National Association of
Children's Hospitals

N • A • C • H

March 12, 2007

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2258-P
7500 Security Boulevard
Mail Stop C4-26-05
Baltimore, MD 21244-1850

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

Dear Centers for Medicare and Medicaid Services:

The National Association of Children's Hospitals (N.A.C.H.) is pleased to provide comments to the Centers for Medicare and Medicaid Services (CMS) on its Medicaid administrative rule published in the January 18th *Federal Register*. The changes proposed in this regulation would have a negative impact on children's hospitals and the children they serve. We ask that you stop implementation of this regulation until the significant direct and indirect effects of the proposed changes can be closely examined and addressed.

The regulation as proposed would cut Medicaid funding by $3.8 billion, which would significantly limit the funding available for state Medicaid programs. If this regulation were to go into effect as planned in September 2007, most states could face significant Medicaid funding shortfalls that could result in cuts to the program. Therefore, the new restrictions in the proposed rule would not only impact public providers, but also all beneficiaries, especially children, and all health care providers participating in the program.

Over the years, Congress and CMS have repeatedly addressed the need for limitations on state financing. Some of the most recent regulatory changes related to upper payment limits are still being phased in. The need for additional restrictions on state financing is unsubstantiated. Not only would additional changes have a negative effect on children and children's providers, but they are unnecessary.

The annual growth in federal Medicaid spending has declined significantly due to both improvements in the economy and cost containment policies adopted by states in

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recent years. Federal spending on Medicaid is not out of control and does not warrant changes such as those proposed, which would have a negative impact on the health care safety net.

We understand the need to protect the fiscal integrity of the Medicaid program, but we do not agree with the proposed changes that would negatively impact the nation's most vulnerable children and the providers who care for them.

**Negative Impact on Children Covered by Medicaid**
Changes to the way states finance their Medicaid programs would have real consequences for the 29 million children in the country who rely on Medicaid for health insurance coverage. Because children are the majority of Medicaid enrollees any changes made to the program, such as those in the proposed regulation, would have a disproportionate impact on them.

The children treated at children's hospitals rely on Medicaid and the coverage it provides for all medically necessary care. With insufficient financing for their share of Medicaid, states would be forced to find new funding sources or make cuts to the program, which could directly affect children's eligibility and the benefits and services provided. These types of cuts would have a significant impact on our patients and threaten our ability to provide quality health care to all children.

As several states and Congress discuss ways to expand coverage to more uninsured children, this regulation would threaten funding for the program that provides health insurance coverage for more than one in four children in the United States.

**Threatens the Viability of Children's Hospitals – the Safety Net for All Children**
Not only does the proposed regulation threaten the financial viability of public safety net providers, it would also threaten reimbursement for children's hospitals. Children insured by Medicaid account for over half of all inpatient days of care provided at free-standing acute care children's hospitals. Children's hospitals, on average, are reimbursed 78 percent of the cost of care provided even when disproportionate share hospital payments are included in the calculation of total payment. Because Medicaid is such a large payer and existing Medicaid payments do not cover costs, any changes to Medicaid can have a profound impact on children's hospitals and their ability to serve all children.

States faced with budget shortfalls would likely institute reimbursement cuts, which could include disproportionate share hospital payment decreases, to make up for the loss of federal funds. Because a large percentage of our patients rely on Medicaid for their health insurance coverage, any decreases in reimbursement impact our ability to provide care to all children.

When faced with payment decreases, our hospital faces tough decisions about the potential for service cutbacks. These cutbacks affect all children, not just children on Medicaid. Any efforts to address these financing mechanisms should consider the

significant impact changes would have on children's hospitals' ability to receive adequate funding and continue to provide health care services to all children.

**Conclusion**

As you can see from our comments, we are extremely concerned about this proposed regulation and the impact it would have on children enrolled in Medicaid and on children's hospitals. We encourage CMS to delay the implementation of the regulation to allow time for a thorough review of the proposed regulation's impact on children enrolled in Medicaid and the providers who serve them.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Aimee Ossman at 703-797-6023 or aossman@nachri.org. Thank you for your consideration.

Sincerely,

Peters D. Willson

Peters D. Willson
Vice President, Public Policy
National Association of Children's Hospitals

CHRISTUS
SANTA ROSA
Children's Hospital

March 8, 2007

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2258-P
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Sir/Madam:

On behalf of the children in our community served by Medicaid, CHRISTUS Santa Rosa Children's Hospital in San Antonio, TX, is pleased to provide comments to the Centers for Medicare and Medicaid Services (CMS) on its Medicaid administrative rule published in the January 18th Federal Register. The changes proposed in this regulation would have a negative impact on our hospital and the children we serve. We ask that you stop implementation of this regulation until the significant direct and indirect effects of the proposed changes can be closely examined and addressed.

The regulation as proposed would cut Medicaid funding by $3.8 billion, which would significantly limit the funding available for state Medicaid programs. If this regulation were to go into effect as planned in September 2007, our state could face a significant Medicaid funding shortfall that could result in cuts to the program. Texas would lose nearly $300M and Bexar County would lose nearly $37 M to our Medicaid program. Therefore, the new restrictions in the proposed rule would not only impact public providers, but also all beneficiaries, especially children, and all health care providers participating in the program.

We understand the need to protect the fiscal integrity of the Medicaid program, but we do not agree with the proposed changes that would negatively impact the nation's most vulnerable children and the providers who care for them.

**Negative Impact on Children Covered by Medicaid**

Changes to the way states finance their Medicaid programs would have real consequences for the 29 million children in the country who rely on Medicaid for health insurance coverage. In our state, 1.9 million children have Medicaid coverage and these children make up 70 percent of the state Medicaid population. Because children are the majority of Medicaid enrollees any changes made to the program, such as those in the proposed regulation, would have a disproportionate impact on them.

At CSRCH in FY06 79% of our inpatient days were Medicaid and our total Medicaid days were 33,000. We have the only Level 3c NICU in our area serving mainly Medicaid newborns. The children we treat rely on Medicaid and the coverage it provides for all medically necessary care. With insufficient financing for their share of Medicaid, states would be forced to find new funding sources or make cuts to the program, which could directly affect children's eligibility and the benefits and services provided. These types of cuts would have a significant impact on our patients and threaten our ability to provide quality health care to all children.

333 North Santa Rosa Street | San Antonio Texas 78207.3198
Tel 210.704.2011

As several states and Congress discuss ways to expand coverage to more uninsured children, this regulation would threaten funding for the program that provides health insurance coverage for more than one in four children in the United States.

**Additional Changes Unnecessary**

Over the years, Congress and CMS have repeatedly addressed the need for limitations on state financing. Some of the most recent regulatory changes related to upper payment limits are still being phased in. The need for additional restrictions on state financing is unsubstantiated. Not only would additional changes have a negative effect on children and children's providers, but they are unnecessary.

The annual growth in federal Medicaid spending has declined significantly due to both improvements in the economy and cost containment policies adopted by states in recent years. Federal spending on Medicaid is not out of control and does not warrant changes such as those proposed, which would have a negative impact on the health care safety net.

**Conclusion**

As you can see from our comments, we are extremely concerned about this proposed regulation and the impact it would have on children enrolled in Medicaid and on children's hospitals. We encourage CMS to delay the implementation of the regulation to allow time for a thorough review of the proposed regulation's impact on children enrolled in Medicaid and the providers who serve them.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Ms. Vicki Perkins at (210)313-2386 or vicki.perkins@christushealth.org. Thank you for your consideration.

Sincerely,

Vicki S Perkins

Vicki S. Perkins, Director of Advocacy and Public Policy

CALIFORNIA

children's

HOSPITAL

ASSOCIATION

March 14, 2007

1215 K STREET
SUITE 1930
SACRAMENTO, CA 95814

916.552.7119
FAX: 916.552.7119

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

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

Dear Ms. Norwalk:

On behalf of California's Children's hospitals, I write to provide comments to the Centers for Medicare and Medicaid Services (CMS) on its Medicaid administrative rule published in the January 18th *Federal Register*. We oppose this rule as written, and ask that you withdraw it. If implemented, this proposed rule will have a devastating impact on California's safety net hospitals and the patients served.

This 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, especially children. If this regulation were to go into effect as planned in September 2007, California could face a significant Medicaid funding shortfall that could result in cuts to the program. It is estimated that California's safety net hospitals could lose approximately $550 million per year for the next three years, and potentially millions more beyond that period.

Medicaid funding to California's safety net providers is based on a waiver that was negotiated between the state and the Center for Medicare and Medicaid Services(CMS) in June 2005. Because this rule explicitly states that its provisions will apply to state waivers, I am concerned that it will limit the availability of funds, already negotiated in the waiver, to California for safety net providers.

The magnitude of the anticipated losses could result in hospital closures in California and the diminished ability to provide services to vulnerable populations such as children. In addition, entire communities could be negatively impacted by the loss or reduction of emergency, trauma, burn, and other essential life saving services that safety net hospitals provide. While the rule could directly and immediately impact public safety net hospitals, I believe that this rule could create a domino effect that would be damaging to California's entire health care system, including children's hospitals.

Many of the children we treat rely on Medicaid and the coverage it provides for all medically necessary care. With insufficient financing for their share of Medicaid, states like California could be forced to find new funding sources or make cuts to the program, which could directly affect children's eligibility and the benefits and services provided.

We urge CMS to permanently withdraw this rule. We understand the need to protect the fiscal integrity of the Medicaid program, but we do not agree with the proposed changes that would negatively impact the nation's most vulnerable children and the providers who care for them. Please contact me at 916-552-7111 should you need additional information. Thank you for your consideration.

Sincerely,

Diana S. Dooley
President & CEO

# Carolinas Rehabilitation

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 to oppose the above regulation on behalf of the largest rehabilitation hospital in the Carolinas at 133 beds, and the only such comprehensive rehab hospital in the local 28 county region of North Carolina. Carolinas Rehabilitation hospital provides a substantial volume of service to Medicaid beneficiaries because many clinical programs such as brain injury, spinal cord injury and others are not available anywhere else in the region.

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 and specialty 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.

1100 Blythe Boulevard • Charlotte, NC 28203 • 704-355-4300

Although there are many troublesome aspects of the proposed regulation, the provision that will have the most detrimental effect to the Carolinas Rehabilitation hospital is the proposed definition of "unit of government." and Non-Public hospitals. Over 40 of North Carolina public hospitals have been participating in Medicaid programs as public hospitals for over a decade with the full knowledge and approval of CMS. 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 wiping out entire valuable programs that are otherwise fully consistent with all of the Medicaid statutes is unreasonable and objectionable. Carolinas Rehabilitation hospital respectfully requests that CMS reconsider its position on the definition of unit of government and defer to applicable State law. This narrow definition basically eliminates all public hospitals in the country as so few have taxing authority since most public hospital boards are to elected by the electorate.

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 beyond the September 1, 2007 date to allow for a reasonable organized response by the State and participating hospitals. 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, because 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. **A minimum of least two years is necessary for the affected stakeholders to try to mitigate the detrimental impact of the changes.** It is our understanding that CMS has set precedent for 3+ years transitions in the past for significant changes such as the UPL change for Pennsylvania Nursing homes several years ago. Why then, should this rule have a less than one year period for hospitals and states to adjust? This is not only unfair, but it is unrealistic for us to make much significant adjustments in the provision of care due to the dramatic reductions in payment that will occur.

Carolinas Rehabilitation hospital 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 Rehabilitation hospital urges CMS to adopt a more reasonable implementation schedule that allows for at least two full years but preferably 3-5 years before the changes take effect. Thank you for your consideration.

Respectfully Submitted,

Dennis Phillips, President
Carolinas Medical Centers-Charlotte

DP:sd

Cc: Senator Elizabeth Dole
Senator Richard Burr
Congresswoman Sue Myrick
Congressman Mel Watt
Congressman Robin Hayes

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# Carolinas Medical Center

Carolinas HealthCare System

March 15, 2007

*Suzanne H. Freeman*
*President*

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 you to oppose the above regulation on behalf of Carolinas Medical Center (CMC), the largest safety net hospital in North Carolina and the largest Medicaid provider in North Carolina.

Having worked in North Carolina healthcare arena since the early 70's and at CMC for about 25 years, this proposed rule will not only 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 but it will be the single most devastating event in the history of Medicaid in North Carolina. It is estimated that the impact of this proposed regulation on the North Carolina Medicaid program is that at least $340 Million in annual expenditures presently used to provide hospital care for these vulnerable populations will disappear overnight creating immense problems with healthcare delivery and the financial viability of the safety net hospitals. At CMC we will experience a reduction of over 20% of amounts provided from CMC operations for capital and debt service.

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." Our understanding is that all of these 43 public

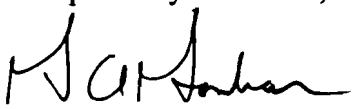
hospitals are in fact public hospitals under applicable State law. Substantially all of them have been participating in Medicaid programs as public hospitals for over a decade with the full knowledge and approval of CMS. Each public hospital certifies annually that it is owned or operated by the State 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 CMS's 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. In fact, CMC, which is a division of the Charlotte Mecklenburg Hospital Authority, which was organized in 1943 under the North Carolina Hospital Authorities Act, and is a public body would not be a public hospital under CMS's very narrow definition. 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. CMC 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 of NC and the participating hospitals. CMC believes that the consequences of allowing anything less than two full years before the rule takes effect will be catastrophic. Having September 1, 2007, as an effective date basically cuts the knees off of the NC program and does not allow adequate time to obtain other funding. 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, because 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. Ironically, CMS has approved on multiple occasions the NC SPA definition of a public hospital, going back to 1996 and as recently as the current SPA, and now they choose to do a 180 degree reversal and disallow as public virtually all hospitals they had approved as public for the last 10 years. At least two years is necessary for the affected stakeholders to try to mitigate the detrimental impact of the changes.

CMC 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, CMC 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,



Greg A. Gombar
Executive Vice President
Administrative Services-CFO

GAG:sd

Cc: Senator Elizabeth Dole
Senator Richard Burr
Congresswoman Sue Myrick
Congressman Mel Watt
Congressman Robin Hayes

6


# NEW YORK STATE CONFERENCE OF LOCAL MENTAL HYGIENE DIRECTORS, INC.

99 Pine St., Suite C100 ▲ Albany, NY 12207 ▲ (518) 462-9422 ▲ FAX (518) 465-2695
E-MAIL: clmhd@clmhd.org ▲ www.clmhd.org




March 9, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
P.O. Box 8017
Baltimore, Maryland, 21244-8017

Re: Code # 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 (42 CFR Part 433, 447 and 457)

On behalf of the New York State Conference of Local Mental Hygiene Directors (NYSCLMHD), I am commenting on the above-referenced proposed rule published in the Federal Register of January 18, 2007 on pages 2236 to 2248.

The NYSCLMHD is created in state statute and is a membership association comprised of the Commissioners and Directors of Mental Hygiene in each of the 57 counties and the City of New York.

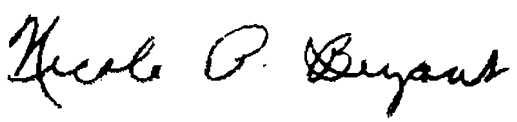
Our members, representing consumers, providers and their respective county governments are concerned that the proposed rule would seriously undermine mental hygiene services in two primary ways. First, new limitations proposed in the regulatory definition of allowable costs for providers which are units of government would be particularly harmful to the continuing viability of the range of services available to seriously mentally ill adults and children living in our communities.

Also, new limitations on allowable services under the rehabilitation option would be particularly harmful to persons with mental retardation and currently receiving health-related specialty services which allow them to participate meaningfully and in a more mainstreamed manner in the public education system.

Additionally, more rural counties appear to be disproportionately disadvantaged/singled out by the proposed rule because (i) there are few if any alternative providers not subject to the costs limitation (not-for-profit agencies which are more available in more populous jurisdictions) which could substitute services previously provided by a rural county-operated clinic, and (ii) a county is particularly dependent on Medicaid transportation funding because of large travel distances for poor clients, so that proposed new limitations on Medicaid transportation could be disproportionately disadvantageous by isolating seriously mentally disabled clients living in the community.

We urge you to reconsider the potential harm to some of our most disenfranchised and disabled citizens that will result from promulgation of this rule, and withdraw it from further consideration.

Very truly yours,



Nicole Bryant, LMSW
Chair

cc: Honorable Charles Schumer, Member, U.S. Senate
Honorable Hillary Clinton, Member, U.S. Senate
Honorable Gary Ackerman, Member, U.S. House of Representatives
Honorable Michael Arcuri, Member, U.S. House of Representatives
Honorable Timothy Bishop, Member, U.S. House of Representatives
Honorable Yvette D. Clarke, Member, U.S. House of Representatives
Honorable Joseph Crowley, Member, U.S. House of Representatives
Honorable Eliot Engel, Member, U.S. House of Representatives
Honorable Vito Fossella, Member, U.S. House of Representatives
Honorable Kirsten E. Gillibrand, Member, U.S. House of Representatives
Honorable John J. Hall, Member, U.S. House of Representatives
Honorable Brian Higgins, Member, U.S. House of Representatives
Honorable Maurice Hinchey, Member, U.S. House of Representatives
Honorable Steve Israel, Member, U.S. House of Representatives
Honorable Pete King, Member, U.S. House of Representatives
Honorable Randy Kuhl, Member, U.S. House of Representatives
Honorable Nita Lowey, Member, U.S. House of Representatives
Honorable Carolyn McCarthy, Member, U.S. House of Representatives
Honorable John M. McHugh, Member, U.S. House of Representatives
Honorable Michael R. McNulty, Member, U.S. House of Representatives
Honorable Carolyn Maloney Member, U.S. House of Representatives
Honorable Gregory W. Meeks, Member, U.S. House of Representatives

Honorable Jerrold Nadler, Member, U.S. House of Representatives
Honorable Charles B. Rangel, Member, U.S. House of Representatives
Honorable Thomas M. Reynolds, Member, U.S. House of Representatives
Honorable Jose E. Serrano, Member, U.S. House of Representatives
Honorable Louise Slaughter, Member, U.S. House of Representatives
Honorable Edolphus Towns, Member, U.S. House of Representatives
Honorable Nydia M. Velazquez, Member, U.S. House of Representatives
Honorable Jim Walsh, Member, U.S. House of Representatives
Honorable Anthony D. Weiner, Member, U.S. House of Representatives

7

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

March 8, 2007

Leslie Norwalk, Esq., Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

MAR 12 2007

**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 Administrator Norwalk:

The National Association of Public Hospitals and Health Systems (NAPH) is pleased to submit the attached comments expressing our serious concern about the devastating impact of the above-referenced Proposed Rule on the nation's health system. NAPH represents more than 100 metropolitan area safety net hospitals and health systems. Our members fulfill a unique and critical role in the health care system providing high intensity services—such as trauma, neonatal intensive care, and burn care—to the entire community. NAPH members are also the primary hospital providers of care in their communities for Medicaid recipients and many of the more than 46 million Americans without insurance. NAPH hospitals represent only 2 percent of the acute care hospitals in the country but provide 25% of the uncompensated hospital care provided across the nation. Our members are highly reliant on government payers, with nearly 70% of their net revenue from federal, state, and local payers.

We strongly believe that the Proposed Rule will very seriously compromise the future ability of NAPH members and other safety net hospitals to serve Medicaid patients and the uninsured and to provide many essential, community-wide services. The harm that will be inflicted on the health safety net by this rule will also inflict fiscal crises on many states and increase the numbers of uninsured, at a time when we should be searching for ways to improve (not diminish) access and coverage.

In 2000, the Institute of Medicine issued a landmark report, *America's Health Care Safety Net: Intact but Endangered*, which recommended that, "Federal and state policy makers should explicitly take into account and address the full impact (both intended and unintended) of changes in Medicaid policies on the viability of safety net providers and the populations they serve." Last fall, the IOM reconvened the commission that produced the report and emphatically restated the findings and recommendations from 2000. Even without the Proposed Rule, the situation of the health safety net is more fragile than ever.

The attached NAPH comments detail many specific concerns about the Proposed Rule. However, please be aware that our primary recommendation is that CMS withdraw the Proposed Rule and work with the Congress and with state and local stakeholders to develop policy alternatives that would strengthen -- not undermine -- the nation's health safety net (and with it, the entire health system).

NAPH appreciates the opportunity to submit these comments. If you have any questions, please contact me or Charles Luband or Barbara Eyman at NAPH counsel Powell Goldstein (202) 347-0066.

