Submitter : Ms. Carol Davis **Date:** 03/14/2007

Organization : Carolinas Medical Center-Union

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#101

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. John Roberts **Date: 03/14/2007**

Organization : Carolinas Medical Center-Union

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-102-Attach-1.PDF

#102

Carolinas Medical Center Union

March 16, 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, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

Carolinas Medical Center-Union is a 157 licensed acute care hospital in Union County, NC providing extremely generous amounts of patient care services to the Medicaid and the uninsured population. 16.4% of our total patients in 2006 were Medicaid and an additional 7.8% of patients had no insurance. We are extremely concerned about and oppose the promulgation of the regulations that were published on January 18, 2007.

The proposed rule will have serious adverse consequences on the medical care that is provided to North Carolina's indigent and Medicaid populations and on the many safety net hospitals that provide that care. It is estimated that the impact of this proposed regulation on the North Carolina Medicaid program is that at least $340 Million in annual federal expenditures presently used to provide hospital care for these populations will disappear overnight, creating immense problems with healthcare delivery and the financial viability of the safety net hospitals.

Although there are many troublesome aspects of the proposed regulation, the provision that will have the most detrimental effect in North Carolina is the proposed definition of "unit of government." Presently, North Carolina's 43 public hospitals certify their public expenditures to draw down matching federal funds to make enhanced Medicaid payments and DSH payments to the Public and Non-Public hospitals that provide hospital care to Medicaid and uninsured patients.

Our understanding is that all of these 43 public hospitals are in fact public hospitals under applicable State law. Substantially, all of them have been participating in Medicaid programs as

public hospitals for over a decade with the full knowledge and approval of CMS. Each public hospital certifies annually that it is owned or operated by the State or by an instrumentality or a unit of government within the State, and is required either by statute, ordinance, by-law, or other controlling instrument to serve a public purpose.

Yet, under the proposed new definition requiring all units of government to have generally applicable taxing authority or to be an integral part of an entity that has generally applicable taxing authority, virtually none of these truly public hospitals will be able to certify their expenditures. Imposing a definition that is so radically different and has the effect of wiping out entire valuable programs that are otherwise fully consistent with all of the Medicaid statutes is unreasonable and objectionable. Carolinas Medical Center-Union respectfully requests that CMS reconsider its position on the definition of unit of government and defer to applicable State law.

If CMS elects to go forward with the proposed regulation and with the proposed new definition of unit of government, it is absolutely critical that the effective date be extended significantly to allow for a reasonable, organized response by the State and participating hospitals. This hospital believes that the consequences of allowing anything less than two full years before the rule takes effect will be catastrophic. North Carolina's indigent patients, the hospitals that provide care for these patients, the State Legislature and the State Agency responsible for the Medicaid program need time to adequately prepare. The new regulations totally eliminate what has always been considered to be a legal and legitimate means for providing the Non-federal share of certain enhanced Medicaid payments and DSH payments to the State's safety net hospitals. At least two years is necessary for the affected stakeholders to try to mitigate the detrimental impact of the changes.

Carolinas Medical Center-Union urges CMS to withdraw its proposed regulation, or in the alternative, revise it substantially by, among other things, adopting applicable state law to define the public hospitals (or units of government). If the regulation is not withdrawn or adequately revised, Carolinas Medical Center-Union urges CMS to adopt a more reasonable implementation schedule that allows for at least two full years before the changes take effect. Thank you for your consideration.

Respectfully submitted,

John W. Roberts
President

cc: Senator Richard Burr
Senator Elizabeth Dole
Representative Robin Hayes
Representative Sue Myrick

Submitter : **Ms. Christine Bronson** **Date: 03/14/2007**

Organization : **Minnesota Department of Human Services**

Category : **State Government**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

Thank you for the opportunity to comment on the proposed rule. Minnesota shares the goal of promoting fiscal integrity in the Medicaid program. However, we have concerns about several of the policies CMS is proposing and strongly recommend that CMS consider these concerns and revise the regulations accordingly.

Most immediately, we are concerned about the timeframes for implementation in the rule. Given states legislative schedules and the breadth of the payment policy changes envisioned in the rule, a September 1, 2007 effective date is not reasonable. Legislative action will be required in order for many states to comply with the proposed policies. Legislatures will adjourn prior to the publication of the final rule. CMS should include transition periods or delayed effective dates for states that require legislative action to comply with changes regarding cost limits, intergovernmental transfers and certified public expenditures.

We are also concerned with the lack of definitions for the three major terms and concepts contained in the proposed rule. While the concepts of costs, units of government and retention of payments are integral to the policies proposed in the rule, CMS has failed to adequately or comprehensively define them, instead leaving the major part of their interpretation to the discretion of the Secretary. This is not feasible. States need to have a reasonably defined framework within which to operate their Medicaid programs. The amount of discretion envisioned in the proposed rule would subject virtually all of a state s Medicaid expenditures to retroactive disallowances and disapprovals based on the administration s interpretations of guidance documents issued without stakeholder input. This level of discretion, which circumvents the purpose of notice and comment rulemaking, denies states and other stakeholders the right to have meaningful input regarding policy decisions affecting the vast majority of Medicaid expenditures, and fails to protect states and other affected parties from disparate decision-making by CMS staff.
Finally, we do not believe that CMS has adequately evaluated the level of administrative burden that this proposed rule will place on states, providers and agency staff. We are not convinced that the level of savings justifies the enormous increase in administrative burden and cost that would ensue from the implementation of the policies proposed in this rule.

Our comments on the specific provisions of the rule are included in the attached file.

GENERAL

GENERAL

See Attachment

CMS-2258-P-103-Attach-1.PDF

#103

Minnesota Department of **Human Services**

March 15, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
PO Box 8017
7500 Security Boulevard
Baltimore, MD 21244-8017

Minnesota Department of Human Services Comments on:
Docket: CMS-2258-P, Cost Limit for Government Providers

Dear Ms. Norwalk:

Thank you for the opportunity to comment on the proposed rule. Minnesota shares the goal of promoting fiscal integrity in the Medicaid program. However, we have concerns about several of the policies CMS is proposing and strongly recommend that CMS consider these concerns and revise the regulations accordingly.

Most immediately, we are concerned about the timeframes for implementation in the rule. Given states' legislative schedules and the breadth of the payment policy changes envisioned in the rule, a September 1, 2007 effective date is not reasonable. Legislative action will be required in order for many states to comply with the proposed policies. Legislatures will adjourn prior to the publication of the final rule. CMS should include transition periods or delayed effective dates for states that require legislative action to comply with changes regarding cost limits, intergovernmental transfers and certified public expenditures.

We are also concerned with the lack of definitions for the three major terms and concepts contained in the proposed rule. While the concepts of "costs," "units of government" and "retention of payments" are integral to the policies proposed in the rule, CMS has failed to adequately or comprehensively define them, instead leaving the major part of their interpretation to the discretion of the Secretary. This is not feasible. States need to have a reasonably defined framework within which to operate their Medicaid programs. The amount of discretion envisioned in the proposed rule would subject virtually all of a state's Medicaid expenditures to retroactive disallowances and disapprovals based on the administration's interpretations of guidance documents issued without stakeholder input. This level of discretion, which circumvents the purpose of notice and comment rulemaking, denies states and other stakeholders the right to have meaningful input regarding policy decisions affecting the vast majority of Medicaid expenditures, and fails to protect states and other affected parties from disparate decision-making by CMS staff.

Finally, we do not believe that CMS has adequately evaluated the level of administrative burden that this proposed rule will place on states, providers and agency staff. We are not convinced that the level of savings justifies the enormous increase in administrative burden and cost that would ensue from the implementation of the policies proposed in this rule.

Our comments on the specific provisions of the rule are included below.

Provisions of the Proposed Rule

Defining a Unit of Government (§433.50)

CMS is proposing to clarify the definition of "unit of government" but has failed to comprehensively define the term. Instead, CMS is proposing to use a survey tool to aid in the determination of a provider's status as a unit of government. We have reviewed the proposed survey and discovered that there is no indication of the final result on the form. It appears that CMS intends to evaluate these forms on a case by case basis and reserve the right to make the final determination regardless of the amount of time between the state's submission of the information and CMS review and decision. This is not a viable or fair process.

It is unreasonable to expect states to withhold or limit Medicaid payments while CMS allows itself months or years to evaluate the governmental status of each provider. This proposed process is even more disconcerting given the agency's recent history of producing evolving policy over time while neglecting to disseminate information about the changes in policy among states. If this same practice is applied to the process of determining the governmental status of providers, it is likely that similarly situated providers would be treated differently over time.

