anticipate that this proposed rule would serve to enhance the fiscal integrity of CPE practices within the Medicaid program.

State and Local Tax Revenue

As explained previously, the Medicaid statute recognizes State and/or local tax revenue as a permissible source of the non-Federal share of Medicaid expenditures. In order for State and/or local tax dollars to be eligible as the non-Federal share of Medicaid expenditures, that tax revenue cannot be committed or earmarked for non-Medicaid activities. Tax revenue that is contractually obligated between a unit of State or local government and health care providers to provide indigent care is not considered a permissible source of non-Federal share funding for purposes of Medicaid payments. Health care providers that forego generally applicable tax revenue that has been contractually obligated for the provision of health care services to the indigent or for any other non-Medicaid activity, which is then used by the State or local government as the non-Federal share of Medicaid payments, are making provider-related donations. Any Medicaid payment

linked to a provider-related donation renders that provider-related donation non-bona fide.

State Child Health Insurance Program (SCHIP)

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

II. Provisions of the Proposed Rule

The background section conveys critical information about the statutory and regulatory context of this proposed rule. We are proposing this rule specifically to (1) Clarify that only units of government are able to participate in the financing of the non-Federal share; (2) establish minimum requirements for documenting cost when using a CPE; (3) limit providers operated by units of government to reimbursement that does not exceed the cost of providing covered services to eligible Medicaid recipients; (4) establish a new regulatory provision explicitly requiring that providers receive and retain the total computable amount of their Medicaid payments; and (5) make conforming changes to the SCHIP regulations.

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

Defining a Unit of Government (§ 433.50)

We are proposing to add new language to § 433.50 to define a unit of government to conform to the provisions of section 1903(w)(7)(G) of the Act. As discussed earlier, section 1903(w)(7)(G) of the Act identifies the five types of units of government that may participate in the non-Federal share of Medicaid payments: A State, a city, a county, a special purpose district, or other governmental units within the State. The proposed provisions at § 433.50 are modified to be consistent with this statutory reference. The newly proposed regulatory definition of unit of government includes:

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

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

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

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

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

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

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

This rule proposes to amend the provisions of § 433.51 to conform the language to the provisions of sections 1903(w)(6)(A) and 1903(w)(7)(G) of the Act that are discussed above, and thus to clarify that the State share of Medicaid expenditures may be contributed only by units of government. This rule also proposes to include provisions requiring documentation of CPEs that are used as part of the State share of claimed expenditures.

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

As discussed previously, the donations and taxes amendments

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

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

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

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

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

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

1. A certification that funds are available at a State or local level. This certification is irrelevant to whether or not State or local dollars have actually been expended to provide health care services to Medicaid individuals.

2. An estimate of Medicaid costs derived from surveys of health care providers.

3. A certification that is higher than the actual cost or expenditure of the governmental unit that has generated the CPE based on its provision of services to Medicaid recipients.

4. A certification that presents costs as anything less than 100 percent of the total computable expenditure. Federal match is available only as a percentage of the total computable Medicaid expenditure documented through a CPE. A certification equal to the amount of the State share only is not acceptable.

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

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

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

The cost limit in § 447.206 specifies that the Secretary will determine a reasonable method for identifying allowable Medicaid costs that incorporates not only OMB Circular A–87 cost principles but also Medicare cost principles, as appropriate, and the statutory requirements of sections 1902, 1903, and 1905 of the Act. While OMB Circular A–87 provides a framework for cost analysis, not all cost principles under OMB Circular A–87 are consistent with Medicare cost principles or requirements found in the Act for economy and efficiency and the proper and efficient administration of the Medicaid State plan. Developing cost finding methodologies more directly to the Medicaid program will provide for a more accurate allocation of allowable costs to the Medicaid program.