Respectfully,

Larry S. Gage
President

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

**March 8, 2007**

**COMMENTS BY THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS ON PROPOSED RULE: CMS-2258-P – Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership**

**Prepared on behalf of NAPH by Powell Goldstein, LLP**

The National Association of Public Hospitals and Health Systems (NAPH) urges the Centers for Medicare and Medicaid Services (CMS) to withdraw Proposed Rule CMS-2258-P (the Proposed Rule). The Proposed Rule exceeds the agency's legal authority, defies the bipartisan opposition of a majority of the Members of Congress and would, in short order, dismantle the intricate system of Medicaid-based support for America's health care safety net, seriously compromising access for Medicaid and uninsured patients. Without any plan for replacement funding, CMS would eliminate billions of dollars of support payments that have traditionally been used to ensure that the nation's poor and uninsured have access to a full range of primary, specialty, acute and long term care. The cuts would restrict funding that has ensured that our communities are protected with adequate emergency response capabilities, highly specialized but under-reimbursed tertiary services (such as trauma care, neonatal intensive care, burn units and psychiatric emergency care), and trained medical professionals. The result of this regulation would be a severely compromised safety net health system, unable to meet current demand for services and incapable of keeping pace with the fast-paced changes in technology, research and best practices that result in the highest quality care.

NAPH endorses CMS' stated goal of ensuring accountability and protecting the fiscal integrity of the Medicaid program. Over the years, Congress and CMS have taken a series of steps to advance these goals with respect to both provider payments and non-federal share financing. These efforts have included restrictions on provider taxes and donations, statewide and hospital-specific limitations on Disproportionate Share Hospital (DSH) payments and a series of modifications to regulatory upper payment limits. All of these steps were taken by or with the consent of Congress.

Over the last three years, CMS has significantly increased its oversight of payment methodologies and financing arrangements in state Medicaid programs, working with states to restructure their programs as necessary to eliminate inappropriate federal matching arrangements. Officials from the Department of Health and Human Services (HHS) have repeatedly claimed success from this initiative, stating that they have largely eliminated "recycling" from those programs under scrutiny. Indeed, since the publication

of the Proposed Rule, it is our understanding that CMS provided to Members of Congress data indicating that its efforts have been enormously successful, with 22 states listed as using intergovernmental transfers (IGTs) appropriately, 30 listed as having removed "recycling" from their programs and 23 with no IGT financing.[1] According to these data, there are only three states about which CMS has any remaining concerns. Clearly the steps taken by Congress and CMS to date have addressed the concerns CMS has raised about state financing mechanisms and it is unclear why CMS feels the need to proceed with this rulemaking. Nor does the agency explain how the restrictive policies in the Proposed Rule will further its stated goals. Instead, the Proposed Rule imposes payment and financing policies that go far beyond merely institutionalizing the oversight procedures CMS has used successfully to date. These policies would cut deep into the heart of Medicaid as a safety net support program with no measurable increase in fiscal integrity.

In its Regulatory Impact Analysis, CMS asserts that the Proposed Rule will not have a significant impact on providers for which relief should be granted, and it projects "this rule's effect on actual patient services to be minimal."[2] It estimates $3.9 billion in federal savings from the Proposed Rule over five years, but provides no detail on how it derived this estimate. From NAPH's survey of its own members, it is clear that CMS has significantly understated the impact of the Proposed Rule on providers, on patients and on total federal Medicaid funding provided to states. Although we do not have sufficient nationwide data to estimate the total amount of funding cuts imposed by the Proposed Rule, data from just a few NAPH members and states illustrates how grossly understated CMS' projections of the impact are.

For example, Florida estimates that its hospitals will lose $932 million. The estimated statewide loss of federal dollars is at least $253 million in Georgia, at least $350 million in New York and is $374 million in Texas. These state programs are not ones that CMS has identified as abusive; on the contrary, CMS has reviewed these hospital payment and financing programs and approved them as legitimate. Despite their current legitimacy, the Proposed Rule will cut payment rates and eliminate approved sources of non-federal share funding in each of these programs. As a result, safety net health systems' ability to serve Medicaid and uninsured patients will be compromised and state Medicaid programs will face substantial budget shortfalls with no apparent gain in fiscal integrity. Moreover, CMS would impose these cuts immediately, effective September 1, 2007, providing no time for state legislators to overhaul their program financing to come into compliance with the new requirements.

CMS's response to concerns about lost funding for important health care needs is that it is Congress' job to determine whether such federal support is needed. NAPH

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[1] *Summary of State Use of IGTs and Recycling,* as of 11/14/06. Several states are listed in more than one category as they have structured different IGT programs for different types of services.
[2] 72 Fed. Reg. at 2245.

respectfully submits that Congress has already determined that such federal support is needed and that states may use their Medicaid programs to provide it. Above-cost Medicaid payments based on Medicare rates have been part of the Medicaid payment system for years. Congress has explicitly rejected CMS' proposals to impose provider-specific cost-based payment limits;[3] it has required the adoption of regulations with aggregate rather than provider-specific limits;[4] it long ago freed states from mandatory cost-based payment systems to allow for the proliferation of payment systems more tailored to localized needs;[5] and it has acquiesced with no expressed concern in the development of supplemental Medicaid payment systems in which states have used the Medicaid program as the primary source of federal support for safety net health care. If Congress is the only entity that can authorize replacement funding, then Congress should also be the entity to consider the types of sweeping payment and financing changes that CMS proposes.

In the wake of President Bush's FY 2007 budget proposal to restrict funding and payment flexibility by regulation, a substantial majority of the House and Senate went on record urging the Administration not to move forward administratively. Members of the 110th Congress have had a similar response. The National Governors Association has also expressed its deep concern about the impact of the Proposed Rule on the governors' ability to implement health reform options and expand affordable health insurance coverage. Given the overwhelming bipartisan opposition to this Proposed Rule and the means by which it is being adopted, CMS should withdraw its proposal immediately.

After a brief summary in the first section, the second section of these comments raises significant legal and policy concerns about three major aspects of the Proposed Rule:

- The limit on payments to governmental providers to the cost of Medicaid services;
- The definition of a unit of government; and
- The restriction on sources of non-federal share funding;

Thereafter, we raise several technical concerns, comments and questions about various aspects of the Proposed Rule, and comment on CMS' Regulatory Flexibility Act analysis.

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[3] Budget of the United States Government, Fiscal Year 2005, pages 149-150; Budget of the United States Government, Fiscal Year 2006, page 143; Letter from Michael O. Leavitt, Secretary of Health and Human Services, to the Honorable Richard B. Cheney, President, United States Senate, August 5, 2005 (transmitting legislative language to Senate implementing the fiscal year 2006 proposals); Letter from Michael O. Leavitt, Secretary of Health and Human Services, to the Honorable J. Dennis Hastert, Speaker of the House of Representatives, August 5, 2005 (transmitting legislative language to House of Representatives implementing the fiscal year 2006 proposals). Congress has rejected each of these proposals.

[4] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), H.R. 5661, 106th Cong., (enacted into law by reference in Pub. L. No. 106-554, § 1(a)(6)), Section 705(a).

[5] Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173.

## I. SUMMARY OF COMMENTS

NAPH's major concerns about the Proposed Rule center around (1) the cost limit on Medicaid payments to governmental providers, (2) the new and restrictive definition of a "unit of government" and (3) the restrictions on sources of non-federal share funding.

The cost limit would impose deep cuts in funding for the health care safety net, with serious repercussions on access and quality for low-income Medicaid and uninsured patients. The cuts would not result in any measurable improvement in the fiscal integrity of the Medicaid program. Cost-based payments and limits are inherently inefficient, rewarding providers with high costs. The current upper payment limits, based on what Medicare would pay for the same services and calculated in the aggregate for each category of hospital, are reasonable (Medicare does not pay excessive rates) and allows states appropriate flexibility to target support to communities and providers where it is most needed.

Moreover, governmental providers, who disproportionately serve the uninsured, should not be subject to a more restrictive limit than private providers. Imposing a cost limit would undermine important policy goals shared by the Administration and providers alike – such as quality, patient safety, emergency preparedness, enhancing access to primary and preventative care, reducing costly and inappropriate use of hospital emergency departments, adoption of electronic medical records and other health information technology and reducing disparities. Finally, the cost limit would violate federal law in at least four respects. First, it will prevent states from adopting payment methodologies that are economic and efficient and that promote quality and access in contravention of Section 1902(a)(30)(A) of the Social Security Act (SSA); second, it defies simplicity of administration and ignores the best interests of Medicaid recipients that states are required to safeguard pursuant to Section 1902(a)(19); third, it would violate Section 705(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 by adopting upper payment limits that are not based on the proposed rule announced on October 5, 2000; and fourth, it would prohibit states from adopting prospective payment systems for their governmentally-operated federally qualified health centers and rural health clinics as required by Section 1902(bb) of the SSA. CMS should not modify the current upper payment limits.

We also believe that CMS does not have the authority to redefine a "unit of government." The statutory definition contained in Section 1903(w)(7)(G) of the SSA does not limit the term to entities that have taxing authority. CMS is far exceeding its authority in placing such a significant restriction on the much broader definition adopted by Congress. Congress' definition afforded due deference to states' determination of which of its instrumentalities are governmental, as required by Constitutional principles of federalism. CMS' proposed definition is an unprecedented intrusion into the core of states' rights to

organize themselves as they deem necessary. The definition also undermines the efforts of states and localities to carry out a core governmental function (ensuring access to health care) through the most efficient and effective means. Countless governments have organized or reorganized public hospitals into separate governmental entities in order to provide them with the autonomy and flexibility to deliver high quality, efficient health care services in an extremely competitive market, yet the Proposed Rule would not recognize such structures as governmental. CMS should defer to state designations of governmental entities.

In asserting that intergovernmental transfers (IGTs) can only be derived from tax revenues, the preamble to the Proposed Rule ignores the much broader nature of public funding. States, local governments and governmental providers derive their funding from a variety of sources, not just tax proceeds, and such funds are no less public due to their source. Limiting IGTs to tax revenues will deprive states of long-standing funding sources for the non-federal share of their programs, leaving them with significant budget gaps that can only be filled by diverting taxpayer funds from other important priorities or cutting their Medicaid programs. Moreover, CMS does not have authority to restrict local sources of funding under Section 1902(a)(2) of the SSA without explicit congressional authorization to do so. CMS should allow all public funding, regardless of its source, to be used as the non-federal share of Medicaid expenditures.

NAPH also raises several more technical issues and concerns about the regulation. Our recommendations in this regard include:

Cost Limit

- CMS should clarify that the limit based on the "cost of providing covered Medicaid services to eligible Medicaid recipients" does not exclude costs for disproportionate share hospital payments or payments authorized under Section 1115 demonstration programs.
- The definition of allowable costs should not be restrictive and should include all costs necessary to operate a governmental provider.
- CMS should confirm that graduate medical education costs would be allowable.
- CMS should clarify that the cost limit applies only to institutional governmental providers and not professional providers that may be employed by or affiliated with governmental entities.
- CMS should allow states to calculate the cost limit on a prospective basis.
- CMS should allow states to make direct payments to governmental providers for unreimbursed costs of serving Medicaid managed care enrollees.

Unit of Government Definition

- CMS should eliminate the requirement that units of government have taxing authority and should defer to state law determinations of public status.
- CMS should clarify that it is not altering federal or state law interpretations of public status outside of the provisions of the Proposed Rule.

Certification of Public Expenditures

- CMS should allow the use of certified public expenditures (CPEs) to finance payments not based on costs.
- CMS should confirm the mandatory and permissive nature of various steps in the reconciliation process.

Retention of Payments

- CMS should clarify whether the retention provision applies to CPEs.
- CMS should eliminate the provision providing authority for the Secretary to review "associated transactions."

Section 1115 Waivers

- CMS should clarify that states may maintain current levels of funding for the safety net care pools, low income pools and expanded coverage established through Section 1115 demonstration projects notwithstanding the new cost limit.
- CMS should clarify that other states may use waivers to adopt similar pools or coverage based on savings incurred by reducing governmental payments to cost.

Upper Payment Limit (UPL) Transition

- CMS should revise the regulation to ensure that it has no impact on transition payments made pursuant to upper payment limit regulations revised in 2001 and 2002.

Provider Donations

- CMS should clarify that it will not view transfers of taxpayer funding as provider donations.

Effective Date

- CMS should extend the effective date of the regulation and provide at least a ten-year transition period.
- CMS should clarify that all parts of the regulation will be imposed prospectively only.

Consultation with Governors

- CMS should immediately consult with states on the Proposed Rule and modify or withdraw it based on state concerns.

Finally, NAPH believes that in its Regulatory Flexibility Act analysis, CMS has seriously underestimated the impact that the Proposed Rule will have. The Proposed Rule will impose significant costs on states and providers in connection with new administrative burdens it establishes. The cost to states of developing new payment systems, adopting new financing mechanisms to pay for the non-federal share, developing new cost reporting systems and administering and auditing them will be significant. The cost to providers of complying with these new requirements is also substantial. More importantly, however, CMS vastly understates the direct and significant impact that the Proposed Rule will have on patient care, as providers and states struggle to cope with multi-million dollar funding cuts. In addition, the Proposed Rule will negatively impact local economies that are built around providers affected by this regulation. CMS should reevaluate its estimate of the impact of the Proposed Rule and the need for regulatory relief under the Regulatory Flexibility Act.

## II. MAJOR LEGAL AND POLICY CONCERNS

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

NAPH objects to the new cost limit on Medicaid payments to government providers under the Proposed Rule on a number of grounds.

*1. The cost limit under the Proposed Rule imposes deep cuts in safety net support without addressing financing abuses.*

Rather than adopting a narrowly tailored solution to identified concerns with inappropriate Medicaid financing practices, CMS proposes to impose a cost limit on governmental providers that is simply a straightforward funding cut. According to CMS' own data, it has largely eliminated the "recycling" that the cost limit purports to address. Even if recycling were occurring, however, a cost limit would not eliminate it; it would simply limit the net funding for governmental providers. Yet the regulation grossly overreaches by imposing the restrictive limit for governmental providers in states that

have removed or never relied on inappropriate financing arrangements. In these cases, the new limit imposes a deep cut to rectify a non-existent problem.

2. *The cost limit imposes inappropriate and antiquated incentives and unnecessary new administrative burdens.*

A payment limit based on costs represents a sharp departure from CMS' efforts to bring cost-effective market principles into federal health programs. Prospective payment systems are structured to encourage health care providers to eliminate excess costs by allowing them to keep payments above costs as a reward for efficiency. Increasingly, CMS is considering new payment models, which would include incentives for providing high quality care as a means to better align payment and desired outcomes. The Proposed Rule would require a return to cost-based reporting and reimbursement that is inconsistent with the efforts of Congress and CMS over the past twenty years to move away from cost-based methodologies and the inefficient incentives these methodologies entail. It would incentivize providers to increase costs and eschew efficiencies in order to preserve revenues. It would also impose enormous new administrative burdens on states and providers, as they engage in cost reconciliation processes that could last for years beyond when services are provided. The massive diversion of scarce resources into such unnecessary bureaucracy is ill-advised at a time when the demands on the health care safety net are greater than ever.

3. *The Medicare upper payment limit is not excessive.*

In proposing the new cost limit, and asserting that it is necessary to ensure economy and efficiency in the program, CMS is effectively stating that the current limit, based on Medicare rates, is unreasonable. Given the substantial effort put into creating the Medicare payment system by both Congress and CMS, it is surprising that CMS would consider payments at Medicare levels to be unreasonable. Moreover, CMS' claim that the Medicare limit is unreasonable for governmental providers is undermined by its perpetuation of that very limit for private providers.

For many providers, Medicare reimbursement, while not excessive, is higher than the direct costs of services for Medicare patients. The prospective payment system is deliberately delinked from costs and is intended to establish incentives for providers to hold down costs by allowing them to retain the difference between prospectively set rates and their costs. Moreover, Medicare reimbursement explicitly recognizes additional costs that are incurred by some providers for public goods from which the entire community benefits, such as operating a teaching program or providing access to a disproportionate share of low income patients. The Medicare reimbursement system is not unreasonable.

Moreover, the adoption of aggregate limits within specified groups of governmental and private providers allows states sufficient flexibility to target additional Medicaid reimbursement to individual providers to achieve specified policy objectives. In the preamble to the Proposed Rule, CMS raises concerns about some governmental providers receiving payments that are higher than those for other governmental providers. But variation in payment rates across providers has been a hallmark of Medicaid payment policy since the early 1980s when Congress eliminated the requirement that providers be reimbursed based on reasonable costs and allowed states flexibility to tailor reimbursement to localized needs. Today, state Medicaid programs feature a variety of targeted supplemental payments: for rural providers, children's hospitals, teaching hospitals, public hospitals, financially distressed providers, trauma centers, sole community providers and the like. Eliminating the aggregate nature of the payment limit restricts states' flexibility to address local needs through reimbursement policies. Such action runs counter to the Administration's commitment, and Congress' efforts, to enhance state flexibility in managing their Medicaid programs.

*4. Hospitals cannot long survive without positive margins.*

In any competitive marketplace, no business can survive simply by breaking even, earning revenues only sufficient to cover the direct and immediate costs of the services it provides. Any well-run business needs to achieve some margin in order to invest in the future, establish a prudent reserve fund, and achieve the stability which will allow it access to needed capital. Organizations that lose money on one line of business need to make up those losses on other lines in order to survive. These fundamental business concepts are equally applicable to the hospital industry. Margins are essential to survival; they are even more essential to a community-oriented mission.

The proposed cost limit would prohibit governmental hospitals from earning any margin on their largest line of business. Moreover, governmental hospitals, as compared to the hospital industry as a whole, are much more likely to have a line of business – care for the uninsured – in which they must absorb significant losses. For example, in 2004, NAPH members provided, on average, over $76 million in uncompensated care per hospital. Their average margin that same year was a mere 1.2 percent (the industry average was 5.2 percent). Under the Proposed Rule, public hospitals still may be able to achieve a small margin on Medicare and perhaps a slightly larger margin on commercially insured patients, but these two revenue sources constitute less than 45 percent of average NAPH net revenues. With self-pay patients comprising 24 percent of NAPH members' patient populations, margins on Medicare and commercial insurance alone are not sufficient to keep these hospitals afloat if CMS denies any margin on Medicaid patients. CMS would not expect a private business to operate with revenues no greater than direct costs. It should not expect public hospitals, with their disproportionate share of uninsured patient populations, to survive and thrive under this limit.

5. *It is unreasonable to impose a lower limit on governmental providers than private providers.*

It is unclear why CMS believes that rates that the agency would continue to allow states to pay private providers under the Proposed Rule are excessive with respect to government providers. The needs of governmental providers are often significantly greater than those of private providers as they typically provide a disproportionate share of care to the uninsured and offer critical yet under-reimbursed community-wide services (such as trauma care, burn care, neonatal intensive care, first response services, standby readiness capabilities, etc.). For example, the members of NAPH represent 2 percent of the nation's hospitals but provide a full 25 percent of uncompensated hospital care. A report issued in December by the Congressional Budget Office confirmed that governmental hospitals provide significantly more Medicaid and uncompensated care and other community benefits than private hospitals.[6] Moreover, governmental providers' payer mix is markedly different from that of private providers, with greater reliance on Medicaid revenues to fund operations and a lower share of commercially insured patients on which uncompensated costs can be shifted. By cutting Medicaid reimbursement for governmental providers, the Proposed Rule would slash their primary funding source.

6. *The cost limit would have a particularly devastating effect on hospitals in low DSH states.*

Medicaid disproportionate share hospital payments help to offset some of the unreimbursed costs that hospitals incur in caring for uninsured patients, but the adequacy of DSH allotments is declining as costs climb and insurance coverage drops. As a percentage of Medicaid expenditures, DSH has fallen dramatically in the last decade, declining from 14 percent of overall Medicaid expenditures in 1993 to approximately 6 percent in 2004. As DSH falls further and further behind growing uncompensated costs, other types of supplemental payments become an even more important source of support for safety net hospitals. This is especially true for hospitals in "low DSH states," where the statewide DSH allotment is significantly lower than the hospitals' need. Yet it is these non-DSH supplemental Medicaid payments that the proposed cost limit would impact most significantly, undermining the ability of governmental hospitals to continue to provide high volumes of care to the uninsured.

7. *The cost limit undermines important public policy goals.*

At a time when the federal government is calling on providers to improve quality and access, and to invest in important new technology, now is not the time to impose unnecessary funding cuts on governmental providers. Although disproportionately reliant on governmental funding sources, NAPH members have, in recent years, made

[6] Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits*, December 2006.

significant investments in new (and often unfunded) initiatives that are in line with HHS' policy agenda.

For example, NAPH members have invested millions of dollars in adopting electronic medical records and other new information systems that have a direct impact on quality of care, patient safety and long-term efficiency, all goals promoted by HHS. Similarly, in the heightened security-conscious post-9/11 world, public hospitals have played a critical role in local emergency preparedness efforts, enhancing their readiness to combat both manmade and natural disasters and epidemics. HHS has focused on expanding access to primary and preventative services -- particularly for low-income Medicaid and uninsured patients -- and reducing inappropriate utilization of emergency departments. NAPH members have been at the forefront of this effort, establishing elaborate networks of off-campus, neighborhood clinics with expanded hours, walk-in appointments, assigned primary care providers and access to appropriate follow-up and specialty care. (In 2004 alone, 89 NAPH member hospitals provided 29 million non-emergency outpatient visits.) HHS is striving to reduce the disparities in care provided to minority populations. With an extremely diverse patient population, NAPH members have been leaders in providing culturally sensitive and welcoming care, in providing access to translation and interpretation services, and in adopting innovative approaches to treating the specific needs of different minority groups. All of these initiatives require substantial investments of resources. CMS does not appear to have considered the impact of the cut imposed by the cost limit on shared policy initiatives that HHS itself has established as key goals of America's complex health care system.