By its own account, CMS has been examining this issue for almost four years. Surely a standardized definition of governmental status can be developed with the information currently available. Minnesota has over 2,000 providers that self-report as being related to government entities. We are willing to re-evaluate that status against a fair and objective set of criteria that will produce impartial and consistent outcomes. However, it is unreasonable to expect states to support CMS in the implementation of a decision making process that has the appearance of being arbitrary, is unlikely to be timely, and which will subject states and providers to significant retroactive disallowances.

We recommend that CMS develop a set of clear standardized criteria or a uniform tool that states can use to determine which providers are allowed to certify expenditures and transfer funds, and are required to submit cost report information. States must be able to make these determinations up front in order to ensure the continued operation of their Medicaid programs without the threat of unanticipated retroactive disallowances. The criteria or tool must also serve as a safe harbor for states that apply it in good faith and make decisions that CMS may later disagree with. The safe harbor would not preclude CMS from requiring prospective state compliance with the agency's determinations.

Sources of State Share and Documentation of CPE (§433.51(b))

In this section, CMS is again proposing to implement new documentation requirements without providing a comprehensive description of the nature and extent of the documentation that will be required or accepted. This subjects a significant percentage of states' Medicaid expenditures to unacceptable levels of uncertainty regarding retroactive disallowances.

We recommend that CMS delay implementation of this provision of the proposed rule until the specific CPE documentation requirements and forms have been shared with all interested parties and they have been given the opportunity to comment on them.

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

CMS is proposing to limit Medicaid payment to government providers to their actual costs of providing Medicaid services. However, the agency has failed to comprehensively define "costs" in the regulation, leaving the final determination to the discretion of the Secretary. This is unacceptably vague. States cannot reasonably be expected to operate Medicaid programs within a framework that subjects a significant portion of their spending to unlimited retroactive disallowances for non-compliance with definitions that haven't been disseminated.

We are not confident that CMS will be able to provide a comprehensive definition of costs for all provider types within a reasonable timeframe. There are few precedents for defining costs for non-institutional providers and the variety of provider types and array of services provided in outpatient and community settings makes the task potentially far more complex than when dealing with institutional providers.

For example, how would a clinic allocate its resources over a client base, a subset of which (likely the Medicaid population), might be fewer in number but more heavily resource intensive. Does CMS intend to develop case mix indices for non-institutional providers or require states to do so? If a county contracts with another entity to provide a Medicaid service, but the state chooses to certify the county's expenditures, which costs will be used and what documentation will be required? It would not be reasonable to require states to document the actual costs of private providers.

How will cost limits be applied to government providers of FQHC and RHC services? The proposed regulation conflicts with federal statutes governing Medicaid payments to FQHCs and RHCs.

What cost finding principles will be used to determine which costs are associated with the provision of the Medicaid service? Will the cost finding principles be standardized? How will they differ from existing cost finding guidance and, more importantly, why?

The need for a more comprehensive definition of costs is imperative given that CMS has explicitly decided not to concede that Medicare's cost principles or the principles of OMB Circular A-87 would always be considered reasonable for Medicaid payments, and has reserved the right to disallow costs in Medicaid that would be allowable under Medicare or A-87.

The need for a comprehensive definition of costs is demonstrated by a proposal in the President's Budget for FY 2008 which indicates that the administration does not support Medicaid reimbursement for graduate medical education (GME) costs. The President's Budget proposes to address the GME issue with new regulation, but the definition of costs proposed in this rule would seem to leave the decision regarding the treatment of GME costs in Medicaid for government providers to the discretion of the Secretary. A decision to preclude Medicaid payment for GME costs for government providers would have considerable ramifications. In many states public safety net providers are also teaching hospitals. The combination of limiting payments to allowable costs and not allowing GME costs to be recognized in Medicaid could seriously undermine the infrastructure for training new physicians in many states.

Given the current lack of a clear and comprehensive definition of "costs" and the complexities involved in developing one, an effective date of September 1, 2007 for this provision is not reasonable. Changes to payment systems have to be prospective. Medicaid providers have rights under state laws that cannot be repealed retroactively.

We recommend that CMS refrain from finalizing the cost limit provisions of the proposed rule until a comprehensive definition of costs or cost finding principles for all provider types is developed. Any implementation of new payment limits should include transition periods so that states are given sufficient notice to make the changes necessary to comply with the new limits prospectively.

Retention of Payments (§447.207)

Again, CMS intends to implement a new requirement that providers must retain the full amount of all Medicaid payments, but has failed to define the concept of what it means to "retain" a payment, leaving the final determination entirely to the discretion of the Secretary. This, again, is unacceptably vague.

Under this definition, CMS has the ability to determine that any and all transfers are a "return" of Medicaid funds. This provision is in violation of §1903(w)(6)(A), which specifically allows intergovernmental transfers and § 5 of Public Law 102-234, which prohibits the Secretary from changing the treatment of public funds as a source of the state share of Medicaid expenditures. CMS must define these transfers that are protected under §1903(w)(6)(A). In addition to the prohibition set out at 42 USC § 1903(w)(6) , Congress specifically prohibited the Secretary from promulgating interim regulations changing the treatment of intergovernmental transfers. The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 contained the following prohibition:

> (b) Regulations Changing Treatment of Intergovernmental Transfers – The Secretary may not issue any interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under tile XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act (as added by section 2(a) of this Act) that are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.
> (c) Consultation with States. – The Secretary shall consult with States before issuing any regulations under this Act.
>
> P.L. 102-234, Sec. 5

Moreover, the text of the proposed rule would apply the retention requirement to all Medicaid providers. It is not clear how or under what authority states would be expected to monitor payments made to private Medicaid providers. States cannot be expected to operate their Medicaid programs under a set of regulations that subjects virtually all of their expenditures to retroactive disallowances should CMS decide at some future date that a routine transaction between a provider and another party constituted a "non-retention" of a Medicaid payment.

We recommend that CMS refrain from finalizing the retention requirement provisions of the proposed rule unless and until a comprehensive definition of the term "retain" is developed.

Administrative Burden vs. Cost Savings

Finally, we do not believe that CMS has fully appreciated the enormous administrative burden this proposed rule will impose on states, providers and CMS itself. This is particularly true for states in which local government providers make up a significant portion of the safety net for mental health and long term care services. The payment limits and cost documentation requirements for payments associated with local governments proposed in this rule impose an undue burden on states with large rural populations where local governments may serve as the provider of last or only resort to ensure access to needed care.

CMS should also consider that leveraging FFP can be controlled without applying cost limits to all government providers. CMS has noted on numerous occasions that states have no incentive to overpay providers if the providers cannot transfer funds back to the state. CMS should consider limiting the application of provider specific cost limits to only those instances in which payment methodologies for government providers differ from the payment methodologies for non-government providers. If payments to government and non-government providers are the same, the expense of cost reporting is not offset by any savings.

Even when cost limits are applied, CMS should reconsider the requirement for interim and final payment rates for all public providers included in the proposed rule. Prospective payment rates such as DRG-based payments for hospitals or case-mix adjusted per diem rates for nursing homes, are often below costs. Requiring states to use interim and settle-up payment methodologies in these cases adds a costly level of administrative burden and produces no cost savings at all. Similarly, given the proposed restrictions on CPEs and IGTs, the savings generated by subjecting cost-based prospective payment rates that are periodically updated for inflation to retrospective reconciliation would not be sufficient to justify the added administrative costs of the reconciliation process.

Sincerely,

Christine Bronson

Christine Bronson
Medicaid Director

Submitter : **Mr. David Zammit** **Date: 03/14/2007**

Organization : **Louis Smith Memorial Hospital**

Category : **Critical Access Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-104-Attach-1.DOC

#104

March 14, 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, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

Louis Smith Memorial Hospital in Lakeland, Georgia and the community appreciate 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 hospital and the patients we serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. These changes would cause major disruptions to Georgia's Medicaid program and hurt providers and beneficiaries alike. And, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

CMS estimates that the rule will cut $3.9 billion in federal spending over five years. The rule will drastically reduce reimbursement for Georgia's "safety net" hospitals, which treat the largest number of indigent and uninsured patients, without any evidence such hospitals ever utilized the financial practices these rules are designed to erase. The preamble describes two financing arrangements which CMS believes are improper: (1) those in which the providers are required to refund a portion of the Medicaid payments received and (2) those in which federal funds are used to absorb costs outside the Medicaid program. Georgia's Medicaid financing arrangement employs none of these characteristics.

This rule also amounts to a budget cut for hospitals and state Medicaid programs that bypasses the congressional approval process and comes on the heels of vocal congressional opposition to the Administration's plans to regulate in this area. Last year 300 members of the House of Representatives and 55 senators signed letters to Health and Human Services Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. More recently, Congress again echoed that opposition, with 226 House members and 43 Senators having signed letters urging their leaders to stop the proposed rule from moving forward.

We urge CMS to permanently withdraw this rule, and we would like to outline our most significant concerns, which 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; and (4) the absence of data or other factual support for CMS's estimate of savings.