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

For non-hospital and non-nursing facility services in Medicaid, we note that a nationally recognized, standard cost report does not presently exist. Therefore, the proposed rule stipulates that Medicaid costs must be supported by auditable documentation in a form approved by the Secretary that, at a minimum, will: (1) Identify the relevant category of expenditure under the State plan; (2) explain whether the contributing unit of government is within the scope of the exception to the statutory limitations on provider-related taxes and donations; (3) demonstrate the actual expenditures incurred by the contributing unit of government in providing services to Medicaid recipients or in administration of the State plan; and (4) be subject to periodic State audit and review.

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

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

reconciliation must also be performed by reconciling the interim payments and interim adjustments to the finalized cost report for the spending year in which interim payment rates were made.

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

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

Retention of Payments (§ 447.207)

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

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

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

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

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

We are proposing a corresponding modification to the Medicaid upper payment limit (UPL) rules found at § 447.272 for inpatient hospital and nursing facility services, as well as the UPL rules at § 447.321 for outpatient hospital and clinic services, to incorporate by reference the new cost limit for providers operated by units of government and to make the defined UPL facility groups consistent with the new provisions of § 433.50.

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

It is important to note that the provisions of this proposed rule are consistent with the regulatory provisions concerning Medicaid DSH payments. Medicaid DSH payments are limited to the uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid beneficiaries and individuals with no source of third party coverage for the services they receive. To the extent any governmentally operated hospital is reimbursed by Medicaid at the level of cost, there will be no Medicaid shortfall factored into the facility's calculation of uncompensated care for purposes of DSH. This is true whether the Medicaid cost reimbursement is funded by CPEs or any other means..

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

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

Conforming Changes to Other Applicable Federal Regulations (§ 457.628)

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

Tool To Evaluate the Governmental Status of Providers

With the issuance of this proposed rule, we recognize the need to evaluate individual health care providers to determine whether or not they are units of government as prescribed by the rule. States will need to identify each health care provider purportedly operated by a unit of government to CMS and provide information needed for CMS to make a determination as to whether or not the provider is a unit of government. We have developed a form questionnaire to collect information necessary to make that determination. The questionnaire will be published in connection with this proposed rule. For new State plan amendments that will reimburse governmentally operated providers or rely on the participation of health care providers for the financing of the non-Federal share, States will be required to complete this questionnaire regarding each provider that is said to be governmentally operated. For any existing arrangement that involves payment to governmentally operated providers or relies on the participation of health care providers for the non-Federal share, States will be required to provide the information requested on this form questionnaire relative to each applicable provider within three (3) months of the effective date of the final rule following this proposed rule.

III. Collection of Information Requirements

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

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.

- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

Public Funds as the State Share of Financial Participation (§ 433.51)

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

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

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

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

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

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

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

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

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attn.: Melissa Musotto, CMS–2258–P, Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Katherine T. Astrich, CMS Desk Officer, CMS–2258–P, *Katherine_T._Astrich@omb.eop.gov*. Fax (202) 395–6974.

IV. Response to Comments

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

V. Regulatory Impact Analysis

A. Introduction

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

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. For the reasons cited below, we have determined that this rule may have a significant impact on small rural hospitals.

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

the section entitled "Anticipated Effects" below.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. For purposes of Executive Order 13132, we also find that this rule will have a substantial effect on State or local governments.

B. Costs and Benefits

This rule is a major rule because it is estimated to result in $120 million in savings during the first year and $3.87 billion in savings over five years.

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

Furthermore, CMS has found several arrangements in which providers did not retain the full amount of their Medicaid payments but were required to refund or return a portion of the payments received, either directly or indirectly. Failure by the provider to retain the full amount of reimbursement is inappropriate and inconsistent with statutory construction that the Federal government pays only its proportional cost for the delivery of Medicaid services. When a State claims Federal reimbursement in excess of net payments to providers, the FMAP rate has effectively been increased, and federal Medicaid funds are redirected toward non-Medicaid services. When a State chooses to recycle FFP in this manner, the Federal taxpayers in other States disproportionately finance the Medicaid program in the State that is recycling FFP. This rule is designed to eliminate such practices.