*8. The proposed cost limit violates federal law.*

The proposed cost limit violates section 1902(a)(30)(A) and 1902(bb) of the Social Security Act (SSA) and section 705(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).[7] CMS is therefore without legal authority to impose the limit by regulation.

Under section 1902(a)(30)(A), state Medicaid programs are required:

> to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.[8]

Many states will be unable to meet the requirements of this provision given the restrictive limits imposed by CMS. By incentivizing providers to maximize costs in order to secure a higher reimbursement limit, the proposal clearly does not promote efficiency or

[7] H.R. 5661, 106th Cong., enacted into law by reference in Pub. L. No. 106-554, § 1(a)(6) ("BIPA").
[8] 42 U.S.C. § 1396a(a)(30)(A).

economy. By removing tools to promote efficiency (such as through prospective payments systems that encourage providers to reduce costs), CMS has hampered states' ability to provide the assurances required by the statute. Similarly, the cost limit thwarts states' efforts to ensure quality of care by eliminating flexibility to provide targeted above-cost incentives to promote and reward high quality care, particularly for providers identified by the state as having particular needs or faced with unique challenges. Finally, to the extent that the cost regulation prohibits states from paying rates that they have determined are necessary to ensure access for Medicaid recipients, CMS's proposed regulation undermines the statutory requirement that states assure access to care and services at least equal to that available to the general population.

Similarly, Section 1902(a)(19) requires states to provide safeguards to assure that "care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients."[9] The Proposed Rule hinders states' ability to make both assurances. Far from streamlining administration, the regulation would require states and providers to engage in elaborate cost reporting and reconciliation processes regardless of the volume of services provided. More importantly, however, CMS' single-minded focus on limiting states' use of local dollars to fund Medicaid and in cutting payments to the largest providers (governmental providers) of Medicaid services, the Proposed Rule patently ignores the best interests of recipients. In fact, it is Medicaid recipients who will be most directly and most severely harmed by this regulation.

The proposed cost limit also ignores Congress's explicit instructions to CMS in Section 705(a) of BIPA to adopt an aggregate Medicare-related upper payment limit (UPL). Adopted shortly after CMS proposed a regulation establishing aggregate UPLs within three categories of providers – state owned or operated, non-state owned or operated and private -- BIPA required that HHS "issue ... a final regulation based on the proposed rule announced on October 5, 2000 that ... modifies the upper payment limit test ... by applying an aggregate upper payment limit to payments made to governmental facilities that are not State-owned or operated facilities." The proposed cost limit for government providers deviates significantly from Congress's clear mandate in BIPA that the upper payment limits: (1) be aggregate limits and (2) include a category of facilities that are "not State-owned or operated." The proposed regulation is provider-specific, not aggregate, and eliminates ownership as a factor in determining whether a facility is a government facility. Moreover, in requiring that the final regulation be based on the proposed rule issued on October 5, 2000, Congress explicitly endorsed the establishment of a UPL based on Medicare payment principles, not costs.

Finally, Section 1902(bb) requires states to pay for services provided by federally qualified health centers (FQHCs) and rural health clinics (RHCs) through rates that are prospectively determined (based on historical costs). FQHCs and RHCs had previously

[9] 42 U.S.C. § 1396a(a)(19).

been guaranteed cost-based reimbursement under Title XIX, but through the Balanced Budget Act of 1997, Congress began phasing out this guarantee.[10] Before the phase-out was complete, Congress stepped in again in 2000 to require a new payment methodology for FQHCs that was specifically *not* cost reimbursement.[11] This evolution of FQHC and RHC payment policy – away from cost reimbursement and towards a prospective payment system that encourages efficiency – is the most recent articulation of Congress' intent with regards to Medicaid reimbursement. The Proposed Rule would require states to reconcile prospectively made payments to public FQHCs and RHCs and to require the clinics to return any "overpayment" (payments that in retrospect turn out to be in excess of cost). This required reconciliation process is in direct conflict with Section 1902(bb).

***Recommendation: CMS should retain the aggregate upper payment limits based on Medicare payment principles for all categories of providers.***

### B. Defining a Unit of Government (§ 433.50)

NAPH urges CMS to reconsider its proposed new definition of a "unit of government." This proposal would usurp the traditional authority of states to identify their own political subdivisions and exceed the authority provided in the Medicaid statute. The new definition would undermine efforts to date by states to make units of government more efficient and less reliant on public tax dollars.

#### *1. CMS' restrictive definition of units of government undermines marketplace incentives to operate public providers through independent governmental entities.*

More than a century ago, state and local governments began establishing public hospitals to provide health care services in their communities, including services for their most needy residents. As the health care system matured, commercial insurance evolved and the Medicare and Medicaid programs were established, public hospitals filled a unique role in serving the poor and uninsured -- patients who were often shunned by other providers. The public hospitals were typically operated as a department of the state or local government, with control over hospital operations in the hands of an elected legislative body, funding appropriated to plug deficits, surpluses reverting into the general fund of the government, and subject to sunshine laws, public agency procurement requirements, civil service systems and other local laws designed with the operations of traditional monopolistic governmental agencies such as libraries, police and fire departments and public schools in mind.

Over time, some states began authorizing local governments to establish public hospitals as separate governmental entities in recognition of the competitive market in which

[10] *See* Balanced Budget Act of 1997, § 4712.
[11] BIPA, § 702,

hospitals operate. Generic state laws authorizing local governments to create hospital authorities, public hospital districts and similar independent governmental structures began to proliferate.

As competition in the health care system intensified and state and local governments became less willing and able to provide open-ended taxpayer funding to ensure access to health care services, many that had previously operated public hospitals as integrated governmental agencies began searching for new ways to organize and operate these entities. Typically they sought to do so without diminishing their commitment to meeting the health care needs of their residents and without relaxing the accountability of these hospitals to the public for the services provided. Fueled by these demands and concerns, many state and local governments have restructured their public hospitals to provide them more autonomy and equip them to better control costs and compete in a managed care environment.

These restructurings have taken a wide variety of forms. Many governments have created hospital authorities, with a separate governing board, appointed by elected officials and dedicated solely to governing the hospital. Other states created hospital districts, public benefit corporations or non-profit corporations engaged in a public-private partnership with the local government to operate the hospital to fulfill the governmental function of serving the health care needs of the local population. Many state university medical schools have spun off their clinical operations into a separate governmental entity for similar reasons.

The variations in these public structures are as numerous as the hospitals themselves. They have been extremely successful in positioning public hospitals to reduce their reliance on public funding sources, to compete effectively with their private counterparts and to continuously enhance the quality of care and access they provide. The autonomy has allowed them to achieve these goals while still fulfilling their unique public mission of serving unmet needs in the community, providing access where the private market alone does not, and being responsive and accountable to the public.

The Proposed Rule's definition of a unit of government runs exactly counter to this decades-long trend in the provision of governmental health care. Under the Proposed Rule, only the most traditional of public hospitals would qualify as a governmental entity capable of contributing to the non-federal share of Medicaid funding. Others simply would not be deemed an "integral part" of a unit of government with taxing authority under the strict criteria set forth in the Proposed Rule.

For example, one very common feature of the restructurings is the establishment of a separate and independent budget and accounting system for the hospital, in which revenues earned by the hospital are retained by the hospital and controlled by the governing board dedicated solely to the hospital rather than automatically reverting to the

government's general fund. Such fiscal independence has been viewed as critical to establishing the necessary incentives and accountability for hospital administrators to operate efficiently, to maximize patient care revenues and to invest in new initiatives widely. Similarly, many restructured hospitals are not granted unlimited access to taxpayer support but are forced to manage to a fixed budget, which again has been viewed as furthering the goals of economy and efficiency. In short, the governmental entities that previously owned and operated these hospitals have restructured them deliberately to be both governmental and autonomous. They are governmental under state law and they remain fully accountable to the public. But they are autonomous governmental entities in that the local or state government with taxing authority is no longer legally responsible for their liabilities, expenses and deficits. For this reason, they likely would not meet CMS' new unit of government definition, even though they have retained several governmental attributes and are considered governmental under the laws of the state.

The rule would undermine the efforts of state and local governments to deliver public health care services more efficiently and effectively, and penalize those that have reduced their reliance on taxpayer support. Governments that had restructured their public hospitals deliberately to retain their nature as a governmental entity under state law, in part so that they could continue contributing to funding the non-federal share of Medicaid expenditures, will find the rules suddenly switched on them as the federal government substitutes its judgment for state law regarding whether they remain public or not. Future restructurings will likely reflect CMS' narrow definition, undermining the important public policy goals achieved through the more flexible array of structures available under state law. CMS does not appear to have contemplated the perverse incentives its restrictive definition of units of government would provide.

*2. CMS does not have statutory authority to restrict the definition of a "unit of government."*

CMS has exceeded its statutory authority in adopting a definition of a "unit of government" more restrictive than that established in Title XIX of the SSA. Section 1903(w)(7)(G)[12] defines a "unit of local government," in the context of contributing to the non-federal share of Medicaid expenditures, as "a city, county, special purpose district, or other governmental unit in the State." The Proposed Rule narrows the definition of "a unit of government" to include, in addition to 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.*"[13] Congress never premised qualification as a unit of government on an entity's access to public tax dollars. Rather, Congress' formulation, which includes an "other governmental unit in the State," provides appropriate deference to the variety of governmental structures into which a state may

[12] 42 U.S.C. § 1396b(w)(7)(G).
[13] Proposed 42 C.F.R. § 433.50(a)(1)(i) (emphasis added).

organize itself. In narrowing this statutory definition, without instruction by Congress, CMS has eliminated the deference to states underlying the statutory formulation.

Section 1903(w)(7)(G) is not the only section of Title XIX which evidences a Congressional intent to allow states to determine which entities are political subdivisions capable of participating in Medicaid financing. The absence of any requirement that units of government have taxing authority in order to contribute to the non-federal share of Medicaid expenditures is supported by the language elsewhere in the Medicaid statute. Section 1903(d)(1) requires states to submit quarterly reports for purposes of drawing down the federal share in which they must identify "the amount appropriated or made available by the State and its political subdivisions." The reference to the participation of political subdivisions in Medicaid funding nowhere includes a requirement that the subdivisions have taxing authority.[14]

In limiting the definition of unit of government, the Proposed Rule also overlooks Congress' specific concern about funds derived from State university teaching hospitals. In 1991, in the course of adopting affirmative limits on states' authority to rely on local funding derived from provider taxes or donations, Congress explicitly stated that the Secretary of HHS "may not restrict States' use of funds where such funds are . . . appropriated to State university teaching hospitals."[15] Clearly, Congress did not want to disrupt longstanding funding arrangements involving these important teaching institutions. In adopting a narrow definition of unit of government, which will have the effect of excluding many of our nation's premier public teaching hospitals, CMS has violated the spirit, and in some cases the letter, of this law.

3. *A federally-imposed restriction on state units of government violates Constitutional principles of federalism.*

In creating a new federal regulatory standard to determine which public entities within a state are considered to be "units of government" and which are not, CMS is encroaching on a fundamental reserved right of states to organize their governmental structures as they see fit. This is an extraordinary step for the federal government to take, as the internal organization of a state into units of government has historically been an area in which, out of respect for federalism, the federal government has been loath to regulate. This federal intrusion into the operation and administration of state government violates the very basis of the Medicaid program -- the federal-state partnership and the federalism principles on which it rests.

***Recommendation: CMS should defer to states regarding the definition of a unit of government.***

[14] 42 U.S.C. § 1396b(d)(1).
[15] 42 U.S.C. § 1396b(w)(6)(A).

### C. Sources of Non-Federal Share Funding and Documentation of Certified Public Expenditures (§ 433.51(b))

Traditionally, states have been able to rely on public funds contributed by governmental entities, regardless of the source of the public funds. As long as funds were contributed by a governmental entity, they were considered to be public and a legitimate source of Medicaid funding.

The Proposed Rule rejects the idea that all funds held by a public entity are public (or, in the language of the regulation, all funds held by a unit of government are governmental), notwithstanding a large body of state law to the contrary.[16] Rather, the regulation (or at least its preamble) would establish a hierarchy of public funds, and only funding derived from taxes would be allowed to fund Medicaid expenditures while those derived from other governmental functions (such as providing patient care services through a public hospital) would be rejected.

The preamble to the Proposed Rule states explicitly that, with respect to intergovernmental transfers, "the source of the transferred funds [must be] State or local tax revenue (which must be supported by consistent treatment on the provider's financial records)."[17] While the proposed regulatory language itself refers only to "*funds* from units of government"[18] without specifying the source of those funds, the preamble language clearly indicates CMS' intent to further restrict funding for state Medicaid programs by imposing the additional requirement that local funds be derived from tax revenues. The preamble does not specify the reason for this restriction, nor whether it would serve to bar federal Medicaid match for support provided by a local government to a hospital derived from such routine governmental funding sources such as the proceeds from bond issuances, revenue anticipation notes, tobacco settlement funds and the like. Moreover, if the regulation does indeed bar the use of such funding sources, how does CMS expect to be able to track the precise source of local support funding, given the fungibility of governmental funding?

The combination of adopting a restrictive definition of a unit of government and then further restricting the source of funds that can be transferred by entities that meet the strict unit of government test will leave state Medicaid programs, including important supplemental payment programs that support the health care safety net, starved for

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[16] *See, e.g. Adams County Record v. Greater North Dakota Association*, 529 N.W.2d 830, 834 (N.D. 1995) ("public funds" include "all funds derived from taxation, fees, penalties, sale of bonds, or from any other source, which belong to and are the property of a public corporation or of the state ...."); *Kneeland v. National Collegiate Athletic Association*, 850 F.2d 224, 227 (1988) (all revenues, except for trust funds, received by public colleges and universities, as well as various types of property of public colleges and universities are public funds).

[17] 72 Fed. Reg. at 2238

[18] Proposed 42 C.F.R. § 433.51(b).

resources. These funding shortfalls will need to be filled either by new broad-based uniform provider taxes (which would ultimately divert Medicaid reimbursement from patient care costs to covering the cost of new taxes), by new general revenue funding (shifting new costs onto state taxpayers) or by a reduction in Medicaid coverage or reimbursement. All of these solutions will ultimately impact the care that Medicaid beneficiaries receive.

In imposing this new restriction on the source of IGTs, CMS is again exceeding its Congressionally delegated authority. Section 1902(a)(2) of the SSA allows states to rely on "local sources" for up to 60 percent of the non-federal share of program expenditures. This provision does not limit the types of local sources that may be used. When Congress has intended to restrict such local sources, it has rejected CMS' attempts to impose limits by regulation and has insisted on legislating the limits itself. For example, in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991,[19] Congress adopted significant restrictions on sources of local funding, but did so by statute after imposing a series of moratoria on HHS' attempts to restrict local sources of funding administratively.[20] CMS is without legal authority to insist that local funding from units of government be limited to tax dollars only.

***Recommendation: CMS should allow all public funding regardless of its source to be used as the non-federal share of Medicaid expenditures.***

## III. THE PROPOSED RULE INCLUDES TECHNICAL ERRORS, AMBIGUITIES AND MISGUIDED POLICY CHOICES

The best course, from a legal and policy perspective, would be for CMS to withdraw the Proposed Rule altogether. To the extent that the agency goes forward with the rule, there are several technical issues that need to be clarified, modified or otherwise addressed in the final rule. NAPH raises the following concerns:

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

1. *The Proposed Rule inappropriately limits reimbursable costs to the "cost of providing covered Medicaid services to eligible Medicaid recipients." (§ 447.206(c)(1))*

Proposed 42 C.F.R. § 447.206(c)(1) provides that "[a]ll health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider's cost of providing ***covered Medicaid services to eligible Medicaid recipients***." By its terms, this provision would prohibit *any* Medicaid reimbursement to

[19] Pub. L. No. 102-234, 105 Stat. 1793.
[20] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 1989 U.S.C.C.A.N. (103 Stat.) 2106; Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 1990 U.S.C.C.A.N. (104 Stat.) 1388.

governmental providers for costs of care for patients who are *not* eligible Medicaid recipients, or for services that are not covered under the state Medicaid plan. Taken literally, states could no longer pay public hospitals for unreimbursed costs for uninsured patients or for non-covered services to Medicaid patients through the disproportionate share hospital program. Similarly, the authority of several states to make payments to public providers pursuant to expenditure authority received through section 1115 demonstration projects to pay for otherwise unreimbursable costs to the uninsured, for infrastructure investments and for other purposes not covered under the state plan would be called into question (including Safety Net Care Pool payments authorized in California and Massachusetts, and Low Income Pool payments authorized in Florida). The cost limit could also extend to Medicaid reimbursement received by governmental providers from managed care organizations (despite CMS' disavowal of any such intent in the preamble). The problem is exacerbated because the regulation defines its scope as applying broadly to all "payments made to health care providers that are operated by units of government ...."[21] By contrast, the UPL regulations are carefully drafted to limit their scope to "rates set by the agency,"[22] and they include an explicit exemption for DSH payments.[23]

We assume that it is CMS' intention either (1) to apply the cost limit only to fee-for-service payments by the state agency for services provided to Medicaid recipients while relying on separate statutory or waiver-based authority to impose cost limits on DSH or demonstration program expenditures, or (2) to apply the cost limit at 42 C.F.R. §447.206 more broadly than the language of the Proposed Rule would suggest. In either case, modifications to the language of the regulation are needed to clarify its scope and the corresponding allowable costs. If the limit is to apply only to fee-for-service rates for Medicaid patients, DSH should be explicitly exempted. If the limit is to be more broadly applied, the language must be expanded to allow costs for the uninsured or non-covered Medicaid services for purposes of DSH payments. In addition, preamble guidance regarding the ongoing validity of expenditure authority granted through existing demonstration projects would help reduce confusion about the intended scope.

***Recommendation: CMS should clarify that the limitation to cost of Medicaid services for Medicaid recipients is not intended to limit Medicaid DSH payments or CMS-approved payments under demonstration programs that expressly allow payment for individuals or services not covered under the state Medicaid plan.***

[21] Proposed 42 C.F.R. § 447.206(a)
[22] 42 C.F.R. § 447.272(a), § 447.321(a).
[23] 42 C.F.R. § 447.272(c)(2).

2. *CMS should clarify that allowable costs will include all necessary and proper costs associated with providing health care services. (§ 447.206)*

The calculation of cost for purposes of applying the cost limit is not well-defined under the Proposed Rule. Since the magnitude of the cut imposed by the cost limit will depend on which costs CMS will and will not allow states to reimburse, NAPH requests that CMS provide further guidance on how Medicaid costs would be determined and in particular clarify that any determination of Medicaid "costs" will include all costs necessary to operate a governmental facility. For governmental hospitals, these costs must, at a minimum, include:

- costs incurred by the hospital for physician and other professional services (e.g. salaries for employed professionals, contractual payments to physician groups for services provided to hospitals, physician on-call and standby costs);
- capital costs necessary to maintain an adequate physical infrastructure;
- medical education costs incurred by teaching hospitals;
- investments in information technology systems critical to providing high quality, safe and efficient hospital care;
- investments in community-based clinics and other critical access points to ensure that Medicaid and uninsured patients have adequate access to primary care;
- costs of a basic reserve fund critical to any prudently-operated business enterprise; and

In addition, some costs on a hospital's cost report are allocated to cost centers judged to be unreimbursable for purposes of Medicare reimbursement, but are appropriately reimbursed under Medicaid or DSH. For example, a hospital may have a clinic that exclusively serves Medicaid and uninsured patients that may have been excluded for Medicare purposes, but are appropriately reimbursed under Medicaid. Similarly, some costs that may not be included in a particular reimbursable cost center for purposes of the Medicare cost report should be included under a cost-based Medicaid reimbursement system (including but not limited to interns and residents, organ acquisition costs, etc.). CMS must ensure that states may make appropriate adjustments to the Medicare cost report to accurately capture all costs reasonably allocated to Medicaid – whether or not Medicare fiscal intermediaries have allowed them.

In addition, NAPH strongly believes that allowable costs should also include costs for the uninsured (beyond costs directly reimbursable through the limited available DSH funding). Absent universal coverage or full reimbursement of uninsured costs, hospitals

must continue to rely on cross-subsidization from other payers, including commercial payers, Medicare and Medicaid, to pay for this care. CMS should allow state Medicaid programs to shoulder such costs rather than placing the full burden on Medicare and commercial payers. We therefore urge CMS to include uninsured costs among reimbursable Medicaid costs.