Limiting Payments to Government Providers

The rule proposes 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. It is unreasonable for CMS to contend the current UPL program results in excessive payments to hospitals, since such payments are based on Medicare rates, which are clearly non-excessive.

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, including Georgia, have adopted this method of hospital reimbursement, yet CMS is proposing to resurrect a cost-based limit that Congress long ago declared less efficient. Limiting a public hospital's Medicaid payment to the undefined "cost" of its services merely punishes those hospitals who have struggled to reduce their cost. In addition, since the proposed rules impose these cost limits only on government-operated hospitals, they have the insidious effect of paying government hospitals less than private hospitals. There has been no articulated justification for this policy change.

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 2002 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.

New Definition of "Unit of Government"

The proposed rule effectively amend the statutory definition of governmental hospitals – something CMS cannot do without the consent of Congress. Section 1903(w)(7)(G) of the Social Security Act defines the term "unit of government" to include "a city, a county, a special purpose district, ***or other governmental unit in the State***." The statute places no additional requirements to qualify as a governmental unit. CMS's proposed rule, however, impermissibly amend this statutory definition by requiring, for example, that a governmental unit must have "generally applicable taxing authority". There is no basis in federal statute that supports this proposed change in definition.

The proposed rule is so restrictive that only one general acute care hospital in Georgia would qualify as a "unit of government." The State of Georgia owns only one general hospital (in conjunction with its medical school), and none of Georgia's 159 counties own a hospital. This is because the Georgia General Assembly elected over six decades ago to create local hospital authorities to discharge the counties' legal duty of caring for their indigent sick. Both the law creating hospital authorities and subsequent judicial precedent consistently confirm that Georgia hospital authorities are indeed local units of government.

Hospital authorities, however, do not have the power to tax. Instead, counties have the power to impose taxes and to agree by contract to utilize those tax revenues to reimburse hospital authorities for their cost of providing indigent care. Since the proposed rule stipulates that a contractual arrangement is insufficient to qualify the receiving hospital as a unit of government, virtually every hospital authority in the State would be disqualified simply because they receive their funds through contract rather than direct appropriation.

Restrictions on Intergovernmental Transfers (IGTs) and Certified Public Expenditures (CPEs)

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). 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.

Insufficient Data Supporting CMS's Estimate of Spending Cuts

CMS is required to examine relevant data to support the 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 years. But CMS fails to provide any relevant data or facts to support this conclusion. Our hospital alone will lose an estimated $1,300,000

annually in federal funding and the overall annual impact in Georgia is estimated to be over $362 million. These figures suggest the actual loss of funding to hospitals and state Medicaid programs is likely far greater than CMS' estimates. 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. As noted previously, Georgia does not do so. 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, Georgia's health care safety net will unravel, and health care services for millions of vulnerable people in both Georgia and the rest of the nation will be jeopardized.

Sincerely,

David Zammit
Controller

Submitter : Mr. Kevin Rogols **Date:** 03/14/2007

Organization : Johnston Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2258-P-105-Attach-1.PDF

#105

Making Our Community Better

March 13, 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, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

On behalf of the Board of Commissioners, Medical Staff, Administration and Employees of Johnston Memorial Hospital Authority, we would like to thank you for this opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule. We oppose this rule and will highlight the harm its proposed policy changes would cause to our hospital and the patients we serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. These changes would cause major disruptions to our state Medicaid program and hurt both providers and beneficiaries.

The proposed rule puts forward a new and restrictive definition of "unit of government." In order for a public hospital to meet this new definition, it must demonstrate that it has generally applicable taxing authority or is an integral part of a unit of government that has generally applicable taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Nowhere in the Medicaid statute, however, is there any requirement that a "unit of government" have "generally applicable taxing authority." This new restrictive definition would disqualify many long-standing truly public hospitals from certifying their public expenditures. There is no basis in federal statute that supports this proposed change in definition.

Existing federal Medicaid regulations allow North Carolina hospitals to receive payments to offset a portion of the costs incurred when caring for Medicaid patients. Even with these payments, however, hospital Medicaid revenues for most North Carolina hospitals still fall significantly short of allowable Medicaid costs. If the proposed rule is implemented and, as a result, this important hospital funding stream is eliminated, those losses would be exacerbated. Hospitals would be forced either to raise their charges to insured patients or to reduce their costs by eliminating costly but under-reimbursed services. The first choice would raise health insurance costs by an estimated four percent. The second would eliminate needed services, not just for Medicaid patients but also for the entire community. Eliminating those services likely would result in the elimination of almost 3,000 hospital jobs. That reduced spending and those lost jobs would be felt in local economies and the resulting economic loss to the State of North Carolina has been estimated at over $600 million and almost 11,000 jobs.

509 North Bright Leaf Blvd, Smithfield, NC 27577 • (919) 934-8171 • Fax (919) 989-7297
www.JohnstonMemorial.org

Specifically for our hospital, the loss of this program would be over $2.5 million. As a result of this loss, we would be forced to reevaluate the services that are offered to the patients in our community and drastically reduce or cut some of the essential services we provide at our hospital and clinics throughout the county. Johnston Memorial Hospital is the only hospital in our county and the impact of a direct loss of $2.5 million would be substantial, not only for the community, but also for our employees. Currently, we are one of the largest employers in Johnston County with more than 1,200 staff members. Additionally, our County is one of the fastest growing in our State as well as the Nation and we are struggling to meet the demands of this increasing population. The number of Medicaid patients we serve has grown significantly over the past several years. As a county-owned facility, it is our duty to serve everyone in our community including the most vulnerable populations and the proposed rule will restrict our ability to care for all patients.

The proposed effective date for this rule is Sept. 1, 2007. If this devastating rule is not withdrawn, North Carolina hospitals will lose approximately $340 million immediately. The results of that would be disastrous, as we have shared in this comment letter. State Medicaid agencies and hospitals would need time to react and plan in order to even partially manage such a huge loss of revenue. The immediate implementation of this rule would result in major disruption of hospital services in our state.

We oppose the rule and strongly urge that CMS permanently withdraw it. If these policy changes are implemented, the state's health care safety net will unravel, and health care services for thousands of our state's most vulnerable people will be jeopardized.

Sincerely,

Kevin L. Rogols, CHE
Chief Executive Officer

Sammy Jackson
Chairman, Board of Commissioners

Eric Janis, M.D.
Chief of Staff

cc: Senator Elizabeth Dole
Senator Richard Burr
Congressman Bob Etheridge

Submitter : Mrs. jospehine barilotti **Date:** 03/14/2007

Organization : the consumer satisfaction team inc

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I believe it's a big mistake to cut federal budgets for Behavioral Health care. If no services are available then where is someone going to go to get help. Want to know where? Right to drugs to self medicate and if we have more people using drugs then we are going to have more crime. Being a person in recovery, I know that if help wasn't availble to me then I would still be leading a life of degradation and crime. People need services, it's the only way for them to recover! I think it's ridiculous that budgets are being cut for services that help people in this country when we are funding a war that there is no way of winning. Want to cut budgets? Then let's cut some of what we are spending on the war and take care of our own at home!

Submitter : Mr. Craig Hostetler **Date:** 03/14/2007

Organization : Oregon Primary Care Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-107-Attach-1.DOC

#107

OPCA
OREGON PRIMARY CARE ASSOCIATION
110 SW Yamhill Street, Suite 300 • Portland, Oregon 97204

March 14, 2007

Secretary Mike Leavitt
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
P.O. Box 8017
Baltimore, MD 21244-8017

Secretary Leavitt:

On behalf of Oregon's Community Health Centers, thank you for the opportunity to provide comments on the proposed rules relating to a number of Medicaid financing issues, including intergovernmental transfers (IGT), certified public expenditures (CPE), and upper payment limits (UPL). *See* 72 Fed. Reg. 2236 et seq., January 18, 2007. In general, we support the steps by the Department to clarify the regulations governing the financing of the non-Federal share of Medicaid payments. At the same time, we have a number of concerns with the regulations as currently proposed, and we outline these concerns below.

Our organization, the Oregon Primary Care Association, provides technical assistance, training and advocacy to Oregon's Community Health Centers to increase access to comprehensive and high-quality health care for vulnerable populations. As core safety net providers, Community Health Centers operate over 140 clinic sites throughout Oregon, serving more than 225,000 individuals, through over 1 million medical, dental and mental health visits. Statewide, approximately 36% of our patients are covered through Medicaid or our State Children's Health Insurance Program (SCHIP).

We outline below two main areas of concern with the proposed regulations:

1. **The Federal regulations should allow use of any type of local government general revenue, not limited to tax revenues.**

The proposed regulations appear to limit eligible non-Federal match to local tax revenues. Local government units, however, raise general revenues (funds that can be used for any general governmental purpose) in a variety of ways not limited to taxes. For example, library fines, restaurant inspection fees, traffic fines may all be general revenues to the local government. These funds should all be eligible as a legitimate source of the non-Federal share of Medicaid and SCHIP payments.