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

We have observed that there are a variety of practices used by State and local governments in identifying costs and submitting a CPE as the basis of matching FFP for the provision of Medicaid services. These different cost methods and CPE practices make it difficult to (1) Align claimed expenditures with specific services covered under the State plan or identifiable administrative activities; (2) properly identify the actual cost to the governmental entity of providing services to Medicaid recipients or performing administrative activities; and (3) audit and review Medicaid claims to ensure that Medicaid payments are appropriately made. Such circumstances present risks of inflationary costs being certified and excessive claims of FFP. This rule will facilitate a more consistent methodology in Medicaid cost identification and allocation across the country, thereby improving the fiscal integrity of the program.

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

- 1,153 hospitals that have identified themselves as operated by local governments or hospital districts/authorities;
- 822 nursing facilities that have identified themselves as operated by counties, cities, or governmental hospital districts;
- 113 intermediate care facilities for the mentally retarded (ICF/MR) that have identified themselves as operated by cities, towns, or counties.

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

Some of the governmental providers identified as small entities for RFA purposes may have been receiving Medicaid payments in excess of cost, but as a result of this rule, payments will not be permitted to exceed cost. Governmentally operated providers will also be required under this rule to receive and retain the full amount of their Medicaid payments, which would result in a net increase in revenue to the extent such providers were returning a portion of their Medicaid payments to the State and payment rates remain the same following the effective date of this rule. On the other hand, if States reduce payment rates to such providers after this rule is effective, these providers may experience a decrease in net revenue. Finally, there are health care providers that are considered under the RFA as small entities (including small rural hospitals) but are not governmentally operated; to the extent these providers have been involved in financing the non-Federal share of Medicaid payments, this rule will clarify whether or not such practices may continue. However, for the most part, private health care providers are not affected by this rule. As stated earlier, for purposes of the RFA, the small entities principally affected by this rule are governmentally operated health care providers. In light of the specific universe of small entities impacted by the rule, the fact that this rule requires States to allow governmentally operated health care providers to receive and retain their Medicaid payments, and the allowance for governmentally operated health care providers to receive a Medicaid rate up to cost, we have not identified a need for regulatory relief under the RFA.

Ultimately, this rule is designed to ensure that Medicaid payments to governmentally operated health care providers are based on actual costs and that the financing arrangements supporting those payments are consistent with the statute. While some health care providers may lose revenues in light of this rule, those revenues were likely in excess of cost or may have been financed using methods that did not permit the provider to retain payments received. Other health care providers that were adversely affected by questionable reimbursement and financing arrangements may now, under this rule, benefit from a more equitable distribution of funds. Private providers

are generally unaffected by this rule, except for limited situations where the clarification provided by the rule may require a change to current financing arrangements.

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

C. Anticipated Effects

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

ESTIMATED REDUCTION IN FEDERAL MEDICAID OUTLAYS RESULTING FROM THE PROVIDER PAYMENT REFORM PROPOSAL BEING IMPLEMENTED BY CMS–2258–P

[amounts in millions]

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

These estimates are based on recent reviews of state Medicaid spending. Payment reform addresses both spending through intergovernmental transfers (IGT) and limiting payments to government providers to cost. For IGT spending, recent reports on spending on Disproportionate Share Hospitals (DSH) and Upper Payment Limit (UPL) spending were reviewed. From these reports, an estimate of the total spending that would be subject to the net expenditure policy was developed and then projected forward using assumptions consistent with the most recent President's Budget projections. The estimate of the savings in federal Medicaid spending as a result of this policy factors in the current authority and efforts of CMS and the impact of recent waivers; the estimate also accounts for the potential effectiveness of future efforts. There is uncertainty in this estimate to the extent that the projections of IGT spending may not match actual future spending and to the extent that the effectiveness of this policy is greater than or less than assumed.