***Recommendation: CMS should specify that any determination of Medicaid costs will include all costs necessary to operate a governmental facility including costs for the uninsured.***

*3. The costs of graduate medical education must be allowable costs.*

The President's FY 2008 budget request includes an administrative proposal to eliminate Medicaid reimbursement for graduate medical education (GME) costs. Given the long-standing policy to permit GME payments (as of 2005, 47 states and the District of Columbia provided explicit GME payments to teaching hospitals, according to the Association of American Medical Colleges[24]) and the dozens of approved state plan provisions authorizing such payments, NAPH was surprised to see this proposal described as an administrative rather than legislative initiative. We question CMS' authority to adopt such a policy change without statutory authorization. To the extent that CMS intends to change the policy administratively, however, we assume that the agency would undertake a full notice and comment rulemaking process. In particular, we assume that CMS will allow governmental providers to include all of the costs of their teaching programs in the cost limits under the Proposed Rule unless and until the law is changed to prohibit Medicaid payments for GME. Please confirm our understanding that full GME costs will be includable as reimbursable costs.

***Recommendation: CMS should clarify that graduate medical education costs will be includable in the cost limit under the Proposed Rule.***

*4. The Proposed Rule does not specify whether and under what circumstances professional providers would be considered to be governmentally operated.*

The Proposed Rule applies the cost limit to "health care providers that are operated by units of government."[25] It is clear from the text of the regulation that it applies not just to hospital and nursing facility providers, but also to "non-hospital and non-nursing facility services."[26] Beyond this clarification, the scope of the term "providers" is unclear. It might be possible for a state to determine that the cost limit extends as far as

[24] Tim M. Henderson, *Direct and Indirect Graduate Medical Education Payments By State Medicaid Programs* (Association of American Medical Colleges), Nov. 2006, at 2.
[25] Proposed 42 C.F.R. § 447.206(a).
[26] Proposed 42 C.F.R. § 447.206(c)(4).

professionals employed by governmental entities. CMS should clarify that it does not intend the regulation's reach to extend this far. Cost-based methodologies are particularly inappropriate for professional services.

***Recommendation: CMS should clarify that the cost limit applies only to institutional government providers and not to professionals employed by or otherwise affiliated with units of government.***

5. *A less costly, equally effective alternative to multiple cost reconciliations is available that would reduce the administrative burden on providers.*

It appears that the cost limits under the regulation must be enforced by reconciling final cost reports (often not final until years after the payment year) to actual payments made to ensure that no "overpayments" have occurred.[27] In addition, in order for states using cost-based payment methodologies funded by CPEs to provide payments to providers prior to the finalization of the payment year cost reports, the state must undertake not one, but two reconciliations after the payment year to ensure payments did not exceed costs.[28] It appears, therefore, that under this Proposed Rule, states and providers are going to be reconciling cost reports and payments for years after the actual payments are received.

The time and resources invested in this process will ultimately have no impact whatsoever on the quality or effectiveness of care provided to patients; in fact, these burdensome requirements divert scarce resources that would be much better spent on patient care. Moreover, the precision gained by reconciling payments to actual costs for the payment year as determined by a finalized cost report simply is not worth the massive diversion of such resources.

Instead, CMS should allow states to calculate cost limits prospectively, based on the most recent cost reports trended forward. While such a prospective methodology may result in a limit that is slightly higher or lower than actual costs incurred in the payment year, over time such fluctuations will even out. Moreover, calculations of cost limits to the dollar, as proposed by CMS, are not necessary to achieve the fiscal integrity objectives articulated by CMS. NAPH therefore urges CMS to reconsider the elaborate reconciliation processes it is requiring in this rule and instead allow providers to invest the savings from the use of a prospective process in services that will actually benefit patients.

***Recommendation: CMS should allow states to calculate the cost limit on a prospective basis.***

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[27] Proposed 42 C.F.R. § 447.206(e).
[28] Proposed 42 C.F.R. § 447.206(d)

*6. CMS should clarify that costs may include costs for Medicaid managed care patients.*

Under current Medicaid managed care regulations, states are prohibited from making direct payments to providers for services available under a contract with a managed care organization (MCO) and Prepaid Inpatient Health Plan or a Prepaid Ambulatory Health Plan.[29] There is an exception to this prohibition on direct provider payments for payments for graduate medical education, provided capitation rates have been adjusted accordingly. Given the extreme funding cuts that will be imposed on many governmental providers by the imposition of the cost limit, NAPH urges CMS to reconsider the scope of the exception to the direct payment provision. NAPH recommends that states be allowed to make direct Medicaid fee-for-service payments to governmental providers for all unreimbursed costs of care for Medicaid managed care patients (not just GME costs). Because the payments would be based on costs pursuant to the new regulation, there would not be the danger of "excessive payments" that has concerned CMS in the current system. Moreover, to avoid double dipping, states could be required to similarly adjust capitation rates to account for the supplemental cost-based payments. If reimbursement to governmental providers is going to be restricted to cost, it should include costs for all Medicaid patients, not just those in the declining fee-for-service population.

***Recommendation: CMS should amend 42 C.F.R. § 438.6(c)(5)(v) and § 438.60 to allow direct payments to governmental providers for unreimbursed costs of Medicaid managed care patients.***

**B. Defining a Unit of Government (§ 433.50)**

As stated above, we believe CMS's restrictive definition of unit of government is fatally flawed and should be abandoned in favor of permitting state discretion. However, to the extent this element is included in a final regulation, CMS must clarify certain aspects. In particular:

*1. CMS should leave the statutory definition of "unit of government" in place.*

The Proposed Rule would permit only units of government to participate in financing the non-federal share of Medicaid expenditures. The regulatory text then goes on to define a unit of government as "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***."[30] A provider can only be considered to be a "unit of government" if it has taxing authority or it is an "***integral part of a unit of government with taxing***

[29] 42 C.F.R. §438.60.
[30] Proposed 42 C.F.R. § 433.50(a)(1)(i).

***authority***."[31] It is clear from this proposed definition that unless a provider has direct taxing authority, CMS will only consider it a "unit of government" if it is an integral part of a unit of government with taxing authority. As explained in Part II of these comments, states and local governments have restructured public hospitals so that they are deliberately autonomous from the state, county or city while retaining their public status under state law. State law, including state law as defined by the state courts, typically looks beyond the presence of taxing authority to other indicia of public status to determine whether an entity is governmental.[32] For example, courts may look to whether an entity enjoys sovereign immunity, to whether its employees are public employees, to whether it is governed by a publicly appointed board, to whether it receives public funding, to whether its enabling statute declares it to be a political subdivision or a public entity. There are a wide variety of factors that go into determining public status beyond whether the provider or the unit of government of which it is an integral part has taxing authority. NAPH urges CMS to eliminate the caveat that units of government must have taxing authority and allow any governmental entity so designated under state law to be treated as public and capable of participating in Medicaid financing.

***Recommendation: CMS should eliminate the requirement that units of government have taxing authority and defer to state law interpretations of public status.***

2. *CMS should clarify that the unit of government definition applies only for purposes of the payment limits and financing restrictions and not to other areas of Medicaid law and policy.*

The use of the term "public" appears in several different contexts throughout the Medicaid statute, and many states employ their own definitions of public status within their Medicaid state plans. For example, federal financial participation is available at the rate of 75 percent of the costs of skilled professional medical personnel of the state agency or "any other public agency."[33] A Medicaid managed care organization that is a "public entity" is exempt from certain otherwise applicable solvency standards.[34] "Public institutions" that provide inpatient hospital services for free or at nominal charges are not subject to the charge limit otherwise applicable to inpatient services.[35] Moreover, many states adopt special reimbursement provisions in their state plans for "public hospitals," "governmental hospitals" or other types of public providers. The use of terms such as

[31] Proposed 42 C.F.R. §433.50(a)(1)(ii).
[32] *See e.g.,* Colorado Associate of Public Employees v. Board of Regents, 804 P. 2d 138 (1990) (the court based its determination that the hospital was a public entity on the State's role in establishing the hospital and its continued involvement in the control of the hospital's internal operations). Woodward v. Porter Hospital, Inc. 217 A.2d 37, 39 (1966)("a public hospital is an instrumentality of the state, founded and owned in the public interest, supported by public funds, and governed by those deriving their authority from the state.").
[33] 42 U.S.C. § 1396b(a)(2)(A).
[34] 42 U.S.C. §1396b(m)(1)(C)(ii)(II).
[35] 42 U.S.C. §1396b(i)(3).

"public," "unit of government" and "governmental" in other areas of state and federal Medicaid law does not incorporate the restrictions CMS is seeking to impose through the Proposed Rule. CMS should clarify that these restrictive definitions are for purposes outlined in the Proposed Rule only.

***Recommendation: CMS should clarify that the Proposed Rule is not intended to place restrictions on public status designations beyond those explicitly contained in the Proposed Rule.***

### C. Certified Public Expenditures (§ 447.206(d)-(e))

*1. CPEs should be allowed to finance payments not based on costs.*

In the preamble to the Proposed Rule, CMS indicates that CPEs may only be used in connection with provider payments based on cost reimbursement methodologies. This restriction on the use of CPEs is unnecessary. Providers will incur costs associated with providing care to Medicaid patients whether they are paid on a cost basis or not. Their costs are no less real or certifiable based on the payment methodology. For example, if a provider incurs $100 in cost in providing care to a Medicaid patient, but the payment methodology is a prospective one that results in a $90 payment, the provider could still certify that it incurred $100 in costs in connection with care for that patient. Because the payment is limited to $90, however, only $90 of the certification would be eligible for federal match. When payment is not based on a cost methodology, CMS should allow providers to certify costs associated with care to Medicaid patients not to exceed the amount of payments provided under the state plan methodology.

***Recommendation: CMS should permit the use of CPEs for providers regardless of the payment methodology provided under the state plan.***

2. *The permissive vs. mandatory nature of the reconciliation process should be clarified.*

In the regulatory language in Proposed 42 C.F.R. § 447.206(d)-(e), CMS alternates between mandatory and permissive language as to state obligations during CPE reconciliations. It appears that it is CMS' intent to *require* the submission of cost reports whenever providers are paid using a cost reimbursement methodology funded by CPEs, to permissively *allow* states to provide interim payment rates based on the most recently filed prior year cost reports, and to *require* states providing interim payment rates to undertake an interim reconciliation based on filed cost reports for the payment year in question and a final reconciliation based on finalized cost reports. In addition, providers whose payments are not funded by CPEs are *required* to submit cost reports and the state is *required* to review the cost reports and verify that payments during the year did not exceed costs. Please confirm this understanding of the regulatory language.

***Recommendation: CMS should confirm the requirements regarding reconciliation of costs.***

### D. Retention of Payments

NAPH supports CMS' attempts to ensure that health care providers retain the full amount of federal payments for Medicaid services. We do not believe, however, that the requirement in the Proposed Rule that providers receive and retain all Medicaid payments to them is enforceable. Nor do we believe that this provision will have a major impact on the funding of safety net providers. Although CMS asserts that governmental providers will benefit from the Proposed Rule in part because of the retention provision, this new requirement does not come close to undoing the significant damage caused by the cuts to payments and changes in financing required by other provisions of the Proposed Rule.

1. *CMS should clarify whether states will be required to pay all federal funding associated with provider-generated CPEs to the provider.*

The retention provision requires providers to "receive and retain the full amount of the total computable payment provided to them."[36] It is unclear whether this requirement applies to *all* payments, whether financed through IGTs, CPEs, general state revenues or otherwise. Currently, some states claim certified public expenditures based on costs incurred by public providers, but do not pass the federal matching payments to the provider. Would this practice be prohibited under the retention provision and would states be required to pay any match received on public provider CPEs to the provider?

***Recommendation: CMS should clarify whether the retention provision applies to payments financed by CPEs.***

[36] Proposed 42 C.F.R. § 447.207(a).

2. *CMS' does not have the authority to review "associated transactions" in connection with the retention provision.*

The retention provision is drafted broadly, requiring, without qualification, providers to "retain" all payments to them, and providing CMS with authority to "examine any associated transactions" to ensure compliance. Taken to extremes, the requirement to retain payments would prohibit providers from making expenditures with Medicaid reimbursement funds. Certainly, any routine payments from providers to state or local governmental entities for items or services unrelated to Medicaid payments would come under suspicion. NAPH members typically have a wide array of financial arrangements with state and local governments, with money flowing in both directions for a variety of reasons. We are concerned that CMS' new authority to examine "associated transactions" will jeopardize these arrangements, and that CMS may use its disallowance authority to pressure public providers to dismantle such arrangements.

CMS' review and audit authority is limited to payments made under the Medicaid program. It does not have authority over providers' use of Medicaid payments received.[37]

***Recommendation: CMS should delete the authority claimed by CMS to review "associated transactions."***

### E. Applicability to Section 1115 Waivers

Currently, a number of states have implemented demonstration programs under Section 1115 waiver authority. Medicaid demonstrations typically must comply with a budget-neutrality expenditure cap calculated based on the Medicaid expenditures that would have been made in the absence of the waiver. Many recent demonstrations have relied heavily on money made available by eliminating certain above-cost payments to public providers. For example, California and Massachusetts established Safety Net Care Pools funded by agreements to eliminate certain supplemental payments. Florida likewise established a Low Income Pool on the same basis. Iowa similarly expanded coverage through Iowa Cares. These demonstrations have been the result of significant and extended discussions between states and CMS.

[37] *See Englund v. Los Angeles County*, 2006 U.S. Dist. LEXIS 82034, at *26 (E.D. Cal. 2006). When analyzing supplemental Medicaid funding paid to Los Angeles County, the Court noted that "once the County received the [Medicaid] payment it was not limited to how it used the money" (*citing* testimony of Bruce Vladeck, Administrator of Health Care Financing Administration, 1993-1997). The Court also cited Mr. Vladeck's statement that, "money is fungible. Once it was paid to the hospitals, if it was paid for services that were actually being provided, at that point our [HCFA's] sort of formal jurisdiction over it and interest of what became of the funds ended." *Id.* at 27.

All of the demonstrations contain language in the Special Terms and Conditions requiring budget neutrality to be recalculated in the event that a change in Federal law, regulation, or policy impacts state Medicaid spending on program components included in the Demonstration. Throughout the Proposed Rule, CMS confirms that the proposed changes would apply to states that operate Section 1115 waiver programs, but fails to discuss the extent to which the Proposed Rule would affect budget neutrality calculations under Medicaid waivers. Will CMS recalculate budget neutrality applicable to these waivers based on the new regulation? If not, will these states be able to continue their new initiatives beyond the term of the current demonstration project? It will be difficult for these states to establish new programs under their waivers if they are going to be terminated within a few years. Moreover, will CMS allow other states to adopt waivers establishing similar pools or expanded coverage based on the termination of above-cost supplemental payment programs?

***Recommendation: CMS must clarify (i) whether current waiver states will be permitted to preserve their waivers, including safety net care pools and expanded coverage currently funded by the states' agreements to limit existing provider payments to cost; (ii) whether CMS plans to enforce requirements under waiver special terms and conditions (STCs) that budget neutrality agreements be renegotiated upon changes in federal law; (iii) whether CMS will allow other states to adopt similar waivers, which may incorporate savings realized from the Proposed Rule's cost limit into their own safety net care pools or coverage expansion initiatives; and (iv) if CMS does not plan to allow other states to make use of cost limit savings, the legal basis for this decision.***

### F. UPL Transition

The Proposed Rule preamble states that "transitional UPL payments ... are unchanged under this policy."[38] However, the Proposed Rule does implement changes to the UPL endpoint -- reducing it for governmental hospitals from the aggregate estimate of what would be paid under Medicare payment principles to the individual provider's cost of providing Medicaid services to eligible Medicaid recipients. Therefore, transition period payments would appear to be significantly impacted, since the transitional UPLs are largely based on the UPL endpoint. If CMS truly intends that transition period UPL payments be unchanged, CMS must revise the regulatory language to make that clear.

***Recommendation: CMS should revise the regulatory language to ensure no diminution of transitional UPL payments.***

### G. Provider Donations

If the Proposed Rule is finalized in its current form, a number of providers that were previously considered public and that provided IGTs or CPEs to help finance the non-

[38] 72 Fed. Reg. at 2245.

federal share of Medicaid expenditures will no longer be able to do so. Some of these providers receive appropriations from a unit of government that does have taxing authority, but the provider cannot be considered to be an integral part of such governmental unit under the terms of the Proposed Rule. CMS should make clear that those appropriations will continue to be fully matchable under the new regulation and that it will not disallow such taxpayer funding as an indirect provider donation. We are particularly concerned in this respect about a passage in the preamble stating that "[h]ealth care providers that forego generally applicable tax revenue that has been contractually obligated for the provision of health care services to the indigent ... are making provider-related donations."[39] A local government must have full authority to redirect taxpayer dollars to the state Medicaid agency for use as the non-federal share.

For example, a county which provides $20 million to support the provision of indigent care at a hospital deemed to be private under the Proposed Rule should be permitted instead to transfer that funding to the State Medicaid agency for use as the non-federal share of a $40 million DSH payment to the hospital. The preamble language appears to indicate that CMS could view such a transfer as a provider donation even though it is transferred from an entity that is clearly governmental and even though the funds transferred are derived from tax revenues. When taxpayer funding is transferred by a unit of government to the Medicaid agency for use as the non-federal share, CMS should provide federal financial participation without question.

***Recommendation: CMS should clarify that it will not view the transfer of taxpayer funding as an indirect provider donation.***

### H. Effective Date

*1. The September 1, 2007 effective date is not achievable.*

The stated effective date of the new cost limit is September 1, 2007.[40] An effective date for other portions of the regulation is not provided. Given that many states will need to overhaul their provider payment systems and plug large budgetary gaps resulting from the required changes in non-federal share financing, the proposed effective date is not feasible. State plans amendments will need to be developed, vetted with the public, submitted to CMS and approved, a process which recently has routinely lasted 180 days or significantly longer. By the time a final rule is published, States will have long finalized budgets for fiscal years that include time periods after September 1, 2007 (SFY 2008 or, in some cases, SFY 2009 budgets). For many states, funding levels have already been set. Many state legislatures are in session for a limited period of time, and some meet every other year. Elimination of federal funding of the magnitude proposed in this regulation cannot possibly be incorporated and absorbed at this late date. Moreover, to

[39] *Id.*
[40] Proposed 42 C.F.R. § 447.206(g); § 447.272(d)(1); § 447.321(d).

the extent that states have had advance warning of at least some of the policies contained in the final rule by virtue of this Proposed Rule and other agency activities, states are under no obligation to modify their programs based on the provisions of a proposed regulation without the force and effect of law, nor would it be wise to undertake such restructuring given that the regulation may undergo significant change.

Moreover, given the widespread impact of the Proposed Rule as discussed elsewhere in these comments, and the longstanding reliance of states on payment and financing arrangements allowable under current law, CMS should adopt generous transition provisions to allow states time to come into compliance and allow providers time to adjust to significantly lower reimbursement rates. Any such transition periods should be at least ten years.

***Recommendation: CMS should revise the effective date of the Proposed Rule and establish a ten-year transition period so that states, health care providers, and other affected entities are provided adequate time to come into compliance.***

*2. The effective date of portions of the Proposed Rule is ambiguous.*

NAPH seeks confirmation that the effective date of the entire regulation is, in fact, proposed to be September 1, 2007. While this date is specifically established as the date by which states must come into compliance with cost limits, effective dates are not provided in connection with other revised sections of the regulations. Moreover, throughout the preamble, CMS characterizes its actions as "clarifying" policies with respect to the definition of units of government, intergovernmental transfers, certified public expenditures and the retention requirement. We are therefore concerned that CMS may view these regulatory changes as being effective immediately and retroactively, as a simple clarification of current policy and not the sweeping regulatory overhaul that it clearly is. Please confirm that these regulations are prospective in their entirety.

Any attempt to impose these policies without going through notice and comment rulemaking would violate the Administrative Procedures Act (APA), which requires legislative rules such as the policy changes articulated in the Proposed Rule to be adopted through a formal rulemaking process.[41] Moreover, in addition to the requirements of the APA, Congress has very explicitly instructed CMS not to adopt policy changes without undertaking notice and comment rulemaking. The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (the 1991 Amendments) contains an uncodified provision stating that:

> 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

[41] 5 U.S.C. § 553.

> funds as a source of State share of financial participation under title XIX of the Social Security Act.[42]

The regulation referred to in this provision (which was subsequently moved without substantive change to 42 C.F.R. § 433.51) is the current regulatory authority for the use of "public funds" from "public agencies" as the non-federal share of Medicaid expenditures, including IGTs and CPEs. The Proposed Rule adopts significant modifications to this provision, including a narrowing of the source and types of funds eligible for federal match, requiring "funds from units of governments" rather than "public funds" from "public agencies." Congress' prohibition of changes to this regulation through an interim final regulation was intended to require HHS to undertake notice and comment rulemaking. To the extent that CMS contends that the current regulatory change is effective at any time prior to the finalization of the formal rulemaking process, it is in violation of both the APA and the 1991 Amendments.