2. **Clarify that Federally Qualified Health Centers operated by public county health departments will continue to be paid in accordance with the federal Medicaid PPS statute.**

Since 2001, Federally Qualified Health Centers are paid in Oregon in accordance with the federal Medicaid Prospective Payment System (PPS) statute. A number of FQHCs in Oregon are operated by county public health departments, and we request clarification that these health centers are entitled to continue to receive reimbursement through their PPS rates in accordance with the federal PPS statute.

The proposed rule would impose a cost limit on Medicaid payments to governmentally operated providers. We assume, however, that the PPS provisions in the Medicaid statute would prevail over these rules and that our public FQHCs would be entitled to continue to receive reimbursement through PPS and the state would continue to receive its federal match for such payments. Finally, we would also like to note that our PPS rates should not be equated to reasonable cost, due to the cumulative difference between medical inflation and the Medicare Economic Index.

Thank you again for the opportunity to comment.

Sincerely,

Craig Hostetler
Executive Director

Submitter : Mr. Waymon Stewart **Date:** 03/14/2007

Organization : Andrews Center, Tyler, Texas

Category : Other Health Care Provider

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

"See Attachment"

GENERAL

GENERAL

"See Attachment"

Regulatory Impact Analysis

Regulatory Impact Analysis

"See Attachment"

#108

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Leo Greenawalt **Date: 03/14/2007**

Organization : Washington State Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-109-Attach-1.DOC

#109

Washington
State
Hospital
Association

Association of
Washington

Hospital

Public

Districts

March 14, 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, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

The Washington State Hospital Association and the Association of Washington Public Hospital Districts represent public hospitals in the state of Washington. Washington State has 42 district hospitals in addition to two other public hospitals (county and state teaching hospitals). We appreciate 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 they serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. These changes would cause major disruptions to our state Medicaid program and hurt providers and beneficiaries alike. And, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

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 and state Medicaid programs that bypasses the congressional approval process and comes on the heels of vocal congressional opposition to the Administration's plans to regulate in this area. Last year 300 members of the House of Representatives and 55 Senators signed letters to Health and Human Services Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. More recently, Congress again echoed that opposition, with House members and 43 Senators having signed letters urging their leaders to stop the proposed rule from moving forward.

We urge CMS to permanently withdraw this rule, and we would like to outline our most significant concerns. These center primarily around the limitation on reimbursement of governmentally operated providers. The rule proposes 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 CMS 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 2002 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.

CMS is required to examine relevant data to support the 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 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, the nation's health care safety net will unravel, and health care services for millions of our nation's most vulnerable people will be jeopardized.

Sincerely,

Leo Greenawalt

Jeff Mero

Leo Greenawalt
President
Washington State Hospital Association

Jeff Mero
Executive Director
Association of Washington Public Hospital Districts

Submitter : Ms. Joanne Fuller **Date:** 03/14/2007

Organization : Multnomah County Dept. of County Human Services

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2258-P-110-Attach-1.DOC

Department of County Human Services
MULTNOMAH COUNTY OREGON
Joanne Fuller, Director

421 SW Oak Street, Suite 620
Portland, Oregon 97204-1817
(503) 988-3691 Phone
(503) 988-3379 Fax
(503) 988-3598 TTY

#110

MEMORANDUM

TO: Centers for Medicare and Medicaid Rule Coordinator

FROM: Joanne Fuller

DATE: March 10, 2007

SUBJECT: Response to Proposed Regulations Centers for Medicare and Medicaid Services – Proposed Rule CMS-2258-P

I am writing to express opposition to the new Medicare regulation published in the Federal Register on January 18, 2007.

These regulations will impose huge administrative burdens on the State Medicaid agency and on local government providers. The Department of County Human Services will be seriously impacted by these proposed regulations. They will require additional documentation each time a governmental unit uses a Certified Public Expenditure (CPE) for Federal Financial Participation (FFP) purposes. Local governments already are following general accepted accounting principles in performing this function. Further documentation and reporting will add additional administrative costs that will take away from our ability to deliver services to our citizens and will diminish our ability to efficiently and effectively administer Medicaid services.

The draft regulations will also significantly shift the cost of Medicaid to states. The policies will impose cost limits for public health care providers and will alter the long standing legitimate state funding mechanisms that the Centers for Medicare and Medicaid Services (CMS) previously approved.

They will impose huge administrative burdens on states, and local providers of Medicaid services. These regulations will undermine the health care safety net for our most vulnerable citizens and will significantly lessen access to healthcare for thousands of our county residents.

Current regulations and practice within Department of County Human Services already assure restricted use of Medicaid funds and place procedural and documentation demands on obtaining and using Medicaid matching funds. Medicaid matching funds are obtained and used exclusively, and in their entirety,

for allowable Medicaid expenditures only. An actual certified public expenditure, through transfer of funds from the local government entity to the state, occurs as a separate action and is separated from any receipt and use of Medicaid matching funds. Local Medicaid Administration reimbursement is currently based on, and therefore limited to, the cost of furnishing services to eligible Medicaid beneficiaries. Therefore, states are held accountable under the current regulations as a means of ensuring compliance. Rule changes of this nature will burden local governments and limit their ability to administer the Medicaid program in the most efficient and effective manner possible.

Submitter : Mr. Len Preslar **Date:** 03/14/2007

Organization : North Carolina Baptist Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2258-P-111-Attach-1.PDF

#111

Wake Forest University Baptist
MEDICAL CENTER

Len B. Preslar, Jr.
President and Chief Executive Officer
North Carolina Baptist Hospital
Telephone: (336) 716-4750
Fax: (336) 716-2067

March 15, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: (CMS-2258-P)
200 Independence. Avenue, S.W. Room 445-G
Washington, DC 20201

Dear Ms. Norwalk:

North Carolina Baptist Hospital (NCBH) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled, "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, 2007." NCBH is part of Wake Forest University Baptist Medical Center, an academic health system comprised of 1,157 acute care, psychiatric, rehabilitation and long-term care beds located in the northwestern section of North Carolina, the region's main tertiary referral center.

We are writing to express our serious concerns about CMS' plan to dramatically cut Medicaid funding and make major policy changes to the program. These proposed cuts to the Medicaid program will have a severe impact on the millions of Americans who rely on this program for their health care.

Background:

On January 18, 2007, CMS released CMS-2258-P, which substantially narrows the definition of a public provider, limits Medicaid payments for public providers to cost and limits the use of intergovernmental transfers (IGTs) and certified public expenditures (CPEs). It specifically singles out safety-net hospitals for drastic reductions in reimbursement by imposing, for the first time, a new and narrow definition of a "unit of government" that will exclude many essential safety-net providers by substantially limiting the types of entities authorized to provide non-federal share funding under the Medicaid program.

Problems with the Definition of "Unit of Government" Proposed Changes:

Although there are many troublesome aspects of the proposed regulation, the provision that will have the most detrimental effect in North Carolina is the proposed definition of "unit of government." Presently, North Carolina's 43 public hospitals certify their public expenditure to draw down matching federal funds to make enhanced Medicaid payments and DSH payments to the public and non-public hospitals that provide hospital care to Medicaid and uninsured patients.

It is our understanding that all of these 43 public hospitals are in fact public hospitals under applicable State law. Substantially all of them have been participating in Medicaid programs as public hospitals for over a decade with the full knowledge and approval of CMS. Each public hospital certifies annually that it is owned or operated by the State or by an instrumentality or a unit of government within the State, and is required either by statute, ordinance, by-law, or other controlling instrument to serve a public purpose.

Yet, under the proposed new definition requiring all units of government to have generally applicable taxing authority or to be an integral part of an entity that has generally applicable taxing authority, virtually none of these truly public hospitals will be able to certify their expenditures. Imposing a definition that is so radically different and has the effect of wiping out entire valuable programs that are otherwise fully consistent with all of the Medicaid statutes is unreasonable and objectionable.

Impact:

According to CMS, the regulation as proposed would cut Medicaid funding by $3.8 billion over five years. It is said that these cuts are necessary in order to ensure the fiscal integrity of the Medicaid program. NCBH believes in having a healthy Medicaid program, but thinks the proposed regulation goes far beyond what is needed to attain financial stability. We firmly believe that CMB-2258-P would undermine the already fragile viability of the nation's health care safety net and reduce or eliminate access to health care services for millions of low-income patients.

The proposed cuts would significantly limit the funding available for state Medicaid programs. If this regulation were to go into effect as planned in September, 2007, North Carolina could face a $340,000,000 shortfall. With insufficient financing for its share of Medicaid, North Carolina would be forced to find new funding sources or make cuts to the program, which would directly affect participant eligibility and a reduction in benefits and services provided. These types of cuts would threaten our ability to continue to provide health care to our Medicaid and uninsured population.