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

D. Alternatives Considered

There is an option to implement policies surrounding retention of payments, certain elements of certified public expenditures, and the definition of a unit of government under existing statutory and regulatory authority. However, the proposed rule is a more effective method of implementation because it promotes statutory intent, strengthens accountability for financing the non-Federal share of Medicaid payments, and clarifies existing regulations based on issues we have identified. Similarly, an option exists to continue to allow governmental providers to be reimbursed at current rates; however, given the information CMS has gathered regarding the use of Medicaid payments to governmental providers, we find that the proposal to limit governmental providers to cost offers a way to reasonably reimburse providers while ensuring that Federal matching funds are used for their intended purpose, which is to pay for a covered Medicaid service to a Medicaid beneficiary and not something else.

E. Accounting Statement

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

ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM FISCAL YEAR 2007 TO FISCAL YEAR 2011

[In Millions]

Category	Transfers
Annualized Monetized Transfers	Negative Transfer—Estimated decrease in expenditures: $774.
From Whom To Whom?	Federal Government to States.

F. Conclusion

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

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

List of Subjects

42 CFR Part 433

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

42 CFR Part 447

Accounting, Administrative practice and procedure Drugs, Grant programs-health, Health facilities, Health professions, Medicaid Reporting and recordkeeping requirements, Rural areas.

42 CFR Part 457

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

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

PART 433—STATE FISCAL ADMINISTRATION

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

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

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

§ 433.50 Basis, scope, and applicability.

(a) * * *

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

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

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

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

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

* * * * *

3. Section 433.51 is revised to read as follows:

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

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

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

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

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

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

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

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

PART 447—PAYMENTS FOR SERVICES

1. The authority citation for part 447 continues to read as follows:

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

2. Section 447.206 is added to read as follows:

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

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

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

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

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

(3) For hospital and nursing facility services, Medicaid costs must be supported using information based on the Medicare cost report for hospitals or nursing homes, as applicable.

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

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

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

(2) States may utilize most recently filed cost reports to develop interim rates and may trend those interim rates by an applicable health care-related index. Interim reconciliations must be

performed by reconciling the interim Medicaid payment rates to the filed cost report for the spending year in which interim payment rates were made.

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

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

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

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

3. Section 447.207 is added to read as follows:

§ 447.207 Retention of payments.

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

(b) [Reserved]

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

§ 447.271 Upper limits based on customary charges.

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

(b) [Reserved]

5. Section 447.272 is amended by revising paragraphs (a) through (d) to read as follows:

§ 447.272 Inpatient services: Application of upper payment limits.

(a) *Scope.* This section applies to rates set by the agency to pay for inpatient services furnished by hospitals, NFs, and ICFs/MR within one of the following categories:

(1) State government operated facilities (that is, all facilities that are operated by the State) as defined at § 433.50(a) of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* * * * *

Section 447.321 is amended by revising paragraphs (a) through (d) to read as follows:

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

(a) *Scope.* This section applies to rates set by the agency to pay for outpatient services furnished by hospitals and clinics within one of the following categories:

(1) State government operated facilities (that is, all facilities that are operated by the State) as defined at § 433.50(a) of this chapter.

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

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

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

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

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

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

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

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

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

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

* * * * *

PART 457—ALLOTMENTS AND GRANTS TO STATES

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

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

2. Section 457.220 is revised to read as follows:

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

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

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

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

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

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

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

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

3. Amend § 457.628 by—

A. Republishing the introductory text to the section.

B. Revising paragraph (a).

The republication and revision read as follows:

§ 457.628 Other applicable Federal regulations.

Other regulations applicable to SCHIP programs include the following:

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

* * * * *

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

Dated: June 16, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: December 12, 2006.

Michael O. Leavitt,

Secretary.

[FR Doc. 07–195 Filed 1–12–07; 4:21 pm]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Chapter I

[CC Docket No. 01–92; DA 06–2548]

Developing a Unified Intercarrier Compensation Regime

AGENCY: Federal Communications Commission.

ACTION: Proposed rule, reopening of reply comment period.

SUMMARY: This document grants a request for an extension of time to file reply comments on a proposed process to address phantom traffic issues and a related proposal for the creation and exchange of call detail records filed by the Supporters of the Missoula Plan, an intercarrier compensation reform plan filed July 24, 2006 by the National Association of Regulatory Utility Commissioners' Task Force on Intercarrier Compensation (the NARUC Task Force). The Order modifies the pleading cycle by reopening the comment period in order to facilitate the development of a more substantive and complete record in this proceeding.