***Recommendation: CMS should clarify that all parts of the regulation are effective on a prospective basis.***

### I. Consultation with Governors

Section 5(c) of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991[43] requires the Secretary to "consult with the States before issuing any regulations under this Act." The preamble of the Proposed Rule does not mention any such consultation with states. Did the agency comply with this statutory mandate, and if so, how and when? Given that the National Governors Association sent a letter on February 23, 2007 to Congressional leadership strongly opposing the Proposed Rule, we also request information on whether the states' concerns have been taken into consideration at all in the formulation of this policy.

***Recommendation: CMS should immediately consult with states on the Proposed Rule and modify or withdraw it based on state concerns.***

## IV. CMS' Regulatory Impact Analysis is Deeply Flawed

### *1. CMS underestimates the administrative burden imposed on states and providers.*

The Proposed Rule imposes significant new burdens on health care providers that CMS fails to acknowledge or severely underestimates. In addition to the significant cut in federal funding that many providers face under the Rule, compliance with new requirements proposed by CMS, including the reporting requirements, will place

[42] Pub. L. No. 102-234, §5(b), 105 Stat. 1793, 1804.
[43] Pub. L. No. 102-234.

substantial additional costs on states and providers. These costs have not been incorporated into CMS' impact analysis; NAPH requests that CMS correct this oversight. As acknowledged in the Proposed Rule, Executive Order 12866 requires agencies to assess both the costs and the benefits of the proposed rule.

For example, costs that are unrecognized in the Proposed Rule include the cost to States that have already formulated complex provider reimbursement methodologies and payment processes based upon existing rules that now must be overhauled to come into compliance with the new rules. As CMS well knows from its role in administering the Medicare program, developing new payment systems for providers is a considerable and costly undertaking. Similarly, many states are going to have to find alternative sources of funding to finance the non-federal share of Medicaid expenditures. To the extent that these sources will involve a redirection of current general revenue funds to plug Medicaid budget holes, other state programs will suffer. To the extent that new taxpayer funding will need to be raised, that is a significant cost to the state. Some states may turn to provider taxes to finance the shortfall, which would not only impose additional costs on providers (including small entities and rural hospitals protected by the Regulatory Flexibility Act) but would involve a substantial commitment of administrative resources to develop and obtain CMS approval for a tax that is compliant under the complex federal provider tax regulations.

The Proposed Rule mandates the creation of additional cost reporting systems to ensure compliance with the cost limit imposed on governmental providers. Even apart from the potential need to create cost reporting systems for provider types that may never have had to deal with cost reporting systems, such as public school districts, states with existing cost reporting systems for hospital providers that do not comply with the Proposed Rule's requirements will be required either to modify their current Medicaid cost report system or to create new ones specifically for this purpose. For example, some states have Medicaid hospital cost report systems that echo the Medicare cost finding system, but may vary in significant ways. The Proposed Rule may require states to adopt cost reports more closely tied to the Medicare cost report to ensure compliance. Furthermore, even in those states that have existing Medicaid cost reporting systems that would pass CMS muster, these systems may not be equipped to capture measurement of costs for the uninsured population or for Medicaid managed care recipients, both of which are potentially relevant in the context of Medicaid DSH payments (or demonstration program payments) to governmental hospital providers.

In addition to the creation and/or modification of these cost reporting systems, states will need to construct new structures for auditing the new cost reports. In the context of CPEs, "periodic State audit and review"[44] is required explicitly, but it is unclear the extent to which CMS expects states to audit and review all cost report submissions.

[44] Proposed 42 C.F.R. § 433.52(b)(4).

Reviewing these cost reports would require additional staffing by state Medicaid agencies and additional expenditures by providers in order to complete the required submissions.

All of these costs -- costs related to creation of the new report system, costs related to auditing the reports, and provider costs of compliance– should be included in the cost/benefit analysis.

2. *The Proposed Rule will have a direct and very significant impact on patient care.*

In addition, we vehemently disagree with the assertion in the Regulatory Impact Analysis that the impact on patient care services will be minimal.[45] As noted above, NAPH members have estimated state-level impacts that anticipate cuts of tens and hundreds of millions of dollars annually per state. With this amount of money drained from the program, significant impacts on patient care services cannot be avoided. These potential impacts include closed community clinics, reduced hours in the remaining clinics, increased reliance on emergency departments for routine care, a reduction in emergency preparedness, less outreach and patient education efforts, little or no investment in expanded access, delayed or canceled plans to upgrade information systems and adopt electronic medical records, less ability to provide translation services to non-English speakers, reduced capacity to maintain or launch intensive disease management programs, etc. The choices available to providers to cope with multimillion dollar funding cuts are not plentiful and are always painful. There is no "fat" left in the system after years of public and private funding cuts; there are no "easy" cuts to make. Virtually any decision made by a hospital system to adjust their budgets to cuts of this magnitude will certainly have a direct impact on patient care, no matter how much the hospital may try to avoid it. CMS ignores the impact this regulation will have, particularly on the poorest and most vulnerable patients.

3. *CMS fails to acknowledge the widespread economic impact on local communities.*

In addition, the Proposed Rule will have a significant economic impact on local communities, as public providers reliant on supplemental Medicaid funding eliminated by this regulation take steps to cut their budgets. Public hospitals typically are a significant economic force in their communities, and their financial health (or lack thereof) has far-reaching ripple effects. Many of these budget cuts will necessarily entail layoffs. The inability to invest in infrastructure will be felt by vendors and contractors in the community. The impact of reduced access will have effects on the health of the community, including the health of the community's workforce, thereby impacting employers throughout the hospital's service area. The community's preparedness for emergencies may suffer because of lack of funding, impacting the ability of the

[45] 72 Fed. Reg. at 2245.

community to attract and retain new businesses and employers crucial to economic vitality. Existing businesses that cater to hospital employees will feel the effects of a shrinking workforce. To the extent that local governments need to step in to fill the gaps caused by the withdrawal of federal funds, every single local taxpayer is affected. A vibrant, dynamic and comprehensive health care safety net is a crucial ingredient in the success of local economies. CMS fails to acknowledge the impact of this Medicaid funding cuts on the economic health of local communities.

***Recommendation: CMS should reevaluate its estimate of the impact of the Proposed Rule and the need for regulatory relief under the Regulatory Flexibility Act. Upon reevaluation of the impact, CMS should either withdraw the proposal or modify as recommended in Part II of these comments.***

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North Carolina Hospital Association

March 15, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and 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), Jan. 18, 2007*

Dear Ms. Norwalk:

On behalf of the 100 North Carolina acute care hospitals, both public and non-public, participating in the State's Hospital DSH and Medicaid Supplemental Payment Program, we appreciate this opportunity to comment on the Centers for Medicare and Medicaid Services' proposed rule. We strongly oppose this rule because of the significant harm these proposed policy changes would cause to these hospitals and the patients and communities they serve.

The rule represents a departure from long-standing Medicaid policy by imposing 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 North Carolina program is based upon the certified public expenditures of 43 public hospitals, used to draw down matching federal funds to make enhanced Medicaid and Disproportionate Share Hospital payments to both public and non-public hospitals that provide essential hospital services to all patients, including Medicaid and uninsured. Approximately $340 million goes to these safety net hospitals to provide quality health care to our state's most vulnerable residents. Hospitals in our state are facing numerous challenges with the growing level of the uninsured and continued threats to reimbursement from government payers and others. In North Carolina, about one-third of our hospitals operate with negative operating margins, while another third have problematic financial results with operating margins of less than five percent, much less than the expected level needed to adequately fund ongoing operations.

We have several concerns with the CMS proposed rule, including the limitation on reimbursement of governmentally operated providers, restrictions on certified public expenditures, the absence of factual data to support the "savings" to the government projected by CMS, and the narrowing of the definition of public hospital.

Of these concerns, the provision that will have the most detrimental impact on North Carolina is the last one noted above, a new and restrictive definition of "unit of government," such as a public hospital. 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. All 43 of North Carolina's public hospitals are considered public under applicable State law. There is no basis in federal statute that supports the proposed change in definition.

Existing federal Medicaid regulations allow North Carolina hospitals to receive payments under our State's program 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 this vital 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, possibly further exacerbating the increasing numbers of the uninsured who cannot afford such high premiums. The second would eliminate needed services, not only 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.

If this devastating rule is not withdrawn, North Carolina hospitals will lose approximately $340 million immediately, or almost $2 Billion over five years. It appears that the rule's estimated losses under such programs or "savings" to the federal government of $3.87 Billion is significantly understated.

The North Carolina Hospital Association opposes the rule and urges CMS to immediately and 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.

If you have questions about these comments, please contact Millie Harding (919/677-4217) or Hugh Tilson (919/677-4229) at NCHA.

Sincerely,

NORTH CAROLINA HOSPITAL ASSOCIATION

William A. Pully
President

cc: Members of North Carolina's Congressional Delegation

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Children's Memorial Hospital

Children's Memorial Foundation

Children's Memorial Research Center

*Affiliated with Northwestern University's Feinberg School of Medicine*

March 16, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2258-P
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Ms. Norwalk:

On behalf of the children in our community served by Medicaid, Children's Memorial Hospital is pleased to provide comments to the Centers for Medicare and Medicaid Services (CMS) on its Medicaid administrative rule published in the January 18th *Federal Register.* Both the National Association of Children's Hospitals and the Illinois Hospital Association have asked Children's Memorial to submit comments on the proposed rule.

CMS estimates that the rule will cut $3.8 billion in federal funding over five years. Rod Blagojevich, Governor of Illinois, has stated that Illinois will lose $623 million per year if the proposed rule is promulgated. Children's Memorial does not have the technical ability to comment on the total cost to the State or many of the legal technicalities raised by the rule; however we would like to share our view on the importance of this issue for our hospital and the children of Illinois. The funding mechanisms impacted by the rule have been used in Illinois for over a decade with the knowledge and approval of the Health Care Finance Administration and the Centers for Medicare and Medicaid Services. We commend CMS for assisting states; however, we are sensitive to the need to maintain the integrity of the Medicaid program.

After two turbulent decades, the Illinois Medicaid program began work with advocates and providers to achieve fiscal and programmatic order. Coincidentally with the inception of SCHIP, Illinois has taken many steps to both expand coverage for children and enhance payments to providers. CMS has been instrumental in helping Illinois and providers who serve children insured by Medicaid. Both the leadership of CMS and its technical staff have provided indispensable support in helping Illinois work through complex and controversial issues such as the Family Care waiver, Senior Care waiver and, most recently, the desperately needed provider assessment.

The proposed rule would create a significant financial disruption to Illinois at a time when it is on the verge of completing a stable foundation for meeting the health care needs of children who rely upon Medicaid.

**Negative Impact on Children Covered by Medicaid**
Changes to the way states finance their Medicaid programs would have real consequences for the 29 million children in the country who rely on Medicaid for health insurance coverage. In Illinois, 1.2 million children have Medicaid coverage which translates to approximately 1 in 3 children in the state who rely upon the program for health care. Because children represent the majority of Medicaid enrollees, any changes made to the program, such as those in the proposed regulation, would have a disproportionate impact on them.

Children's Memorial is the State's largest provider of pediatric Medicaid care, representing 57% of our gross patient revenues. In total, Children's Memorial provides 30% more inpatient, outpatient and physician pediatric Medicaid services than the next highest provider in Illinois.

**Threatens the Viability of Children's Hospitals – the Safety Net for All Children**
Not only does the proposed regulation threaten the financial viability of public safety net providers, it would also threaten reimbursement for children's hospitals, which, on average, devote more than 50 percent of their care to children on Medicaid and virtually all care for children with complex health care conditions.

In the past, states faced with budget shortfalls instituted reimbursement cuts, which included safety net hospital payment decreases, to make up for the loss of federal funds. Because a large percentage of our patients rely on Medicaid for their health insurance coverage, any decreases in reimbursement impact our ability to provide care to all children.

In FY 2006, Children's Memorial Medicaid losses were a staggering $16.7 million. When faced with payment decreases, our hospital faces tough decisions about the potential for service cutbacks. These cutbacks affect all children, not just children on Medicaid. Any efforts to address these financing mechanisms should consider the significant impact changes would have on children's hospitals' ability to receive adequate funding and continue to provide health care services to all children.

**Additional Changes Unnecessary**
Over the years, Congress and CMS have repeatedly addressed the need for limitations on state financing. Some of the most recent regulatory changes related to upper payment limits are still being phased in. The need for additional restrictions on state financing is unsubstantiated. Not only would additional changes have a negative impact on children and children's providers, but they are unnecessary.

The annual growth in federal Medicaid spending has declined significantly due to both improvements in the economy and cost containment policies adopted by states in recent years. Federal spending on Medicaid is not out of control and does not warrant changes such as those proposed, which would have a negative impact on the health care safety net.

**Conclusion**
We are extremely concerned about this proposed regulation and the impact it would have on children enrolled in Medicaid and on children's hospitals.

We encourage CMS to delay the implementation of the regulation to allow time for a thorough review of the proposed regulation's impact on children enrolled in Medicaid and the providers who serve them.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Jill Fraggos, Director, Government Relations or jfraggos@childrensmemorial.org . Thank you very much for your consideration.

Sincerely,

Patrick M. Magoon
President and CEO

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CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

March 16, 2007

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

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

Dear Ms. Norwalk:

On behalf of the California Association of Public Hospitals and Health Systems ("CAPH"), I am writing to express strong opposition to the proposed Medicaid rule regarding cost limits on Medicaid payments to public health care providers. (CMS-2258-P) We appreciate the opportunity to advise the agency of the far-reaching, damaging effects that the rule would have on California's public health care safety net. The proposed limits on Medicaid payments to public health care providers and the proposed restrictions on the states' ability to use local public funds to finance Medicaid services will lead to devastating results for safety net providers and the communities they serve across the country. CAPH urges you to withdraw this proposed rule.

CAPH represents 21 public hospitals, health care systems and academic medical centers, located in 16 counties in California. Our hospitals are a cornerstone of the State's health care system. Public hospitals operate nearly 60% of California's top-level trauma centers, which are state-of-the-art emergency medical units that treat the most catastrophic, life-threatening injuries. We also operate almost 45% of the State's burn centers and provide more than 60% of California's emergency psychiatric care. Our members also operate other types of providers that participate in the Medicaid program, including clinics, Federally Qualified Health Centers ("FQHC"), and managed care organizations, all of which would be adversely affected by this rule. This rule will likely result in the reduction of critical health care services that public hospitals are uniquely qualified to provide, thereby limiting services and health care access—a result directly contrary to the purpose of the Medicaid program.

The rule will limit Medicaid payments to the cost of Medicaid services to Medicaid recipients. This will eliminate funding for indigent non-Medicaid patients whose costs

are currently covered under the Safety Net Care Pool, which is an integral part of California's Hospital/Uninsured Care Demonstration Project, approved under Section 1115 of the Social Security Act, ("Hospital Waiver"). As CMS clearly states in the preamble that the rule applies to all waivers, CAPH is concerned this critical funding for the uninsured will be eliminated. Based on the impact on the Hospital Waiver, we estimate that California's public hospitals will lose $500 million per year for the next three years, and additional funds beyond that period.

The Centers for Medicare and Medicaid Services ("CMS") claims that the rule is necessary to address state financing abuses, while at the same time the agency touts its success in eliminating these abuses on a state-by-state basis. While we acknowledge and support CMS' efforts in this regard, it is clear that the agency already has the legal tools needed to address these problems and that the proposed limits on state flexibility through this overreaching rule are unnecessary. Any solution to issues of funding integrity should be narrowly tailored to result in the least harmful effects to public providers and their patients. The sweeping restrictions set forward in the rule exceed this basic principle to the extent that its implementation will negatively affect legitimate funding practices, like those used in California.

Since the rule was published, a bipartisan letter lead by Congresswoman Eshoo and Congressman King, which expressed strong opposition to the implementation of the rule, was signed by 226 members of Congress. A similar bipartisan letter circulated by Senators Dole and Durbin received 43 signatures. In addition, the National Governors Association, the National Association of Counties, and others have formally registered their opposition to the rule. The provisions of this rule are clearly contrary to the will of Congress and many organizations with the expertise to predict its potential impact. CMS must respond to this overwhelming resistance and withdraw the proposed rule.

## I. Key Concerns.

A. The proposed rule inappropriately limits states' ability to fund the nonfederal share of Medicaid expenditures by narrowing the types of public entities that can participate in that funding and by restricting the states' ability to use local public funding for the Medicaid program. These restrictions are not authorized by statute and are inconsistent with Congressional intent.

B. The cost limit rule would contravene the rate-setting flexibility granted to the states by Congress. CMS is not authorized to impose the proposed cost limit on public providers. Such a limit will result in inadequate payment and will ultimately restrict access to services for Medicaid recipients and the community as a whole.

C. The proposed retention requirement is too broad and serves no legitimate purpose. Congress has never granted CMS the authority to regulate how providers use the Medicaid revenues they receive for Medicaid services they have already rendered.

## II. Specific Comments on proposed rule.

CAPH is concerned with the rulemaking approach reflected in this publication. In places, the preamble discussion mischaracterizes current law and at times it is inconsistent with the language of the proposed rule itself. CMS' rationale for this rule--to protect against states' financing abuses--does not support the draconian measures proposed. Taken as a whole, the notice of proposed rulemaking does not fairly present the issues for public consideration and comment as required by the Administrative Procedures Act ("APA").[1]

The proposed rule is inconsistent with express statutory provisions and with Congressional intent to protect states' flexibility under the Medicaid program, both in terms of funding sources and payment rates. The rule will dramatically reduce funds available to care for the most vulnerable populations—those who are in need of medical care, but who lack financial resources. CAPH urges CMS to withdraw the proposed regulation in its entirety. In the event that CMS goes forward with a final regulation, we urge you to make the extensive revisions necessary to protect public safety net hospitals and the people they serve.

### A. The proposed rule inappropriately limits states' ability to fund the nonfederal share of Medicaid expenditures.

#### 1. Definition of Unit of Government

The proposed amendments to Sections 433.50 and 433.51 would inappropriately limit those entities qualified to provide the nonfederal share of Medicaid expenditures to units of government with generally applicable taxing authority. CMS relies on Sections 1902(a)(2)[2] and 1903(w)(6) and (7)[3] of the Social Security Act ("Act") in support of these changes. For a number of reasons, however, the legal analysis presented in support of the proposed rule is flawed.

First, there is nothing in Section 1902(a)(2) that supports restrictions on the types of units of government that can make Medicaid certified public expenditures ("CPEs") or intergovernmental transfers ("IGTs"). That section of the Medicaid statute recognizes the states' authority to use public funds, in addition to state funds, to finance Medicaid expenditures. The provision, which has been in place in its current form since 1967, has never been interpreted by CMS in any regulation or formal policy statement to support such narrow restrictions on the categories of public entities that can participate in Medicaid financing. The current regulation reflects the longstanding policy that allows a broad range of public agencies to make CPEs or

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[1] 5 U.S.C. § 533.

[2] 42 U.S.C. § 1396a(a)(2).

[3] 42 U.S.C. § 1396b(w)(6) and (7).

IGTs. Section 1902(a)(2) remains unchanged and, as discussed below, the 1991 legislation adding Section 1903(w) was not intended to change this result.[4]

Second, the proposed regulatory definition is inconsistent with the plain language of the statutory definition of unit of government on which CMS relies.[5] The proposed rule conspicuously adds the requirement of "generally applicable taxing authority" to the statutory definition. If Congress had intended to impose this additional requirement, it would have done so. Instead, Congress adopted a broad definition with the intent of maintaining then existing policy allowing any public agency to fund Medicaid.

Third, the rule would apply the term "unit of government" well beyond its stated applicability. Section 1903(w)(7) expressly limits the scope of the terms defined therein to be used only "for purposes of this subsection." CMS goes far beyond this limitation and would use the term to change the interpretation of Section 1902(a)(2) of the Act to limit the use of local funds under a completely different section of the Medicaid law.

Fourth, the proposed rule is directly inconsistent with the reason that Congress included these provisions in the 1991 Medicaid Amendments. While Section 1903(w) generally was designed to limit certain types of Medicaid financing methods, paragraphs (6) and (7)(G) of 1903(w) were intended to protect the states' ability to use local public funds to finance the nonfederal share of Medicaid expenditures. The purpose of these provisions was to make it clear that IGTs were not to be restricted like provider-related taxes and donations, which were considered abusive. The Conference Committee stated:

> The conferees note that current transfers from county or other local teaching hospitals continue to be permissible if not derived from sources of revenue prohibited under this act. The conferees intend the provision of section 1903(w)(6)(A) to prohibit the Secretary from denying Federal financial participation for expenditures resulting from State use of funds referenced in that provision.[6]

By limiting the definition of unit of government, the proposed rule is directly contrary to this Congressional directive. In California, the requirement that the unit of government providing the nonfederal share of Medicaid expenditures itself have generally applicable taxing authority would result in eliminating the use of University of California teaching appropriations for Medicaid funding purposes. Moreover, it would eliminate the use of Alameda County Medical Center funds as the nonfederal share of Medicaid expenditures.