At NCBH we fulfill a unique and critical role in the health care system by providing high intensity services, such as trauma and neonatal intensive care to the entire community and the western region of our state while also ensuring that Medicaid recipients and the uninsured have access to all medical services. In fact, the number of Medicaid inpatient admissions for NCBH has grown from 5,028 admissions in 2001 to 7,198 in 2006; an increase of 43.2%. In 2001, Medicaid admissions represented 16.3% of our total admissions. In 2006, it represented 20.8% of our total admissions. The number of our uninsured patient admissions from 2001 to 2006 has grown by 75.5% from 1,225 admissions in 2001 to 2,150 in 2006. To help put this in perspective, our total admission grew only 12% from 2001 to 2006, from 30,828 in 2001 to 34,525 admissions in 2006. The Medicaid and uninsured patient population admissions have significantly outpaced our overall growth rate.

It is estimated if the new definition of unit of government in the proposed rule goes into effect, NCBH would lose approximately $25,000,000 annually in supplemental Medicaid funding, which is crucial to our ability to fulfill our mission as an academic medical center. The draconian measures we would be forced to take as a consequence would include the elimination of needed services and jobs.

Recommendations:

NCBH opposes the proposed rule and respectfully requests that CMS reconsider its position on the definition of unit of government and permanently withdraw it.

NCBH remains committed to working with CMS, other health care organizations, such as the American Hospital Association (AHA), Association of American Medical Colleges (AAMC), National Association of Children's Hospitals (NACH), the National Association of Public Hospitals (NAPH) and the National Governors Association (NGA) to ensure that Medicaid beneficiaries have continued access to high quality, efficient and effective health care. We look forward to a continuing dialog as it relates to this proposed rule.

If you have any questions concerning these comments, please contact Joanne C. Ruhland, Vice President, Government Relations at jruhland@wfubmc.edu or 336-716-4772.

Sincerely,

Len B. Preslar, Jr.

c: Senator Elizabeth Dole
Senator Richard Burr
Representative Virginia Foxx
Representative Mel Watt

NCBH Board of Trustees

Submitter : **Ms. Kathleen DeVine** **Date: 03/15/2007**

Organization : **Saint Anthony Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

For Illinois, the impact of the proposed rules would represent a serious financial impact to hospitals providing healthcare for thousands of low-income, elderly, and disabled 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. The total negative impact to Illinois Medicaid program could be even greater.

We urge CMS to permanently withdraw this rule, and we would like to outline our most significant concerns, which include: (1) 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.

The rule proposes 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. Illinois Medicaid program has adopted this method of hospital reimbursement, yet CMS 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.

The impact on neighboring safety net hospitals like ours of the impact of these cuts directly and throughout the entire states Medicaid budget would be devastating. We too provide for extremely high percentages of Medicaid and uninsured. To pay a limited definition of cost with no recognition of the need for capital investment or the cost of caring for the nations most vulnerable creates a recipe for failure for many of the nations safety net hospitals. This is a flawed plan based on a flawed understanding of the needs of these communities and the nature of the medicaid allowable cost structure. We too have to subsidize medical staff to make them available to the poorest and least healthy citizens; many costs are not recognized.

We urge you not to implement this rule. Its consequences are real and foreseen. It will impact those that the government has identified in its own studies are the sickest and further delaying their access to care costs the nation the most in lost human capital because of disparate rates of illness and disability.

Submitter : Mr. Brian Moore **Date:** 03/15/2007

Organization : Mission Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-113-Attach-1.PDF

#113

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, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

I am writing on behalf of Mission Hospital in Asheville North Carolina, a 730 bed regional acute care referral center. We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule. We oppose this rule and will highlight the harm its proposed policy changes would cause to our hospital and the patients we serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. These changes would cause major disruptions to our state Medicaid program and hurt both providers and beneficiaries.

The proposed rule puts forward a new and restrictive definition of "unit of government." In order for a public hospital to meet this new definition, it must demonstrate that it has generally applicable taxing authority or is an integral part of a unit of government that has generally applicable taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Nowhere in the Medicaid statute, however, is there any requirement that a "unit of government" have "generally applicable taxing authority." This new restrictive definition would disqualify many long-standing truly public hospitals from certifying their public expenditures. There is no basis in federal statute that supports this proposed change in definition.

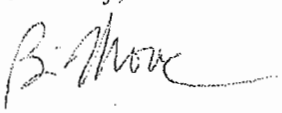
Existing federal Medicaid regulations allow North Carolina hospitals to receive payments to offset a portion of the costs incurred when caring for Medicaid patients. Even with these payments, however, hospital Medicaid revenues for most North Carolina hospitals still fall significantly short of allowable Medicaid costs. If the proposed rule is implemented and, as a result, this important hospital funding stream is eliminated, those losses would be exacerbated. Hospitals would be forced either to raise their charges to insured patients or to reduce their costs by eliminating costly but under-reimbursed services. The first choice would raise health insurance costs by an estimated four percent. The second would eliminate needed services, not just for Medicaid patients but also for the entire community. Eliminating those services likely would result in the elimination of almost 3,000 hospital jobs. That reduced spending and those lost jobs would be felt in local economies and the resulting economic loss to the State of North Carolina has been estimated at over $600 million and almost 11,000 jobs.

Specifically for our hospital, the loss of this program would mean a reduction in payments of over $16.2 million dollars per year. This reduction will result in the hospital having to reduce access to the most vulnerable segments of our society by eliminating programs and services. This reduction could result in the elimination of 300 full time equivalents, or 5 % of our workforce. This would have profound negative impact on the health of the region and the hospital's ability to meet federal and state mandates.

The proposed effective date for this rule is Sept. 1, 2007. If this devastating rule is not withdrawn, North Carolina hospitals will lose approximately $340 million immediately. The results of that would be disastrous, as we have shared in this comment letter. State Medicaid agencies and hospitals would need time to react and plan in order to even partially manage such a huge loss of revenue. The immediate implementation of this rule would result in major disruption of hospital services in our state.

We oppose the rule and strongly urge that CMS permanently withdraw it. If these policy changes are implemented, the state's health care safety net will unravel, and health care services for thousands of our state's most vulnerable people will be jeopardized.

Sincerely,



Brian Moore
Director of Public Policy and Planning

cc: Senator Elizabeth Dole
Senator Richard Burr
Representative Health Shuler

Submitter : **Mr. Gary Bowers** **Date: 03/15/2007**

Organization : **WNC Health Network**

Category : **Hospital**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

CMS-2258-P-114-Attach-1.DOC

#114

WNC
HEALTH
NETWORK
Providers Working Together

March 15, 2007

Ms. Leslie Norwalk
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-2258-P
P.O. Box 8017
7500 Security Boulevard
Baltimore, MD 21244-8017

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, N0. 11), January 18, 2006

Dear Ms. Norwalk:

I am writing on behalf of the 16 hospitals serving western North Carolina to comment on the above-referenced proposed changes to the Medicaid program. We are opposed to the proposed changes due to the significant impact on our hospitals and patients.

The WNC Health Network is a collaboration of the 16 hospitals serving the region with an objective of providing cost-effective, quality care to our residents. Our hospitals serve a very rural, mountainous area and are often in isolated communities. Over the past decade, the region has lost most of its manufacturing, textile and furniture plants to foreign competition. The economy of the region survives on tourism, which provides comparatively low-paying jobs with few health care benefits. North Carolina's percentage of uninsured and underinsured population ranks near the top of the nation, while western North Carolina's percentage of 22% is even higher than the statewide average. In 2005, the 16 hospitals collectively provided over $220 million in uncompensated care to the region. These hospitals serve as the safety net for their communities.

The proposed rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. These changes would cause major disruptions to our state Medicaid program and hurt both providers and beneficiaries.

The proposed rule puts forward a new and restrictive definition of "unit of government." In order for a public hospital to meet this new definition, it must demonstrate that it has generally applicable taxing authority or is an integral part of a unit of government that has generally applicable taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Nowhere in the Medicaid statute, however, is there any requirement that a "unit of government" have "generally applicable taxing authority." This new restrictive definition would disqualify many long-standing truly public hospitals from certifying their public expenditures. There is no basis in federal statute that supports this proposed change in definition.

Existing federal Medicaid regulations allow North Carolina hospitals to receive payments to offset a portion of the costs incurred when caring for Medicaid patients. Even with these payments, however, hospital Medicaid revenues for most North Carolina hospitals still fall significantly short of allowable Medicaid costs. If the proposed rule is implemented and, as a result, this important hospital funding stream is eliminated, those losses would be exacerbated. Hospitals would be forced either to raise their charges to insured patients or to reduce their costs by eliminating costly but under-reimbursed services. The first choice would raise health insurance costs by an estimated four percent. The second would eliminate needed services, not just for Medicaid patients but also for the entire community. Eliminating those services likely would result in the elimination of almost 3,000 hospital jobs. That reduced spending and those lost jobs would be felt in local economies and the resulting economic loss to the State of North Carolina has been estimated at over $600 million and almost 11,000 jobs.