DATES: Submit reply comments on or before January 5, 2007.

ADDRESSES: You may submit comments, identified by CC Docket No. 01–92, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Federal Communications Commission Web Site: http://www.fcc.gov.* Follow the instructions for submitting comments on the Electronic Comment Filing System (ECFS) */http://www.fcc.gov/cgb/ecfs/.*
- *E-mail:* To *randy.clarke@fcc.gov.* Include CC Docket 01–92 in the subject line of the message.
- *Fax:* To the attention of Randy Clarke at 202–418–1567. Include CC Docket 01–92 on the cover page.
- *Mail:* Parties should send a copy of their filings to Randy Clarke, Pricing Policy Division, Wireline Competition Bureau, Federal Communications Commission, Room 5–A360, 445 12th Street, SW., Washington, DC 20554.
- *Hand Delivery/Courier:* The Commission's contractor, Natek, Inc., will receive hand-delivered or messenger-delivered paper filings for the Commission's Secretary at 236 Massachusetts Avenue, NE., Suite 110, Washington, DC 20002.

—The filing hours at this location are 8 a.m. to 7 p.m.

—All hand deliveries must be held together with rubber bands or fasteners.

—Any envelopes must be disposed of before entering the building.

—Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743.

- *People with Disabilities:* To request materials in accessible formats for people with disabilities (braille, large print, electronic files, audio format), send an e-mail to *fcc504@fcc.gov* or call the Consumer & Governmental Affairs Bureau at 202–418–0530 (voice), 202–418–0432 (tty).

Instructions: All submissions received must include the agency name and docket number. All comments received will be posted without change to *http://www.fcc.gov/cgb/ecfs/,* including any personal information provided. For detailed instructions on submitting

Winona Health

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March 14, 2007

Leslie Norwalk
Centers for Medicare & Medicaid Services
P.O. Box 8017
Baltimore, MD 21244-8017
RE: CMS-2258-P Medicaid Program – Cost Limit for Providers

Dear Ms. Norwalk:

Winona Health appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed Medicaid rule, which we oppose as it would harm the patients we serve. The rule imposes new restrictions on how states fund their Medicaid program and reimburse hospitals. These changes would cause major disruptions to our state Medicaid program, hurting providers and beneficiaries alike.

CMS estimates that the rule will cut $3.9 billion in federal spending over five years, amounting to a budget cut for safety-net hospitals and state Medicaid programs. At the state level, the Minnesota Hospital Association estimates the potential impact of this policy change to the state's hospitals at more than $100 million.

Locally, using Fiscal Year 2006 data, Winona Health's Community Memorial Hospital calculated our costs above Medicare/Medicaid reimbursements at $2.6 million; our Medicaid losses represent about 15% of this amount or, conservatively, $390,000. The proposed CMS rule would increase these losses, which may seem insignificant to the federal government but represents great significance for a rural healthcare hospital. The end result is a negative impact for these patients, our organization and our community.

We urge CMS to permanently withdraw this rule. Some of our concerns include:

(1) the limitation on reimbursement of governmentally operated providers
(2) the narrowing of the definition of public hospital
(3) the restrictions on intergovernmental transfers and certified public expenditures
(4) the absence of data or other factual support for CMS's estimate of savings.

Most importantly, however, we oppose this rule because of the negative impact on the many patients we serve – whether Medicaid-eligible or insurance or private pay. All would be impacted in one way or another, if Medicaid reimbursements are reduced. If this policy change is implemented, the nation's healthcare safety net will unravel, and healthcare services for millions of our nation's most vulnerable people will be jeopardized.

Feel free to contact me if you have any questions about the local impact of this proposed change. I may be reached at 507.457.4300 or rschultz@winonahealth.org.

Sincerely,

Rachelle Schultz
President/CEO

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