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[4] *See* Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Pub. Law No. 102-234) ("1991 Medicaid Amendments").

[5] *See* § 1903(w)(7)(a); 42 U.S.C. § 1396b(w)(7)(a).

[6] H.R. Conf. Rep. No. 102-409, at 1444 (1991).

The University hospitals are owned and operated by the Regents of the University of California, a constitutionally created unit of State government. The Regents do not have independent taxing authority and the University hospitals are not an integral part of those units of state government that do have such authority. Therefore, as currently drafted, the proposed rule would restrict the use of "funds appropriated to State university teaching hospitals" in direct violation of the plain language of Section 1903(w)(6) of the Act.

Similarly, Alameda County Medical Center ("ACMC"), a public entity that expends public funds in the provision of hospital services to Medi-Cal beneficiaries, is protected under Section 1903(w)(6) from the restrictions the proposed rule would impose. However, ACMC is operated by a hospital authority which is separate from Alameda County. It is the County, and not the separate authority, that has the generally applicable taxing authority. Under the proposed regulation, California could not rely on the IGTs or CPEs generated at ACMC as a source of Medicaid funding. CMS has set forth no rationale for, or valid federal interest in, limiting ACMC's ability to participate in Medicaid financing.

There is no legitimate federal interest in imposing these restrictions on California's ability to fund its Medi-Cal program. While the proposed rule would result in federal savings, those saving would be accomplished in violation of the State's right to use local funds as the nonfederal share of Medicaid expenditures under Section 1902(a)(2) of the Act.

**2. Preamble statements on restricting sources of funds cause confusion and raise concerns.**

In the preamble, CMS states that tax revenue is the only valid source of IGTs.[7] While neither current law nor the proposed regulations expressly impose such a requirement, the preamble statements suggest that CMS intends to adopt an interpretation that would limit local Medicaid funding to those funds derived directly from taxes. Any such limitation on the use of public funds would be directly inconsistent with the long-standing implementation of the Medicaid statute and with the protections intended by Congress in Section 1903(w)(6) of the Act.

Section 1902(a)(2) is the statutory provision that has long been interpreted as granting states authority to use public funds, other than state funds, to finance Medicaid expenditures. Beyond a broad reference to the adequacy of "local sources" of funds, the provision, which has been in place in its current form since 1967, imposes no restriction on the sources of local funds that may be used by the states. Until 1991, when Congress imposed strict limitations on federal financial participation ("FFP") designed to preclude the use of provider-related taxes and donations to finance Medicaid expenditures, there were no statutes or regulations in place that imposed any such restrictions. The Health Care Financing Administration's attempt to impose such restrictions through regulations was rejected by

[7] *See* 72 Fed. Reg. 2238.

Congress.[8] As discussed above, at the same time, Congress chose to protect, rather than restrict, the use of public funds to finance Medicaid expenditures.

CMS has no authority to look behind public Medicaid expenditures to determine their source. If it had that authority, the 1991 Medicaid Amendments would not have been necessary.[9] Once funds are in the hands of a public entity, they are public dollars that can be used for any appropriate public purpose, including the provision of covered Medicaid services. If public expenditures are made for this purpose under an approved state plan or under an approved waiver program, CMS is obligated under Section 1903(a) of the Act to provide FFP.[10]

CMS has expressed no rationale for limiting local Medicaid funding to tax revenues. Public entities obtain funds from a number of sources. For example, California counties receive tobacco settlement funds, earn interest on amounts deposited in financial institutions, experience gains on the sale or lease of property, obtain donations from individuals, and earn revenues from various operations, including the operation of their health care providers. CMS has identified no valid policy reason to preclude counties from using these funds to support the Medicaid program.

In any event, it would be virtually impossible for a public entity to demonstrate compliance with such a requirement. Even the suggestion of such an ability reflects a lack of understanding of governmental accounting practices. Generally, tax revenues are not held in separate accounts, but are intermingled with various revenues in a "general fund." Any attempt on the part of CMS to impose a requirement to segregate and track tax revenue in order to support Medicaid expenditures is unworkable. This is particularly true in multi-hospital systems where tax dollars may be co-mingled with patient care revenue and other available public funds in system-wide accounts.

CAPH urges CMS to withdraw the proposed changes to Sections 433.50 and 433.51. If CMS goes forward with a final rule, the definition of unit of government must be broadened to allow recognition of the legitimate use of all public funds by entities such as the University of California hospitals and ACMC to finance the nonfederal share of Medicaid services. CMS should clarify that sources of the nonfederal share will not be limited to tax revenue.

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[8] Section 2(c)(3) of the 1991 Medicaid Amendments.

[9] Even the 1991 Medicaid Amendments do not provide such authority. FFP is denied for provider-related taxes or donations regardless of whether they are used for Medicaid.

[10] 42 U.S.C. § 1396b(a).

**B. The proposed cost limit on public providers is inconsistent with the Medicaid statute and Congressional intent, will result in inadequate payment and will restrict access to services for Medicaid beneficiaries.**

**1. The proposed rule is inconsistent with Section 1902(a)(13)(A) of the Act,[11] which provides for state flexibility in setting rates.**

Since 1980, Congress unequivocally has provided for state flexibility in establishing payment methodologies for inpatient services. Prior to 1980, Medicaid law imposed a reasonable cost limit on all inpatient services. Under legislation collectively referred to as the Boren Amendment,[12] Congress expressly eliminated this requirement, allowing states to set rates without reference to Medicare cost principles. In 1997, Congress repealed the Boren Amendment in favor of granting states even more flexibility to develop innovative payment systems.[13]

Both before and after passage of the BBA, CMS consistently has acknowledged that the BBA was intended to increase state flexibility in rate-setting for inpatient facilities. Former HCFA Administrator Bruce Vladeck, setting forth the agency's support of the BBA provision, stated that the repeal of the Boren Amendment would provide states "with much greater flexibility to develop innovative and more efficient health care delivery and payment systems."[14] CMS guidance regarding the implementation of the BBA also states: "we recognize that the intent in repealing the Boren Amendment was to reduce [CMS'] role in the institutional payment rate setting process and to increase state latitude in this area."[15]

Given Congress' clear mandate, it is surprising for CMS now to assert that it has authority to reinstate a facility-specific payment restriction that Congress eliminated more than 25 years ago. When Congress intends for a facility-specific limit to apply, it has specifically enacted one, such as the restriction on payment for inpatient hospital services (exclusive of disproportionate share hospital ("DSH") payments) in excess of a hospital's customary charges (*see* § 1903(i)(3) of the Act[16]), and the hospital-specific limit on DSH payments (*see* § 1923(g)

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[11] 42 U.S.C. § 1396a(a)(13)(A)(1).

[12] Omnibus Reconciliation Act of 1980 § 962 (Pub. Law No. 96-499) and Omnibus Budget Reconciliation Act of 1981 § 2173 (Pub. Law No. 97-35).

[13] Balanced Budget Act of 1997 ("BBA") § 4711.

[14] Statement of Bruce C. Vladeck, Ph.D Administrator Health Care Financing Administration on the President's Budget Proposal FY 1998 Before the House Committee on Commerce Subcommittee on Health, Feb. 12, 1997.

[15] Letter from Sally K. Richardson, Director, CMS Center for Medicaid and State Operations, to State Medicaid Directors, December 10, 1997.

[16] 42 U.S.C. § 1396b(i)(3).

of the Act[17]). Congress also authorized CMS to establish *aggregate* upper payment limits ("UPLs") that are based on what Medicare would pay.[18] The existing statutory structure can only be interpreted to reinforce the maximum flexibility of states to establish provider rates. The proposed cost limit would have precisely the opposite effect for a significant group of providers.

CMS' prior regulatory actions have never before been so dismissive of state flexibility in regard to rates. For example, in establishing the current aggregate UPLs, CMS recognized states' flexibility to "make a reasonable estimate" of the limits based on Medicare payment principles, noting that "[t]here are many factors and elements that States may consider to support their estimates."[19] At no time was it suggested that the estimates would be reconciled to actual data. Moreover, CMS expressly rejected the approach of imposing facility-specific limits "when balanced against the additional administrative requirements on States and [CMS], *coupled with Congressional intent for States to have flexibility in rate setting ....*"[20]

The proposed regulation at Section 447.206 essentially dictates one payment method for public providers. Under this rule, states would not be able to exercise the flexibility afforded by the BBA to develop payment methodologies, such as prospective payment systems, that deviate from the retrospective Medicare cost principles. This is because *any* payment to public providers will be considered "interim," subject to settlement based on Medicare cost reporting.

Importantly, very few services are reimbursed by Medicare on a cost basis. Congress has over time rejected this inefficient payment method in favor of prospective rate setting. As a result, Medicare cost principles are outdated and have failed to keep up with industry and technological changes. Additionally, as more fully discussed below, the proposed rule would eliminate the aggregate UPLs for public providers, thereby eliminating the ability of states to target rate differentials for particular types of providers in order to address standards relating to quality of care and access.

**2. The proposed cost limit is inconsistent with the statutory standard that states establish payments adequate to ensure access.**

The preamble to the proposed rule refers to "statutory principles of economy and efficiency as required by Section 1902(a)(30)(A) of the Act" in support of imposing individual cost-based payment limits upon public providers. However, the complete statutory principle is that:

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[17] 42 U.S.C. § 1396r-4(g).

[18] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act ("BIPA") § 705.

[19] 66 Fed. Reg. 3148, 3153 (January 12, 2001).

[20] Id. at 3175 (emphases added).

payments are consistent with efficiency, economy, *and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area...*[21]

As Congress has recognized, this standard is not best met with a generic, one-size-fits-all approach, but the proposed rule attempts to do just that. The rule assumes that, in every geographic area in each of the states, access to Medicaid services provided by public providers can be assured with payments that are at or below Medicare costs, even though Medicare has abandoned that payment method with respect to most services. The rule ignores the fact that many actual expenditures of public providers essential to maintaining access for Medicaid patients would not be reflected as Medicare costs. For example, CAPH members maintain emergency rooms and trauma centers that are required to provide care to anyone in need of emergency care.[22] While the costs for the uninsured must be incurred by the hospitals, the cost limit would not recognize such costs. If enough hospitals close their emergency rooms because of these losses, it will be impossible for the state to maintain access for its Medicaid population. The result is loss of access to critical care, not just for Medicaid beneficiaries, but for the entire community. Clearly, this is not good public policy.

As noted above, states have not been restricted to Medicare cost reimbursement for over 25 years. Congress allowed states to pay providers on a different basis to satisfy the statutory quality and access standard. The states, rather than CMS, are better able to determine the quality and access standard in particular geographic areas within the state and how best to meet the standard, which may include prospective payments and rate differentials that may be based on performance or other factors. Congress did place some limitation on state flexibility when it directed CMS to establish aggregate payment limits based on what Medicare would pay. The proposed cost-based limit on individual providers would virtually handcuff states in their ability to comply with the quality and access standard, and usurp clear Congressional intent as reflected in the existing Medicaid statutory structure.

### 3. The proposed rule violates the statute as applied to FQHCs.

The proposed rule at Section 447.206 would impose a cost limit on payments for all publicly operated providers. This rule directly contravenes the statutorily imposed prospective payments for FQHCs at Section 1902(bb) of the Act.[23] Under Section 1902(bb), FQHCs are paid per visit amounts based on their average costs incurred during 1999 and 2000, increased by the percentage increases in the applicable Medicare Economic Index. Importantly, the statute permits states to establish alternative payment methodologies that pay in excess of the

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[21] § 1902(a)(30)(A) of the Act (emphasis added); 42 U.S.C. § 1396a(a)(30)(A).

[22] § 1867 of the Act; 42 U.S.C. § 1395dd.

[23] 42 U.S.C. § 1396a(bb).

statutory prospective payments system. Under the proposed rule, however, the prospective payments to publicly operated FQHCs would be interim, subject to reconciliation to actual costs. This consequence vividly demonstrates why the proposed rule does not fit within the statutory structure of state flexibility that Congress has methodically set forth.

**4. CMS' analysis of Congressional intent to cover only Medicaid recipients does not support the cost limit.**

CMS cites the statutory restrictions on matching only Medicaid expenditures as the basis of limiting payments to cost for public providers. This rationale is flawed, however, because the statutory restrictions apply to *states'* expenditures. When a state makes a payment to a provider for Medicaid covered services rendered to a beneficiary, it is that payment by the state which is recognized as the medical assistance expenditure for which federal matching is made and not the provider's expenditures in rendering the services. Contrary to the suggestion in the preamble, Congress has never attempted to legislate what a provider can do with its Medicaid payments once they have been earned for services rendered.

Congress never has precluded providers from using their Medicaid revenues to care for the uninsured. In fact, the mission and purpose of public and private non-profit providers is to provide health care to those in need. It is entirely appropriate for revenues to be used for this purpose. The fact that there is specific legislation that permits federal payments to providers for services to the uninsured does not mean, as CMS implies, that Congress intended these to be the exclusive sources of funding that providers can use for these services.

As CMS has acknowledged, there is no federal restriction on what a provider can do with the revenue it earns.[24] This is the case regardless of whether the provider is public or private. CMS' attempt to impose a payment limit on only public providers assumes that there is no operational expense or other use of revenue by private providers that is unrelated to Medicaid. This assumption is without merit. Support for uninsured services is not necessarily unique to public providers, and there are a variety of different purposes for which public and private providers may apply their revenues. There is no rational basis for limiting payments for public providers to costs, while allowing payments to private providers to exceed costs. In fact, CMS has recognized the importance of payment equity across provider types.[25]

**5. The proposed restriction will severely under fund California's safety net providers, jeopardizing access to care for Medicaid beneficiaries.**

As discussed above, Medicaid rates must be sufficient to ensure quality of care and access to care and services for beneficiaries. CMS assumes that reimbursement of individual providers' costs at or below that determined under Medicare cost-finding principles is sufficient. This assumption is incorrect, because Medicare cost principles do *not* recognize all of a

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[24] *See* 67 Fed. Reg. 2602, 2605 (Jan. 18, 2002).

[25] *See* 67 Fed. Reg. 2602, 2603 *passim* (Jan. 18, 2002).

provider's expenditures. In the case of public providers, these unrecognized costs are substantial.

For example, because of the requirements of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), as well as similar state laws, hospitals that operate trauma centers must provide certain trauma and emergency services, and screening services, without regard to the patient's ability to pay. Given the high cost of trauma services, and the increasing numbers of uninsured seen by public hospitals, trauma hospitals incur substantial losses in complying with these requirements. While not all of these losses are directly tied to Medicaid beneficiaries, if the losses reach such a level that the hospital is forced to close its trauma center, access to trauma services for Medicaid beneficiaries, as well as others in the community, will be impaired.

Even with DSH funding, essential costs of operating public providers to ensure access to care remain unfunded. First, DSH funding in the aggregate is capped, and this cap is imposed without regard to costs incurred. Second, in recent years CMS has shifted its policies regarding the computation of the hospital-specific DSH limits to exclude the costs of physicians and other professional services. Public providers typically incur significant costs for recruiting and retaining physicians and other health professionals to treat their uninsured patients. These costs are not taken into account under DSH.

All of these costs are necessary and legitimate to consider in establishing rates that assure quality of care and access pursuant to Section 1902(a)(30)(A), yet under the proposed limit such costs would be disregarded. If states lose their flexibility to establish adequate rates, access to care and services for Medicaid beneficiaries will be substantially curtailed, as increasingly more providers become unable and unwilling to treat them.

**6. Implementing the proposed cost limit poses numerous practical problems.**

The proposed rule at Section 447.206 does not set forth the specific methodology for identifying and allocating individual provider costs, but instead provides that, at some point, the Secretary will determine the appropriate procedures. The preamble suggests use of the Medicare cost reports for hospital and nursing facility services, with "exceptions" to be addressed on a case-by-case basis.[26] The proposed regulatory language, however, provides differently, stating that costs for such services "must" be supported using Medicare cost report information.

As previously discussed, Medicare currently reimburses for almost all services on a prospective payment basis and not on the basis of reasonable costs. Thus, the reliability of Medicare cost principles for widespread use today is suspect because these cost principles were developed 30 years ago, and they were designed to address a different program structure and

[26] *See* 72 Fed. Reg. 2241.

scope of services. What this means is that the use of Medicare cost reports without substantial changes would not be appropriate.

For example, the Medicare cost report provides for the removal of the salaries and benefits for interns and residents as well as related overhead costs, from Medicare allowable costs. The reason Medicare removes these is not because such costs were not incurred or were not allowable, but because Medicare reimburses hospitals for medical education activities through a separate graduate medical education ("GME") payment mechanism. The GME payment amount is based on the application of a historical per resident rate to a capped and reduced number of residents. If adopted in final, the rule should recognize the full costs of GME.

Another example is with respect to physician services. Medicare separates out the professional services component that is covered under Part B, leaving only the cost of physician services to the hospital ("provider component") on the hospital cost report. While this distinction was required under Medicare rules, it has no similar rationale under Medicaid, particularly for public hospitals in California, which typically directly employ or contract for physicians to serve their patients.

Medicare historically did not reimburse physician services on a cost basis, except with respect to the provider component. Limits on such physician services costs, known as the reasonable compensation equivalents ("RCE"), were established in 1983 and derived from limited physician salary data from 1979. The extremely narrow application of the RCEs in the Medicare context has not warranted much administrative or analytical attention by CMS and is inappropriate to apply in the Medicaid context.

Apart from institutional settings, there is no Medicare cost-reporting precedent and no other "standardized" mechanism to collect cost information. Such publicly-operated settings include medical offices and clinics, including public health clinics. In California, the development of an appropriate methodology has been challenging, with no approved form to date.

Implementation of the proposed limit with respect to all public providers would be immensely burdensome, not only because of the administrative hardships it would impose on already stressed public resources, but because it will create financial uncertainties for many years. This is because the limit essentially makes all payments received by public providers interim, subject to retrospective reconciliation to costs. Even under Medicare, it typically took years before cost and reimbursement settlements were finalized. The proposed cost limit will wreak havoc upon the currently precarious finances of public providers, since Medicaid constitutes a substantial proportion of their revenues. Furthermore, many states do not have the substantial administrative procedures and mechanisms in place to conduct the audits and appeals necessary to implement the proposed limit. The "efficiencies" of the proposed rule are simply not evident.

Finally, we note that the proposed cost limit appears to apply to payments made by Medicaid participating managed care organizations to public providers. If this is CMS' intent, we do not understand its rationale. The application of a retrospective cost limit to

managed care services will preclude providers from negotiating for and receiving capitation payments, and would seem to contradict the principles of managed care. CMS should clarify that these payments are excluded from the limit.

**7. As drafted, the application of the proposed cost limit to DSH payments would contradict the Medicaid DSH requirements.**

Proposed Section 447.206 does not exclude DSH payments from the restriction on payments in excess of the individual provider's cost of providing covered services to eligible Medicaid recipients. DSH payments are, however, payments for inpatient hospital services rendered to Medicaid recipients; they are payment adjustments that provide additional compensation to take into account the situation of hospitals which serve disproportionate volumes of low-income patients. Even though the hospital-specific DSH limits (Section 1923(g) of the Act) include the uncompensated costs of uninsured patients, a DSH payment is *not* reimbursement for a non-Medicaid patient, that is, it does not convert a service rendered to a non-Medicaid patient into a Medicaid covered service to a Medicaid recipient.

If the proposed cost limit is applicable to DSH payments, then DSH payments to a public hospital could not exceed the cost of services to Medicaid recipients. As a result, DSH payments could not reflect a hospital's uncompensated costs of care rendered to uninsured patients. Such a result is in direct conflict with the provisions of Sections 1902(a)(13)(A) and 1923(g) of the Act. Therefore, DSH payments must be expressly excluded from the proposed limit.

**8. The impact of the proposed cost limit on the UPL transition provisions is unclear.**

The proposed rule modifies somewhat the existing aggregate UPLs for non-state government operated facilities under Sections 477.272 and 477.321. However, there remain a number of inconsistencies in how the proposed cost limit will interrelate with these UPLs. For example, the UPLs as modified by the proposed rule would be individual limits, as opposed to aggregate, yet the amount that is in excess of the UPLs that are to be phased out over the transition period appears to still be an aggregate amount. Even if the excess amount to be phased out is supposed to be an individual provider-specific amount, it is unclear as to how that should be calculated. Finally, we note that, notwithstanding the modifications to the UPL transition rules, the proposed cost limit at Section 447.206 appears to be in conflict because there is no exception to reflect transition payments.

**C. CMS has no authority to require providers to retain payments received for services already rendered.**

As currently drafted, proposed Section 447.207 is too broad. Although the preamble suggests that this requirement would only apply to IGT funded Medicaid payments, the language of the regulation is much broader, applying to all Medicaid payments to all types of providers.