Specifically for our 16 western North Carolina hospitals, the loss of this program would mean a $24 million reduction in payments to our hospitals. As noted above, these hospitals are already financially challenged with the rising amount of uncompensated care within the region. Any further reductions in funding could impact the programs and services available to our patients and our ability to serve the vulnerable population.

The proposed effective date for this rule is Sept. 1, 2007. If this devastating rule is not withdrawn, North Carolina hospitals will lose approximately $340 million immediately. The results of that would be disastrous, as we have shared in this comment letter. State Medicaid agencies and hospitals would need time to react and plan in order to even partially manage such a huge loss of revenue. The immediate implementation of this rule would result in major disruption of hospital services in our state.

We oppose the rule and strongly urge that CMS permanently withdraw it. If these policy changes are implemented, the state's health care safety net will unravel, and health care services for thousands of our state's most vulnerable people will be jeopardized.

Sincerely,

Gary Bowers
Executive Director

cc: Senator Elizabeth Dole
Senator Richard Burr
Congressman Heath Shuler
Angel Medical Center
Carepartners Health Services
Cherokee Indian Hospital
Harris Regional Hospital
Haywood Regional Medical Center
Highlands-Cashiers Hospital
Mission Hospitals
Murphy Medical Center
Pardee Memorial Hospital
Park Ridge Hospital
Rutherford Hospital
Spruce Pine Community Hospital
St. Luke's Hospital
Swain Community Hospital
The McDowell Hospital
Transylvania Community Hospital

Submitter : Mr. David LaLumia **Date:** 03/15/2007

Organization : Michigan Association of Community Mental Health Bd

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

See Letter Attached

CMS-2258-P-115-Attach-1.DOC

#115

March 13, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTENTION: CMSB2258BP
Post Office Box 8017
Baltimore, MD 21244B8017

We appreciate the opportunity to comment on the CMS notice of proposed rule making (CMSB2258BP); cost limits for providers operated by units of government and provisions to ensure the integrity of federal state financial partnerships.

The Michigan Association of Community Mental Health Boards represents 46 county-based community mental health services programs that serve all 83 Michigan counties. Eighteen (18) of these organizations meet applicable federal criteria and are designated as prepaid inpatient health plans (PIHPs). The 18 PIHPs manage the Michigan specialty services program for Medicaid beneficiaries with mental illnesses, developmental disabilities and substance use disorders.

While we share the CMS goal of ensuring accountability and fiscal integrity of the Medicaid program, we strongly oppose this proposed rule. This rule, if implemented, will disrupt financing of specialty services in Michigan by applying a narrow definition of governmental entity and limiting reimbursement of public providers and managers of care.

State law, in particular the Michigan Mental Health Code (Act 258 of the Public Acts of 1974 as amended), allow counties to create community mental health programs. The law is also clear that community mental health services programs are public entities that are units of government. Our statute, however, does not grant taxing authority to these governmental entities. This rule could limit the use of county tax revenue as Medicaid match. If these payments from counties to CMHSPs are disallowed, it will result in the loss of substantial funding currently used to serve and support Medicaid beneficiaries who are some of our most vulnerable citizens. These payments are a part of the current financing plan for specialty services in Michigan which has been approved by CMS each time our specialty services waiver has been renewed. To arbitrarily change the definition of government entity in this way will disrupt this legitimate transaction and harm

individuals served under the Michigan specialty services waiver.

Likewise, limiting reimbursement of governmental entities to actual cost will harm Medicaid beneficiaries in Michigan. PIHPs bear risk and must retain the ability to have risk reserves and carry forward funds for services and supports to Medicaid beneficiaries that are specifically approved as part of reinvestment planning. Oversight of Medicaid expenditures by PIHPs is already tightly regulated by our state Medical Services Administration and has been since our initial specialty services waiver in 1998.

This proposed rule will not improve accountability and fiscal integrity of the Michigan specialty services program. It will make it more difficult to manage and provide services and disrupt essential safety net services to Medicaid beneficiaries. **We urge the Center for Medicare and Medicaid Services to withdraw this proposed rule.**

Thank you for this opportunity to comment.

David A. LaLumia, M.S.W.
Executive Director

cc:
The Honorable Carl Levin
The Honorable Debbie Stabenow
Members of the Michigan Congressional Delegation
Governor Jennifer Granholm
Janet Olszewski, Director, Michigan Department of Community Health
Paul Reinhart, Director of Medical Services Administration,
Michigan Department of Community Health
Patrick Barrie, Deputy Director for Mental Health and Substance Abuse Administration,
Michigan Department of Community Health
Don Allen, Director, Office of Drug Control Policy, Michigan Department of
Community Health
Timothy McGuire, Executive Director, Michigan Association of Counties

Submitter : Mr. James Hanko **Date:** 03/15/2007

Organization : North Country Health Services

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-116-Attach-1.DOC

#116

March 14, 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, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

On behalf of North Country Health Services, we appreciate 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 hospital and the patients we serve. The Minnesota Hospital Association has estimated the potential impact to Minnesota hospitals could be well over $100 million dollars.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. These changes would cause major disruptions to our state Medicaid program and hurt providers and beneficiaries alike. And, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

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 and state Medicaid programs that bypasses the congressional approval process and comes on the heels of vocal congressional opposition to the Administration's plans to regulate in this area. Last year 300 members of the House of Representatives and 55 Senators signed letters to Health and Human Services Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. More recently, Congress again echoed that opposition, with 226 House members and 43 Senators having signed letters urging their leaders to stop the proposed rule from moving forward.

We urge CMS to permanently withdraw this rule, and we would like to outline our most significant concerns, which 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; and (4) the absence of data or other factual support for CMS's estimate of savings.

Limiting Payments to Government Providers

The rule proposes 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 CMS 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 2002 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.

New Definition of "Unit of Government"

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 helping states finance their share of Medicaid funding. There is no basis in federal statute that supports this proposed change in definition.

Restrictions on Intergovernmental Transfers (IGTs) and Certified Public Expenditures (CPEs)

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). 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.

Insufficient Data Supporting CMS's Estimate of Spending Cuts

CMS is required to examine relevant data to support the 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 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, the nation's health care safety net will unravel, and health care services for millions of our nation's most vulnerable people will be jeopardized.

Sincerely,

James F. Hanko
President and CEO
North Country Health Services
1300 Anne Street NW
Bemidji, MN 56601
jhanko@nchs.com

Submitter : Mrs. Roshunda Drummond-Dye **Date:** 03/15/2007

Organization : American Physical Therapy Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#117

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mrs. Roshunda Drummond-Dye **Date:** 03/15/2007

Organization : American Physical Therapy Association

Category : Health Care Professional or Association

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachmcnt

GENERAL

GENERAL

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

CMS-2258-P-118-Attach-1.PDF

#118

APTA
American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

March 19, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
P.O. Box 8017
Baltimore, MD 21244-8017

Submitted via Electronic Submission

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 American Physical Therapy Association (APTA)[1], we appreciate the opportunity to submit comments regarding the Medicaid regulations recently issued. Specifically, the Center for Medicare and Medicaid Services (CMS) published a proposed rule in the Federal Register *(72 FR 2236)* on January 18, 2006 under which state Medicaid reimbursements to health care providers operated by local governments could not exceed actual costs.

Under the rule, health care providers, rather than state and local governments, would have to receive all Medicaid reimbursements to which they are entitled. The rule is intended to help eliminate financing agreements under which health care providers receive state Medicaid reimbursements that exceed the actual cost of services and states receive extra matching funds from the federal government as a result.

[1] The APTA is a professional organization representing the interests of over 68,000 physical therapists, physical therapist assistants, and students of physical therapy.

We urge CMS to reconsider the proposed policy and recognize the detrimental effects to access to care that will result if this rule is implemented in its current form. While APTA appreciates the Administration's efforts to reduce Medicaid costs that result from potentially abusive financing arrangements, we believe that any steps to prevent abuses should be taken in a manner that causes the least harm to Medicaid beneficiaries and providers.

Quantifying the Total Impact of the Proposed Rule

CMS estimates the savings from the proposed provisions to the federal government to total about $3.87 billion over five years. In this proposed rule, CMS failed to provide any aggregate data of how these figures were derived. We are concerned that this number may be understated and that further data will show a greater loss of funding to the States to administer their Medicaid programs.

Several States have already expressed their difficulties in maintaining their Medicaid programs under the current funding structure. The further restriction of funds can only result in a loss of additional "optional benefits" to beneficiaries. Physical therapy falls into this category of "optional benefits," although it is currently covered in 37 states. When covered, this benefit serves the most vulnerable Medicaid populations—children and individuals with disabilities.

Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations. Physical therapy is practiced in hospitals, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, sub-acute facilities; patients' homes, education or research centers, schools, and hospices.

APTA is concerned that as the Medicaid system is streamlined to become more efficient and cost-effective, "optional services" such as physical therapy will be marginalized. It is our fear that beneficiaries who could greatly benefit from physical therapy will lose access to these services. Elimination of "optional services," which in fact are essential services could likely cost the states and federal government more when eliminating coverage for physical therapy services could translate to institutionalized care and the development of more severe health conditions.

Limiting Payments to Providers

The proposed regulations appear to prohibit payments of costs other than the marginal expenses associated with treating Medicaid patients, therefore leaving public providers uncompensated for the range of costs that underlie the delivery of healthcare to this vulnerable population. For a majority of these providers, Medicaid is the largest payor

within their patient population. Medicaid reimbursement rates in a majority of the states are already very low in comparison to Medicare and private insurers.

By further limiting payments to providers, physical therapists and other providers will be forced to significantly reduce the number of Medicaid patients that they treat, and in some instances, these providers may choose to withdraw their enrollment from the Medicaid program completely.

In CMS' discussion of limiting payment, the Agency failed to define allowable costs. **APTA is very concerned that in the effort to reduce federal Medicaid funding, important costs for preventive and wellness care services would not be recognized or reimbursed. Physical therapists help patients maintain health by preventing further deterioration or future illness. Private insurers have led the way in implementing prevention and wellness programs, using health information technology, and requiring a team approach in patient care. Medicaid should not be any different from these private initiatives. Both entities aim to provide quality health care, efficiently and cost-effectively.**

Physical therapists are involved in prevention, promoting health, wellness, and fitness, and in performing screening activities. These initiatives decrease program costs by helping Medicaid patients: (1) achieve and restore optimal functional capacity; (2) minimize impairments, functional limitations and disabilities related to congenital and acquired conditions; (3) maintain health; and (4) create appropriate environmental adaptations to enhance independent function.

Conflicts with Current Federal Initiatives

In response to mandates of the recent Deficit Reduction Act of 2005 (DRA), the Department of Health and Human Services outlined new flexibilities available to states that will help people served by Medicaid programs maintain access to affordable health care, and allow states to use innovative approaches to providing health insurance and long-term care services.

On March 31, 2006, as one of its first initiatives in implementing the DRA, CMS issued two "Roadmaps to Medicaid Reform." These documents outline options for states to tailor their benefit packages to select populations and explain ways that states can support individuals with disabilities and long-term care needs.

The roadmap on coverage options outlines how states can:

- Expand access to affordable mainstream coverage;
- Promote personal responsibility for health care; and
- Improve quality and coordination of care.

The long-term care roadmap guides states as they:

- Expand coverage for individuals with disabilities, by moving to beneficiary control of decisions about long-term care services;
- Increase access to community supports; and
- Promote community-based care, independence, and choice.

In addition to the roadmaps, CMS issued letters to State Medicaid Directors that give states the option to amend their state plan to provide alternative benefit packages to beneficiaries without regard to comparability, statewide coverage, freedom of choice or certain traditional Medicaid requirements.

We believe that CMS has made many strides in the right direction in giving states the flexibility to structure their Medicaid program in a manner that works best for their patient population and budgetary environment by implementing the numerous provisions of the DRA and the "Roadmaps to Medicaid Reform." This proposed rule, in its current form, would clearly erode the intent of the DRA and CMS' on-going Medicaid reform efforts. APTA strongly urges the Agency to consider the effect that this proposed rule will have on current initiatives implemented on the federal level and the conflicting message that will be sent to the states that have begun to take advantage of the current reform measures.

APTA appreciates the opportunity to provide these comments and looks forward to working in partnership with CMS, the Administration, and Congress in reforming the Medicaid program while ensuring that beneficiaries have access to comprehensive and quality health care. Please feel free to contact Roshunda Drummond-Dye, Esq., Associate Director of Regulatory Affairs at (703) 706-8547 or at roshundadrummond-dye@apta.org, if you have any questions regarding our comments.

Sincerely,

G. David Mason
Vice President, Government Affairs

Submitter : Mrs. Nancy Payne **Date:** 03/15/2007

Organization : Allina Hospitals and Clinics

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2258-P-119-Attach-1.DOC

#119

Allina Hospitals & Clinics
Regulatory Affairs
PO Box 43 Mail Route 10105
Minneapolis, MN 55440-0043

ALLINA.
Hospitals & Clinics

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, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

On behalf of Allina Hospitals & Clinics (Allina), I appreciate the opportunity to comment on the proposed changes identified in this rule. Allina is a family of hospitals, clinics and care services that believes the most valuable asset people can have is their good health. We provide a continuum of care, from disease prevention programs, to technically advanced inpatient and outpatient care, to medical transportation, pharmacy, durable medical equipment, home care and hospice services. Allina serves communities around Minnesota and in western Wisconsin. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospital and the patients we serve. Although these proposed changes are directed mainly at public or governmental hospitals, any reduction in Medicaid funding impacts our hospitals and the patients we serve. The Minnesota Hospital Association has estimated the potential impact to Minnesota hospitals could be well over $100 million dollars.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. These changes would cause major disruptions to our state Medicaid program and hurt providers and beneficiaries alike. And, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

CMS estimates that the rule will cut $3.9 billion in federal spending over five years. This creates a very significant budget cut for safety-net hospitals and state Medicaid programs that bypasses the congressional approval process and comes on the heels of vocal congressional opposition to the Administration's plans to regulate in this area. Last year 300 members of the House of Representatives and 55 senators signed letters to Health and Human Services Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. More recently, Congress again echoed that opposition, with 226 House members and 43 Senators having signed letters urging their leaders to stop the proposed rule from moving forward.

We urge CMS to permanently withdraw this rule. Our most significant concerns are: (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; and (4) the absence of data or other factual support for CMS's estimate of savings.

Limiting Payments to Government Providers

The rule proposes 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 CMS 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 2002 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.

New Definition of "Unit of Government"

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 helping states finance their share of Medicaid funding. There is no basis in federal statute that supports this proposed change in definition.

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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.

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We oppose this rule and strongly urge that CMS permanently withdraw it. If these policy changes are implemented, the nation's health care safety net will unravel, and health care services for millions of our nation's most vulnerable people will be jeopardized.

Sincerely,

Nancy G. Payne

Nancy G. Payne, RN
Director Compliance and Regulatory Affairs

Submitter : **Deborah Sauers** **Date: 03/15/2007**

Organization : **Prologue Inc.**

Category : **Social Worker**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See attachment

CMS-2258-P-120-Attach-1.DOC

#120

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Louise Howell **Date:** 03/15/2007

Organization : Kentucky River Community Care, Inc.

Category : Health Care Provider/Association

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

CMS-2258-P-121-Attach-1.DOC

CMS-2258-P-121-Attach-2.DOC

#121

Regional Office
PO Box 794
178 Community Way
Jackson, KY 41339
606-666-9006
(fax) 606-666-5840
www.krccares.com

To Whom It May Concern:

My name is Louise Howell, Ph.D. and I represent Kentucky River Community Care, Inc. a Community Mental Health Center in the State of Kentucky. I am writing to comment on two specific ways the proposed regulation CMS 2258-P will impact the Medicaid Behavioral Health System in a number of states.

Cost Limit Provisions in States with At-Risk Provider Contracts

A large number of county governments provide substantial amounts of Medicaid Behavioral Health Services under 1915(b), 1915(c) or 1115 waivers across the country. In many cases the counties are the critical safety net provider, treating the most seriously disabled Medicaid enrollees in their communities.

In many of these systems, the Medicaid health plans use risk-bearing payment mechanisms where counties are sub-capitated or case rated for all or a portion of the Medicaid enrollees. Under these financial arrangements the counties are responsible for meeting the behavioral health needs of enrollees regardless of whether sufficient sub-capitation revenue is available in a given year.

As with any risk-bearing arrangement for the provision of healthcare, revenues do not necessarily match costs in a given month, quarter, or year, and risk reserves are necessary to ensure financial viability of the risk-bearing entity – in this case the county health department.

As currently written, it appears that the drafters of CMS 2258-P did not envision these types of payment arrangements between the MCO and the provider organization. By limiting allowable Medicaid payments to cost, using a cost reporting mechanism that doesn't take into account a risk reserve, it appears that CMS has assumed that all risk is being held by the MCOs/PIHPs. This is not the case in a significant number of waiver states.

The Cost Limits for Units of Government provision, as currently written, would render all of the sub-capitation arrangements with counties financially unsustainable due to the fact that there would be no mechanism for building a risk reserve and managing the mismatch of revenue and expense across fiscal years – something that is a core requirement for health plans and all risk-bearing entities.