The proposed rule lacks the specificity necessary to make it enforceable. It is unclear how a provider can "retain the full amount of" its total Medicaid payments. Would

providers be required to place all Medicaid revenues in a separate account and never use them, even to pay employees or to purchase supplies? This would be a problem, particularly for managed care organizations that would be precluded from using their capitation payments to obtain services for their enrollees. Clearly, CMS did not intend this absurd result, but the language of the rule does not provide guidance as to how a provider is to comply with the rule. Although the regulation appears to base compliance with the retention requirement on an "examination" of the underlying Medicaid expenditures, this language does not add clarity to the regulation because it fails to state the standards that will be applied in such an examination. As a result, the regulation is impermissibly vague.

Through this regulation, CMS is apparently attempting to regulate providers' use of the Medicaid revenues that they have earned for the Medicaid services they have already provided. As discussed above, nothing in the Medicaid statute grants CMS the authority to impose such restrictions. CMS simply has no statutory authority to tell providers, public or private, what to do with their Medicaid revenues. This proposal is particularly egregious when applied to public providers that will never receive more than reimbursement of costs already incurred under this proposed rule. If the provider has already spent the full amount on services, what is left to be "retained"?

The preamble suggests that this rule is necessary to protect against abuses. However, the rule is neither a necessary nor effective means of addressing state funding abuses. If CMS is concerned that state Medicaid expenditures are not consistent with legal requirements, then CMS should impose regulations on the calculation of those expenditures. CMS is attempting to regulate states' behavior by imposing unwarranted restrictions on providers. Moreover, if, as the preamble states, current law requires offsets to ensure appropriate net expenditures, then this proposed regulation is unnecessary.[27]

Proposed Section 447.207 should be withdrawn.

**D. If, as the preamble states, all payments under Medicaid waivers are subject to all provisions of this rule, the impact on the California safety net would be devastating.**

California's Medi-Cal program operates under a number of waiver programs. The Hospital Waiver provides Medicaid funding for inpatient hospital services to Medi-Cal recipients and for services to the uninsured. Under the Hospital Waiver and related State plan amendments, private safety net hospitals receive negotiated contract rates for Medi-Cal inpatient hospital services and additional Medi-Cal payments in lieu of DSH funding. The State's 23 designated public DSH hospitals are paid based on their CPEs for inpatient hospital services rendered to Medi-Cal recipients. These CPEs are made with local public funds and, based on the current federal medical assistance percentage, the public hospitals receive 50 cents on each dollar of allowable cost for these services. The public hospitals also receive most of the State's DSH allotment under Section 1923(f) of the Act,[28] based on their CPEs. They can receive 50 cents in

[27] *See* 72 Fed. Reg. 2238.

[28] 42 U.S.C. § 1396r-4(f).

DSH funding on each dollar spent on hospital services to the uninsured, subject to hospital-specific DSH limits under Section 1923(g) and up to the to California's DSH allotment.

The Hospital Waiver also includes a Safety Net Care Pool of $766 million per year of federal funds available to match State, public hospital and other public entities' expenditures on services to the uninsured. Section 1115(a)(2) of the Act[29] allows CMS to pay these funds to California, even though expenditures for the uninsured would not normally be eligible for federal matching under Medicaid. CMS has determined that, even taking into account the Safety Net Care Pool dollars, the Hospital Waiver is budget neutral. That is, CMS will pay no more under the Hospital Waiver than it would have paid California in the absence of the waiver. Thus, the amount in the Safety Net Care Pool represents federal Medicaid dollars that currently could be paid to California, such as the amount above allowable costs that public hospitals could earn under the existing federal rules, an amount representing the UPL transition, and other savings resulting from Hospital Waiver.

CAPH is concerned that the proposed rule will dramatically lower payments to its member hospitals under the Hospital Waiver, resulting in reduced access to services for the vulnerable populations served by public hospitals. Our concern is based on the unequivocal statements in the preamble that all Medicaid payments "made under the authority of the State plan and under Medicaid waiver and demonstration authorities are subject to all provision of this regulation."[30] Moreover, the Special Terms and Conditions that govern the Hospital Waiver require that the State come into compliance with any regulatory changes, and that CMS must adjust the budget neutrality cap to take into account reduced spending that would be anticipated under new regulations. (See, Section II, paragraphs 2 and 4 of the Special Terms and Conditions.)

If CMS implements its stated intent to apply these rules to the Hospital Waiver without significant changes to the proposed regulatory language, the result is clear: Medicaid funds under the Hospital Waiver will no longer be available for services to the uninsured, the budget neutrality cap will be adjusted accordingly and a substantial portion of the Safety Net Care Pool will be lost.

In response to expressions of these concerns, CAPH has been advised that CMS officials have stated that the proposed rules will have no impact on California's Hospital Waiver. If these statements reflect the intent of CMS, then substantial changes will be necessary in the final regulations to make the rule consistent with that intent. Although CAPH would welcome the changes set forth below, they would protect the Hospital Waiver only in the short term, and would do nothing to address the fundamental policy concerns we have raised in this letter. Even if the Hospital Waiver is protected until it expires in 2010, California's safety net providers will soon have to begin planning the changes that will be necessary to deal with the adverse consequences of these flawed regulations. Therefore, we strongly urge that CMS withdraw this

[29] 42 U.S.C. § 1315.

[30] 72 Fed. Reg. 2236, 2240.

ill-considered proposal altogether. If the rule goes forward, however, the following changes should be made:

- The preamble language quoted above should be replaced with a clear statement that the new regulations do not apply to waivers and demonstration projects like those in California and that, as a result, no adjustment to the budget neutrality limit will be necessary.

- CMS should either revise Sections 433.50 and 433.51 to address the issues identified above, **or** it should clarify that, notwithstanding these provisions, the University of California hospitals and Alameda County Medical Center can continue to fund the nonfederal share of Medi-Cal through CPEs and IGTs under the terms of the Hospital Waiver.

- CMS should either revise the regulations or otherwise clarify that neither CPEs nor IGTs need be drawn solely from tax revenue, as long as they are not derived from sources prohibited under Section 1903(w) of the Act, **or** it should clarify that the specific terms of the Hospital Waiver to this effect continue to apply in California.

- CMS should eliminate the proposed retention requirement in Section 447.207, **or** CMS should expressly state that the retention rule applies only to IGT funded payments and that it does not restrict the redistribution of federal dollars earned through public hospitals' CPEs as expressly allowed under the Hospital Waiver.

- CMS should eliminate the cost limit proposed in Section 447.206, **or** CMS should expressly state that federal Safety Net Care Pool funds will continue to be available for services to the uninsured under the authority of Section 1115(a)(2) of the Act, notwithstanding the new regulations.

## III. Comments on other aspects of Notice of Proposed Rulemaking.

### A. Collection of information.

The proposed regulations have three information collection requirements each of which raises issues of CMS' compliance with the requirements of the Paperwork Reduction Act of 1995 ("PRA").

The proposed Section 433.51 would require that CPEs be supported by auditable documentation on forms to be approved by the Secretary and that, at a minimum, the documentation identifies the relevant Medicaid category of expenditures; demonstrates the cost of providing services; and is subject to periodic audit and review by the State. CMS estimates that completion of the forms will require from 10-60 hours, for each provider depending on the size of the provider. CMS asserts it is unable identify the total number of affected providers or the aggregate hours of paperwork burden as it has not identified the number of providers who are governmentally operated.

CMS' assessment of the scope of the information collection burden is not based on a realistic assessment. The experience of public providers with the implementation of the

Hospital Waiver in California suggest that the estimate is unreasonably low. CAPH staff and members have spent hundreds of hours working with the State and attempting to implement the new CPE and cost-finding rules. At present, CMS has not developed the format or the criteria for approval of the form used to maintain the documentation required by its proposal. The PRA implementing regulations define "burden" to include reviewing instructions and training personnel to respond to the collection.[31] Since the proposed Section 433.51 only sets out the minimum documentation requirements and leaves the development of the form of documentation subject to future approval, it is unlikely that CMS has fully assessed the extent of the paperwork burden associated with the requirement.

In addition to the documentation requirement imposed in the proposed Section 433.51, CMS also is proposing that each governmentally operated health care provider subject to cost reimbursement be required to file a cost report with the State Medicaid agency. The proposed Section 447.206 provides that methods for identifying and allocating costs will be determined by the Secretary. Many providers who are not currently subject to cost-based reimbursement will be required to file cost reports under the proposed rules. Because the cost identification and allocation methods have yet to be determined, the CMS paperwork burden estimates cannot be based on a realistic assessment of the extent of time necessary to comply with the new requirements. Again, the California experience suggests that the estimates set forth in the preamble are unreasonably low.

Finally, the CMS proposal also includes a notice that CMS intends to require each State to complete a questionnaire for each provider it claims is governmentally operated. In its submission to OMB, CMS estimates the paperwork burden associated with completion of the form to be approximately two hours per provider based on the assumption that the States will request that providers supply the information required in the questionnaire. To obtain OMB approval for a collection of information, CMS must show that its proposal is the least burdensome option necessary for the proper performance of the agency's functions. The CMS OMB submission fails to set out any analysis of alternative approaches to obtaining the information that CMS believes necessary to determine State compliance with the relevant regulations.

CMS also must show that the collection of information has practical utility. Practical utility means the actual usefulness of the information to or for an agency taking into account its accuracy, validity adequacy and reliability.[32] The form unsuccessfully attempts to face a complex legal analysis into a Q&A format. CMS has failed to demonstrate the practical utility of the information collected by the form. Moreover, the form itself is deficient in that it fails to provide the necessary context so that the person completing the form will understand the consequences of the answers.

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[31] *See* 5 C.F.R. § 1320.3(b)(1).

[32] *See* 5 C.F.R. § 1320.3(l).

**B. Regulatory impact statement.**

CAPH also disagrees with CMS' regulatory impact analysis. The costly and burdensome administrative requirements taken together with the substantial reduction in Medicaid funding will unquestionably have a severe impact on patient care. The regulatory analysis discussed in the preamble fails to recognize the far-reaching consequences of the proposed rule. Because public hospitals represent a significant economic element of their communities, a substantial reduction in funding for the hospitals will likely have a ripple effect on the communities they serve. There is no indication that CMS has taken these adverse consequences into account. Most importantly, the rule is substantially more burdensome than necessary to address the alleged abuses that are the impetus for the rule. The rule is clearly not the least restrictive alternative available to CMS to address its policy goals.

**IV. Conclusion**

The proposed regulations will adversely affect the ability of CAPH members to continue to provide critically needed health services to the most needy in California. CMS' goal to eliminate state financing abuses, while important, does not support the broad limitations proposed in this rule. The rule would limit the state flexibility guaranteed by the Medicaid statute to set appropriate Medicaid payment rates and to use local funds for Medicaid. The loss of federal funding for the health care safety net in California under this rule will be devastating to the providers, the people they serve, and to the well-being of the State as a whole. CAPH urges you to withdraw this proposed rule.

Sincerely,

Melissa Stafford Jones
President and Chief Executive Officer

cc: Melissa Musotto, CMS
cc: Katherine T. Astrich, OMB

DUKE UNIVERSITY HEALTH SYSTEM

William J. Fulkerson, M.D.
Professor of Medicine
Chief Executive Officer, Duke University Hospital
Vice President, Duke University Health System

March 15, 2007

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

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

Dear Ms. Norwalk:

Duke University Health System is a private, nonprofit corporation affiliated with Duke University, a private, nonprofit institution of higher education, research and health care located primarily in Durham, North Carolina. Duke University Health System's primary hospital facility is Duke University Hospital, one of the largest private hospitals in the Southeast with 989 licensed beds. It also includes two additional hospital facilities, 186-bed Duke Raleigh Hospital located in Raleigh, North Carolina, and 369-bed Durham Regional Hospital, located in Durham, North Carolina. In 2006, Duke University Health System provided over $114 million in uncompensated community benefits, measured in cost according to industry standards.

Duke University Health System opposes the proposed Medicaid rule for the reasons outlined below. These changes would 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 will be at least $340 million in annual federal expenditures that are currently used to provide hospital care for these populations. Loss of this funding will create significant problems with health care delivery and the financial viability of the safety net hospitals.

**DEFINITION OF "UNIT OF GOVERNMENT"**

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." At present, 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. This program has CMS approval.

Our understanding is that all of these 43 public hospitals do in fact qualify as 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

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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. *Duke University Health System respectfully requests that CMS reconsider its position on the definition of unit of government and defer to applicable State law.*

**TIMING OF RULE ADOPTION**

CMS has proposed that the provisions of this law become effective on September 1, 2007. 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. Duke University Health System 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, because the new regulations will 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 are necessary for the affected stakeholders to try to mitigate the detrimental impact of the changes.*

**POLICY**

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.

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, 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 will be exacerbated. Hospitals will be forced to either raise their charges to insured and uninsured patients or to reduce their expenses by eliminating costly but under-reimbursed services. The first option would raise health insurance costs to the private-pay community by an estimated 4 percent. The second would eliminate needed services, not just for Medicaid patients but also for the entire community. Eliminating those services could result in the elimination of almost 3,000 hospital jobs state-wide. The reduced spending and lost jobs would be felt in local economies. The resulting economic loss to the State of North Carolina and local communities has been estimated at over $600 million and almost 11,000 jobs.

Duke University Health System alone stands to lose over $25 million per year if these changes are made without the State having adequate time to develop alternatives. This loss would severely limit our ability to provide the levels of service that we do, and our ability to continue providing the community benefits cited above.

Duke University Health System urges CMS to withdraw its proposed regulation, or to revise it substantially. At minimum, CMS should adopt applicable State law to define the public hospitals (or units of government). If the regulation is not withdrawn or adequately revised, Duke University Health System 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 the opportunity to comment on these proposed regulatory changes. We appreciate your consideration.

Respectfully submitted,

William J. Fulkerson, M.D.
Vice President for Acute Care Services,
Duke University Health System
Chief Executive Officer,
Duke University Hospital

UNIVERSITY of VIRGINIA HEALTH SYSTEM

VICE PRESIDENT *and* CHIEF EXECUTIVE OFFICER
*of the* MEDICAL CENTER

March 16, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201
**Submitted Electronically**

Re: CMS-2558-P

Dear Ms. Norwalk:

On behalf of the University of Virginia Medical Center (UVAMC), I am responding to the request for comments on the proposed Medicaid program rule, entitled *Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership*, published in the Federal Register on January 18, 2007 at pages 2236-2248. The UVAMC, a 574 bed hospital located in Charlottesville, Virginia, is a division of the University of Virginia, a state university. The UVAMC opposes the proposed rule and urges CMS to withdraw it.

**Unit of Government**

This comment addresses proposed 42 CFR 433.50(a)(1), which would create a new regulatory definition of a "unit of government" as a standard for being treated as a public entity for Medicaid program purposes. As the Virginia Department of Medical Assistance Services (DMAS) points out in its comment letter to you, it cannot determine what kinds of entities would qualify as a unit of government.

The proposed rule undercuts the states' authority to organize themselves as they deem necessary. As a general principle of federalism, the states should determine what constitutes a unit of state government, and CMS is overstepping its bounds by redefining it. Congress implicitly acknowledged this level of state authority in its drafting of the Title XIX definition of "unit of local government": "a city, county, special purpose district or other governmental unit in the State." 42 USC §1396b(w)(7)(G). Nothing in this definition requires the unit of government to either have "generally applicable taxing authority" or to receive tax revenues for its general operating budget. CMS is far exceeding its authority in placing such a significant restriction on the much broader definition adopted by Congress. Furthermore, Congress directed the Secretary not to restrict, as the non-Federal share of Medicaid payments, states' use of funds "appropriated to state university teaching hospitals...." 42 USC §1396b(w)(6).

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**Inequitable Reimbursement**

If the UVAMC is deemed to be a unit of government, the effect of the rule will be unfair to us as a state institution in that units of government are limited to cost reimbursement. As DMAS explains in its comment letter to you, the current UPL methodology, based on what Medicare would pay for the same services and calculated in the aggregate for each category of hospital, is appropriate and reasonable. Further, governmental providers who disproportionately serve the uninsured should not be subject to a more restrictive limit than private providers. Such a policy would endanger the ability of public hospitals to ensure quality and patient safety and maintain vital and irreplaceable community services, such as trauma centers, burn units, and emergency departments.

**Harm to Medicaid Recipients**

The general effect of the proposed rule on the underserved population nationwide would be unacceptable. It would shift greater cost burdens onto states and leave them with no choice but to further cut benefits or eliminate coverage altogether. The results would be devastating and would likely increase the number of uninsured Americans rather than help improve our health care system.

We hope that you will give serious consideration to the concerns addressed in this letter, and that the proposed definition will be withdrawn or substantially revised. Thank you.

Sincerely,

R. Edward Howell
Vice President and Chief Executive Officer

cc: E. Darracott Vaughan, Jr., MD
Chair, Medical Center Operating Committee

Leonard W. Sandridge
Executive Vice President and Chief Operating Officer
University of Virginia

Arthur Garson, Jr., MD
Vice President and Dean
University of Virginia School of Medicine

Patrick W. Finnerty
Director, Department of Medical Assistance Services

13


# SHOALWATER BAY INDIAN TRIBE

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Telephone (360) 267-6766 • FAX (360) 267-6778


March 15, 2007

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

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

Dear Ms. Norwalk:

I am Charlene Nelson, Tribal Chairwoman for Shoalwater Bay Indian Tribe which is located in Tokeland, Washington. We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule published on January 18, 2007 at 72 Federal Register 2236. As currently written, we oppose the proposed rule and would like to offer suggested regulatory language that we believe will address tribal concerns consistent with existing CMS policy.

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

***Criteria for Indian Tribes to Participate***

The proposed rule attempts to make clear that Indian Tribes may participate by specifically referencing them in proposed section 433.50(a)(1). However, as currently proposed, an Indian Tribe would only be able to participate if it has "generally applicable

taxing authority," a criteria applied to all units of government referenced here. Although in principle Indian Tribes do enjoy taxing authority, as with all other matters about Indian Tribes, the law is complex and fraught with exceptions. To impose this requirement will burden each State with trying to understand the specific status of each Indian Tribe and to make decisions about the taxing authority of the Tribe – a complex matter often the subject of litigation between Indian Tribes and States. A requirement to make such determinations will almost certainly negatively affect the willingness of States to enter into cost sharing agreements with Indian Tribes since an error in the determination regarding this undefined term could have potentially negative effects for the State.

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

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

***Criteria for Tribal Organizations to Participate***

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

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

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

(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 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.

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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").

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. Such an exclusion would swallow the rule that allows Indian Tribes and Tribal organizations to participating in cost sharing.

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

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

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

*Masi, Masi*

Sincerely,

Charlene Nelson

Charlene Nelson
Chairwoman
Shoalwater Bay Indian Tribe

Cc: National Indian Health Board

Jackson PUBLIC HEALTH TRUST
MEMORIAL HOSPITAL
Jackson Health System

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March 16, 2007

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Acting Administrator
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Room 445-G
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200 Independence Ave, SW
Washington, DC 20201

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

Dear Ms. Norwalk:

On behalf of Jackson Health System (JHS), I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes $129 million in critical Medicaid support payments for the JHS, funding that has been essential to our ability to serve as a major safety net health care system in our community.

JHS is the only safety net provider in Miami-Dade County with a mission of providing one single high standard of care to any resident entering our doors, regardless of their ability to pay. We specialize in the areas of Neurology and Neurosurgery, Ophthalmology, Organ Transplantation, and Urology just to name a few. In addition to that our Level 1 Trauma Center, Neonatal Intensive Care Unit, and Burn Treatment Centers are second to none. JHS is also improving the community's health overall through primary care initiatives. We have primary care clinics, school based clinics and two mobile van units that travel throughout the county offering high-quality primary care services to adults and children in high-risk communities. Last year alone, we provided over $500 million in charity care, a level which is among the highest in the country. Our institution is an integral part of the community.

As the major safety net provider in our community, we strongly oppose the Proposed Rule, and respectfully request you to withdraw it immediately. Moreover, we endorse the comments on the Proposed Rule by the National Association of Public Hospitals and Health Systems, submitted to the Centers for Medicare and Medicaid Services (CMS) on March 8, 2007. Below we provide more detailed comments on specific aspects of the

rule, along with a description of how we believe each of these provisions would impact our hospital, our patients and our community.

**Impact on Waiver States (72 Fed. Reg. 2240)**

The preamble to the Proposed Rule states that "all Medicaid payments ... made under ... Medicaid waiver and demonstration authorities are subject to all provisions of this regulation." (72 Fed. Reg. 2240). Recently, our state negotiated an extremely complex Section 1115 demonstration program with CMS that we have been working hard to implement. The underpinning of this demonstration project is the establishment of Low Income Pool funding for which CMS has authorized through its authority under Section 1115(a)(2) of the Social Security Act to provide federal financial participation for expenditures that are not otherwise matchable. Florida has agreed, pursuant to the demonstration project, to limit Medicaid reimbursement to governmental hospitals to their costs, similar to the limit contained in the Proposed Rule. The savings derived from this voluntary agreement to keep payments lower than what would be allowed under the current upper payment limit regulation has been reinvested in the Low Income Pool.