This level of federal intervention in the reimbursement and clinical designs of state and local governments appears to be unintended. In essence, the regulation is creating a de facto rule that provider organizations that are units of government cannot enter into Medicaid risk-based contracts.

I am writing to request that this be corrected through a modification of the proposed regulation. **Specifically I am requesting the Cost Limit section of the regulation be revised to include, as allowable cost, an actuarially sound provision for risk reserves when a Unit of Government has entered into a risk-based contract with an MCO or PIHP.**

Intergovernmental Transfers in States with Government-Organized Health Plans

A second issue concerns a number of states where Medicaid Behavioral Health Plans have been set up as government entities by one county or a group of counties to manage the risk-based contract. Under this arrangement, local dollars are paid to the health plan for Medicaid match and these funds are then submitted to the state to cover the match.

In reviewing the proposed regulation, specifically pages 22 – 23, it appears that the intergovernmental agreements that set up the Medicaid Health Plans do not meet the definition of a "unit of government" because the plans were not given taxing authority and the counties have not been given legal obligation for the plan's debts. Thus, it appears that the regulation would render the flow of local dollars, the purpose of which is to supply Medicaid match, un-allowed match, simply because of the chain of custody of those dollars.

This regulatory language, which is intended to prevent provider-related donations, appears to have the impact in a number of states of preventing bona fide local dollars from being use as match. I am writing to request that this be corrected through a modification of the proposed regulation. **Specifically I am requesting the regulation explicitly state that local dollars will be considered valid Intergovernmental Transfers if they originated at a Unit of Government regardless of the entity that submits the payment to the state.**

Sincerely,

Louise Howell, Ph.D.
Executive Director

Submitter : Mr. Michael Pelc **Date:** 03/15/2007

Organization : Detroit Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-122-Attach-1.DOC

#122

DMC
DETROIT MEDICAL CENTER

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, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

The Detroit Medical Center– and its affiliated hospitals: Children's Hospital of Michigan, Detroit Receiving Hospital, Harper-Hutzel Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan, Michigan Orthopaedic Specialty Hospital, and Sinai-Grace Hospital – operate as a private non-profit health care delivery system in the Detroit, Michigan area. Twenty-five percent of the care delivered is provided to Medicaid program patients within the State of Michigan. We appreciate 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.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. These changes would cause major disruptions to our state Medicaid program and hurt providers and beneficiaries alike. And, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

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Insufficient Data Supporting CMS's Estimate of Spending Cuts

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We oppose the rule and strongly urge that CMS permanently withdraw it: If these policy changes are implemented, the nation's health care safety net will unravel, and health care services for millions of our nation's most vulnerable people will be jeopardized.

Sincerely,

Michael A. Pelc
Vice President, Finance
Reimbursement

Submitter : **Date: 03/15/2007**

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2258-P-123-Attach-1.DOC

Stephens County Hospital

2003 Falls Road Tocc oa, Ga. 30577 - 706 282-4200 - Fax 706 886-8045
www.stephenscountyhospital.com

#123

March 14, 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, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

Stephens County Hospital Authority 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 hospital and the patients we serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. These changes would cause major disruptions to Georgia's Medicaid program and hurt providers and beneficiaries alike. And, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

CMS estimates that the rule will cut $3.9 billion in federal spending over five years. The rule will drastically reduce reimbursement for Georgia's "safety net" hospitals, which treat the largest number of indigent and uninsured patients, without any evidence such hospitals ever utilized the financial practices these rules are designed to erase. The preamble describes two financing arrangements which CMS believes are improper: (1) those in which the providers are required to refund a portion of the Medicaid payments received and (2) those in which federal funds are used to absorb costs outside the Medicaid program. Georgia's Medicaid financing arrangement employs none of these characteristics.

This rule also amounts to a budget cut for hospitals and state Medicaid programs that bypasses the congressional approval process and comes on the heels of vocal congressional opposition to the Administration's plans to regulate in this area. Last year 300 members of the House of Representatives and 55 senators signed letters to Health and Human Services Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. More recently, Congress again echoed that opposition, with 226 House members and 43 Senators having signed letters urging their leaders to stop the proposed rule from moving forward.

We urge CMS to permanently withdraw this rule, and we would like to outline our most significant concerns, which 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; and (4) the absence of data or other factual support for CMS's estimate of savings.

Limiting Payments to Government Providers

The rule proposes 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. It is unreasonable for CMS to contend the current UPL program results in excessive payments to hospitals, since such payments are based on Medicare rates, which are clearly non-excessive.

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, including Georgia, have adopted this method of hospital reimbursement, yet CMS is proposing to resurrect a cost-based limit that Congress long ago declared less efficient. Limiting a public hospital's Medicaid payment to the undefined "cost" of its services merely punishes those hospitals who have struggled to reduce their cost. In addition, since the proposed rules impose these cost limits only on government-operated hospitals, they have the insidious effect of paying government hospitals less than private hospitals. There has been no articulated justification for this policy change.

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 2002 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.

New Definition of "Unit of Government"

The proposed rule effectively amend the statutory definition of governmental hospitals – something CMS cannot do without the consent of Congress. Section 1903(w)(7)(G) of the Social Security Act defines the term "unit of government" to include "a city, a county, a special purpose district, ***or other governmental unit in the State***." The statute places no additional requirements to qualify as a governmental unit. CMS's proposed rule, however, impermissibly amend this statutory definition by requiring, for example, that a governmental unit must have "generally applicable taxing authority". There is no basis in federal statute that supports this proposed change in definition.

The proposed rule is so restrictive that only one general acute care hospital in Georgia would qualify as a "unit of government." The State of Georgia owns only one general hospital (in conjunction with its medical school), and none of Georgia's 159 counties own a hospital. This is because the Georgia General Assembly elected over six decades ago to create local hospital authorities to discharge the counties' legal duty of caring for their indigent sick. Both the law creating hospital authorities and subsequent judicial precedent consistently confirm that Georgia hospital authorities are indeed local units of government.

Hospital authorities, however, do not have the power to tax. Instead, counties have the power to impose taxes and to agree by contract to utilize those tax revenues to reimburse hospital authorities for their cost of providing indigent care. Since the proposed rule stipulates that a contractual arrangement is insufficient to qualify the receiving hospital as a unit of government, virtually every hospital authority in the State would be disqualified simply because they receive their funds through contract rather than direct appropriation.

Restrictions on Intergovernmental Transfers (IGTs) and Certified Public Expenditures (CPEs)

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). 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.

Insufficient Data Supporting CMS's Estimate of Spending Cuts

CMS is required to examine relevant data to support the 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 years. But CMS fails to provide any relevant data or facts to support this conclusion. Our hospital alone will lose an estimated $1.7 million annually in federal funding and the overall annual impact in Georgia is estimated to be over $362 million. These figures suggest the actual loss of funding to hospitals and state Medicaid programs is likely far greater than CMS' estimates. 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. As noted previously, Georgia does not do so. 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, Georgia's health care safety net will unravel, and health care services for millions of vulnerable people in both Georgia and the rest of the nation will be jeopardized.

Sincerely,

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Submitter : Mr. Clayton Hanson **Date:** 03/15/2007

Organization : Alaska Native Health Board

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2258-P-124-Attach-1.PDF

#124

Alaska Native Health Board

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March 14, 2007

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
P.O. Box 8017
Baltimore, MD 21244-8017

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:

The Alaska Native Health Board is a recognized statewide voice regarding health care services provided to Alaska Natives and other eligible individuals pursuant to compacts and funding agreements with the United States Indian Health Service. We promote the spiritual, physical, mental, social, and cultural well-being of Alaska Native people.

We also serve as advisor to the Director of the Alaska Area Native Health Service, to the United States Senate Committee on Indian Affairs, to the U.S. House Committee On Interior and Insular Affairs, to the Alaska Legislature, and to your own Department of Health and Human Services.

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, and as clarified by the letter of June 9, 2006. Unfortunately, we are convinced that, as written, the proposed rule would, in fact, negatively affect Tribal 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 these determinations will almost certainly negatively affect the willingness of States to enter into cost sharing agreements with Indian Tribes since any error in the determination regarding this undefined term could have serious 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 by a contract or compact under 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 these 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. [1]

[1] The October letter contained the incorrect footnote that said ISDEAA funds cannot be

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.

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

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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").

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.

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.

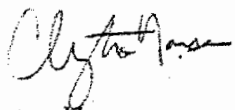
The caveat to paragraph (2) above regarding the source of payments was added to expressly address a new limitation that CMS proposed on February 23, 2007, with regard to approving the Washington State Medicaid Administrative Match Implementation Plan to exclude any "638 clinics that are reimbursed at 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. This type of exclusion would swallow the rule that allows Indian Tribes and Tribal organizations to participate 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,



Clayton Hanson
Interim President/CEO

Cc: National Indian Health Board