Because the Special Terms and Conditions on the demonstration project require CMS to incorporate any changes in federal law into the budget neutrality expenditure cap for the program, we request clarification as to whether implementation of the Proposed Rule will reduce available funding for the demonstration. Such an outcome would be unthinkable, given the enormous time, effort and resources that have been devoted to implementing the demonstration as approved by CMS. Our state negotiated the waiver in good faith for a five-year term in full expectation that CMS would honor the painstakingly negotiated deal. We hope and expect that the Proposed Rule will not undo that deal, but given the unconditional preamble statement that payments made under waiver and demonstration authorities are subject to the provisions of the Rule, we are concerned. Therefore, we request that CMS state unequivocally that the funding provided for the Low Income Pool will not be reduced or eliminated.

We appreciate the opportunity to comment on the Proposed Rule. Given the devastating impact that it would have on JHS, our patients and on our community as a whole, we request that you withdraw the regulation immediately.

Thank you for your attention to this urgent matter. If you have any questions about this letter, please feel free to contact me at (305) 585-6754.

Sincerely,

Marvin O'Quinn

# Alabama Medicaid Agency

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CAROL A. HERRMANN-STECKEL, MPH
Commissioner

March 16, 2007

**VIA FEDERAL EXPRESS**

Leslie V. Norwalk, Esq.
Acting Administrator
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U.S. Department of Health and Human Services
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Mail Stop C4-26-05
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Baltimore, MD 21244-1850

Re: Notice of Proposed Rulemaking CMS-2258-P

Dear Ms. Norwalk:

The Alabama Medicaid Agency respectfully submits this comment letter in opposition to the notice of proposed rulemaking entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership," which was published by the Centers for Medicare & Medicaid Services ("CMS") in the January 18, 2007 edition of the *Federal Register*. The proposed rules should be withdrawn in their entirety because they represent a fundamental alteration of the "Federal-State Partnership" that contradicts congressional intent and well-established practice. Changes of the scope proposed by CMS fall within the purview of Congress, not an administrative agency. CMS acknowledged that fundamental alterations in the Federal-State relationship, such as that proposed here, should be made only by Congress by seeking, albeit unsuccessfully, to have Congress legislate the changes CMS now seeks to impose unilaterally through agency regulations.

In addition, implementation of the proposed rules would have a devastating impact on the State of Alabama, its Medicaid beneficiaries and the providers who serve them. If the rules are implemented as proposed, Alabama could stand to lose about one-fourth (approximately $1 billion) of its annual Medicaid budget (approximately $4 billion).

Although the proposed rules all suffer from the same common defects, the following two portions of CMS's notice of proposed rulemaking best illustrate how CMS has overstepped its statutory authority in attempting to legislative via unilateral regulatory action: (1) CMS's attempt to dictate to States what constitutes a "unit of government" within a State, and (2) CMS's fundamentally flawed regulatory impact analysis. Therefore, in the interest of brevity, our comments focus on these two aspects of the notice of proposed rulemaking.

***Defining a Unit of Government (§ 433.50)***

Nearly forty-two years after Congress first created the Medicaid program and sixteen years after Congress enacted legislation protecting States' use of revenues from sources other than State coffers, CMS has proposed regulations that will *for the first time* effectively require that entities have "generally applicable taxing authority" in order to qualify as "units of government within a State" capable of assisting the State in funding its Medicaid program. In relevant part, CMS proposes to amend 42 C.F.R. § 433.50(a)(1) such that it reads:

> (i) A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has *generally applicable taxing authority.*
>
> (ii) A health care provider may be considered a unit of government only when it is operated by a unit of government as demonstrated by a showing of the following:
>
> (A) The health care provider has *generally applicable taxing authority*; or
>
> (B) The health care provider is able to access funding as an integral part of a unit of government with *taxing authority* which is legally obligated to fund the health care provider's expenses, liabilities, and deficits, so that a contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues.[1]

According to CMS, the agency is merely "proposing to add new language to § 433.50 to define a unit of government to conform to the provisions of section 1903(w)(7)(G) of the [Social Security] Act."[2] However, CMS's proposed definition goes far beyond section 1903(w)(7)(G) of the Social Security Act, which reads: "The term 'unit of local government' means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State."[3] The phrase "generally applicable taxing authority" does not appear in section 1903(w)(7)(G), nor does it appear anywhere else in title XIX of the Social Security Act.

If implemented, CMS's proposed definition will usurp the traditional discretion afforded States in how they define those entities within their borders that qualify as "units of government within a State." CMS's proposed definition also sharply conflicts with well-established Federal precedent for determining whether an entity is governmental in nature. The proposed definition is therefore seriously flawed and should not be adopted.

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[1] 72 Fed. Reg. 2236, 2246 (Jan. 18, 2007) (emphasis added).

[2] *Id.* at 2240.

[3] 42 U.S.C. § 1396b(w)(7)(G).

### A. The Proposed Definition Usurps State Discretion

Since the Medicaid program's creation in 1965, a State has been afforded the discretion to fund the "non-Federal share" of its Medicaid program with up to 60 percent non-State funds (i.e., funds from governmental units within the State).[4] Giving States the discretion to use non-State funds was an important product of the legislative process that first produced the Medicaid program. For example, when it finalized the legislative language creating the Medicaid program, the House-Senate Conference Committee specifically rejected language in the House bill that would have required the non-Federal share to be made up of 100 percent State funds.[5]

In codifying States' ability to use non-State funds, Congress did not limit States' discretion in determining what types of governmental units could assist States in funding their respective Medicaid programs. To do so would have improperly injected the Federal government into a process of making normative judgments about the wisdom of certain forms of government chosen by State and local leaders.

Congress later reaffirmed States' ability to use non-State funds by passing the Voluntary Contribution and Provider-Specific Tax Amendments of 1991 ("1991 Amendments").[6] As amended by section 2(a) of the 1991 Amendments, Federal law currently prohibits the Secretary of Health and Human Services from restricting States' use of funds where such funds are "transferred from or certified by *units of government within a State* as the non-Federal share of expenditures under this subchapter, regardless of whether the unit of government is also a health care provider . . . ."[7] In enacting the 1991 Amendments, Congress continued its practice of not dictating to States what types of entities would qualify as entities capable of assisting States in funding the non-Federal share of their respective Medicaid programs. In fact, Congress did not even attempt to define what types of entities qualified as "units of government within a State."[8]

Congress defined another term, "unit of local government," very broadly to mean "a city, county, special purpose district, or other governmental unit in the State."[9] However, as noted above, the statutory definition of "unit of local government" contains no language suggesting that an entity must have "generally applicable taxing authority." Even if it did, the phrase "units of government within a State" and "unit of local government" are not the same, as the Departmental Appeals Board recently recognized:

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[4] *See* Social Security Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 370-71 (codified at 42 U.S.C. § 1396a(a)(2)).

[5] *See* H.R. Rep. No. 89-682, at 50 (1965) (Conf. Rep.), *as reprinted in* 1965 U.S.C.C.A.N. 2228, 2244-45.

[6] *See* Pub. L. No. 102-234, 105 Stat. 1793.

[7] Social Security Act § 1903(w)(6)(A), 42 U.S.C. § 1396b(w)(6)(A) (emphasis added).

[8] Of course, this does not mean that a State's discretion is boundless. The words "units of government within a State," as well as the statutory prohibition against provider-related donations, clearly place limits on a State's ability to accept funding from purely private, for-profit entities that have no governmental characteristics.

[9] Social Security Act § 1903(w)(7)(G), 42 U.S.C. § 1396b(w)(7)(G).

> The use of the undefined phrase "units of government within a State," instead of the phrase "unit of local government," which is defined at section 1903(w)(7), clarifies that . . . a state Medicaid agency could continue to receive [intergovernmental transfers ("IGTs")] from those units of state government that had traditionally helped supply its non-federal share of Medicaid funding, such as state departments of health and mental health, state developmental disabilities agencies and publicly-owned hospitals.[10]

CMS's proposed definition of "unit of government"—with its "generally applicable taxing authority" requirement—eliminates the traditional discretion shown to States in how they finance their respective Medicaid programs. During the past four decades, States have reasonably relied on this discretion in designing their respective Medicaid programs. CMS cannot, in the absence of express statutory authority, "pull the rug out from under" States by dictating to them what entities qualify as "units of government within a State." This is especially true in light of the fact that, despite its best efforts, CMS has repeatedly failed over the past few years to obtain the statutory authority necessary to promulgate the definition of "unit of government" it now seeks to impose via unilateral agency action.[11]

CMS's proposed definition of "unit of government" also fails to recognize that States depend on funding from a wide variety of legitimate governmental entities that, although they do not possess the power to tax, nonetheless perform essential governmental functions. For example, many States have enacted legislation authorizing the creation of health care authorities and hospital districts that serve as efficient means to finance and oversee the construction and operation of critical health case infrastructures. In Alabama, such legislation either predates the creation of the Medicaid program altogether[12] or Congress's passage of the 1991 Amendments.[13] In fact, the U.S. Court of Appeals for the Eleventh Circuit has twice held that one category of governmental entity authorized by Alabama law—health care authorities—are political

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[10] *Ga. Dep't of Cmty. Health*, No. A-03-50, 2005 WL 1164058, at *8 (2005).

[11] The absence of statutory authority has not stopped CMS from abusing its discretion through the enforcement of a "generally applicable taxing authority" requirement during the State plan amendment review process. *See, e.g.*, 69 Fed. Reg. 71,817 (Dec. 10, 2004) (rejecting State plan amendment wherein governmental entity created by State statute was to transfer funds to State because entity did not have generally applicable taxing authority); Letter from Mark B. McClellan, MD, PhD, Administrator, CMS, to Charles E. Grassley, U.S. Senator (Iowa) (Apr. 28, 2004) (stating that "for a governmental health care provider to make a protected transfer/certification, it must have access to state or local tax revenues").

[12] *See* Ala. Code §§ 22-21-50 *et seq.* (legislation first enacted in 1945 authorizing creation of public hospital associations); *id.* §§ 22-21-70 *et seq.* (legislation first enacted in 1949 authorizing creation of county hospital boards); *id.* §§ 22-21-100 *et seq.* (legislation first enacted in 1949 authorizing creation of county hospital corporations); *id.* §§ 11-58-1 *et seq.* (legislation first enacted in 1955 authorizing creation of medical clinic boards); *id.* §§ 22-21-130 *et seq.* (legislation first enacted in 1961 authorizing creation of municipal hospital building authorities).

[13] *See* Ala. Code §§ 22-21-170 *et seq.* (legislation first enacted in 1975 authorizing creation of County and Municipal Hospital Authorities); *id.* §§ 11-62-1 *et seq.* (legislation first enacted in 1979 authorizing creation of Municipal Special Health Care Facility Authorities); *id.* §§ 22-21-310 *et seq.* (legislation first enacted in 1982 authorizing creation of Health Care Authorities).

subdivisions of the State immune from federal antitrust liability.[14] Despite the foregoing, CMS's proposed definition of "unit of government" indiscriminately disqualifies a great number of these entities from helping Alabama fund its Medicaid program.

Furthermore, by drastically changing its interpretation of the statutory phrase "units of government within a State" and dictating to States what entities fall within the meaning of that phrase, CMS tramples upon the federalist principles that underpin the State-Federal partnership that is the Medicaid program. In essence, CMS has trumped the States' classification of public institutions within their own borders. Surely this is not what Congress intended when it created the Medicaid program.

If there is going to be a change in the long-standing understanding and application of the statutory phrase "units of government within a State," it must come from Congress, not an administrative agency. This is especially true because CMS stands in an adverse position to the States on this issue in as much as the proposed rules are designed to limit the amount of Federal dollars paid from the agency's budget to the States. In other words, CMS is not a fair or disinterested party in this matter, a matter that requires the balancing of competing State and Federal interests in which the health, safety and welfare of the Medicaid-eligible elderly (approximately 40,000 persons in Alabama) and the disabled (approximately 175,000 persons in Alabama) is at stake. This type of matter requires balancing by the people's duly elected representatives, not by bureaucrats.

### B. The Proposed Definition Conflicts with Well-Established Practice and Precedent for Determining Whether an Entity is Governmental in Nature

The phrase "units of government within a State," as used in section 1903(w)(6)(A) of the Social Security Act and as implemented by CMS during the past sixteen years, has a common and well-understood meaning. Indeed, that meaning transcends the Medicaid Act and was understood long before the 1991 Amendments were enacted. As explained above, Alabama has long used funding from a wide variety of legitimate governmental entities whose statutory basis either predates the creation of the Medicaid program altogether or Congress's passage of the 1991 Amendments. Alabama is by no means unique in this regard.[15]

Congress therefore understood that States like Alabama relied upon such funding when it enacted the 1991 Amendments. Moreover, Congress did not give CMS the authority to eradicate this vital source of funding through the guise of changing the agency's interpretation of the statutory phrase "units of government within a State" some sixteen years after those words were added to the Social Security Act. Instead, Congress intended that CMS would adhere to that

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[14] *See Askew v. DCH Reg'l Health Care Auth.*, 995 F.2d 1033, 1041 (11th Cir. 1993); *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438, 1461 (11th Cir. 1991).

[15] *See, e.g.*, U.S. Census Bureau, *2002 Census of Governments: Volume 1, Number 1, Government Organization* 13 (Dec. 2002) (listing over 1400 total health-related "special district governments"—i.e., independent governmental units, other than school district governments, that exist as separate entities with substantial administrative and fiscal independence from general purpose local governments—dispersed throughout thirty-five States).

phrase's common understanding in implementing the 1991 Amendments. As the agency that originally implemented and administered the 1991 Amendments, CMS understood the meaning of the statute and, until recently, respected congressional intent.

The common and well-understood meaning of "units of government within a State," which recognizes that "generally applicable taxing authority" is *not* the *sine qua non* of being a unit of government, is further evidenced by long-standing Internal Revenue Service ("IRS") guidelines, Federal court decisions and U.S. Attorney General opinions. CMS is not the first Federal agency to examine the characteristics of units of government within a State. As discussed below, the IRS has extensive experience in deciding whether an entity is governmental in nature. For example, the IRS must determine this issue in the context of addressing: (1) the taxability of interest from State or local bonds, and (2) the exemption of certain government employee income from Federal Insurance Contributions Act ("FICA") withholding. The IRS, with its decades of experience in determining whether an entity is governmental in nature, has explicitly *rejected* the notion that taxing authority is the end-all-be-all characteristic of a unit of government, a conclusion shared by the Federal judiciary.

In the face of this well-established precedent and hard-earned experience, CMS myopically focuses on one characteristic common to *some* units of government—"generally applicable taxing authority"—and dictates to States that any entity without this characteristic is not governmental in nature. Because CMS's proposed definition flies in the face of well-established Federal precedent, it should be withdrawn in its entirety.

### *1. Taxation of Interest From State or Local Bonds*

Federal law excludes from taxable income interest earned from any "State or local bond."[16] As defined by Congress, "State or local bond" means "an obligation of a State or political subdivision thereof."[17] IRS regulations, in turn, define a "political subdivision" as "any division of any State or local governmental unit which is a municipal corporation or which has been delegated the right to exercise part of the sovereign power of the unit."[18] A "political subdivision" may include "special assessment districts . . . such as road, water, sewer, gas, light, reclamation, drainage, irrigation, levee, school, harbor, port improvement, and similar districts and divisions . . . ."[19]

In the leading judicial decision addressing the taxability of interest from State or local bonds, the U.S. Court of Appeals for the Second Circuit was asked to determine whether interest from bonds issued by the Port of New York Authority ("Port Authority") was exempt from federal taxation.[20] The Port Authority was a corporate body created by the States of New York and New

[16] 26 U.S.C. § 103(a).

[17] *Id.* § 103(c)(1).

[18] 26 C.F.R. § 1.103-1(b).

[19] *Id.*

[20] *See Commissioner v. Shamberg's Estate*, 144 F.2d 998 (2d Cir. 1944).

Jersey tasked with building tunnels and bridges in the port of New York.[21] Although the Port Authority had the power to issue bonds, it could not levy taxes.[22]

The court of appeals found that the absence of taxing authority was not dispositive of whether the Port Authority qualified as a "political subdivision," stating:

> Here the activities, even though some of them might have been exercised by private corporations under appropriate legislation, are exercised for a public purpose by an agency set up by the states and given many public powers, though not of taxation or control through the suffrages of citizens. *It minimizes its public and political character to treat such an agency as a private corporation merely because of the lack of taxing power which is only one of the attributes of sovereignty.*[23]

In concluding that the Port Authority was a "political subdivision," the court of appeals also adopted the reasoning of an opinion of the U.S. Attorney General issued decades earlier. The Attorney General's opinion explained:

> The term "political subdivision" is broad and comprehensive and denotes any division of the State made by the proper authorities thereof, acting within their constitutional powers, for the purpose of carrying out a portion of those functions of the State which by long usage and the inherent necessities of government have always been regarded as public. The words "political" and "public" are synonymous in this connection. . . . It is not necessary that such legally constituted "division" should exercise all the functions of the State of this character. It is sufficient if it be authorized to exercise a portion of them.[24]

### *2. Exemption of Certain Government Employee Income From FICA Withholding*

Federal law imposes an excise tax on every employer based on a percentage of each employee's wages.[25] However, Federal law excludes from the definition of "employment" services performed in the employ of a "State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned thereby . . . ."[26] The IRS has taken the following six factors into consideration in cases examining whether an organization qualifies as a government employer:

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[21] *See id.* at 1000.

[22] *Id.*

[23] *Id.* at 1005 (emphasis added).

[24] *Id.* at 1004 (quoting 30 Op. Att'y Gen. 252 (1914)).

[25] *See* 26 U.S.C. § 3111(b).

[26] *Id.* § 3121(b)(7).

(1) Whether the organization is used for a governmental purpose and performs a governmental function;

(2) Whether performance of the organization's function is on behalf of one or more States or political subdivisions;

(3) Whether there are any private interests involved, or whether the States or political subdivisions involved have the powers and interests of an owner;

(4) Whether control and supervision of the organization is vested in public authority or authorities;

(5) If express or implied statutory or other authority is necessary for the creation and/or use of such an instrumentality, and whether such authority exists; and

(6) The degree of financial autonomy and the source of the organization's operating expenses.[27]

Importantly, no one factor is dispositive; the IRS examines the totality of the circumstances when deciding whether, on balance, an organization is governmental in nature.[28] The IRS and Federal courts continue to apply these six factors almost fifty years after they were first enunciated.[29]

The lesson of the above is simple: CMS is treading into an area in which it has absolutely no experience. Rather than acting as if it is the first Federal agency to address the question of what makes an entity governmental, CMS should at the very least follow preexisting Federal practice and recognize that "generally applicable taxing authority" does not singularly define what makes an entity a "unit[] of government within a State."

### C. The Proposed Rules Contradict Representations Made by CMS Officials

If applied as-written, the proposed rules have the potential to eliminate 25 percent of Alabama's current Medicaid funding. Yet, during Alabama's lengthy negotiations of recent State plan amendments, CMS officials reviewed every transferor of funds and the transfers themselves. Not a single exception was entered asserting that a single transferred dollar was inappropriate State match. Instead, after the review CMS assured Alabama that the transfers—as restructured

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[27] Rev. Rul. 57-128, 1957-1 C.B. 311 (1957).

[28] *See, e.g.*, IRS Tech. Adv. Memo. 200222029 at 5 (Jan. 9, 2002).

[29] *See, e.g.*, *Federal-State Reference Guide* 2-4, IRS Pub. No. 963 (Rev. 10-2006); *Michigan v. United States*, 40 F.3d 817, 826-27 (6th Cir. 1994) (citing six factors in support of finding that the Michigan Education Trust was an instrumentality of the State of Michigan whose income was exempt from Federal taxation); *Rose v. Long Island R.R. Pension Plan*, 828 F.2d 910, 918 (2d Cir. 1987) (citing six factors in support of finding that pension plan was a "governmental plan" exempt from the requirements of the Employee Retirement Income Security Act of 1974).

to satisfy CMS—were in compliance with Federal law. This review occurred at precisely the same time that CMS was finalizing the proposed rules, as is evidenced by the fact that the proposed rules were approved by then-CMS Administrator Mark McClellan on June 16, 2006 (some six months before they were approved by the Secretary and published in the *Federal Register*). Thus, at the same time that CMS was assuring Alabama that it was in compliance with Federal law, CMS was developing proposed rules that, if applied as-written, make CMS's assurance that Alabama's restructured program complies with Federal law false. The only remaining question is whether it also makes those assertions disingenuous.

One can draw two conclusions from this chain of events: (1) that CMS acted in good faith and agreed to the restructured plan and assured Alabama that the State would be in compliance because CMS knows that the proposed rules do not accurately reflect Federal law regarding IGTs and certified public expenditures ("CPEs"), thereby making the proposed rules unenforceable; or (2) that CMS acted in bad faith because the agency never intended to fulfill the promises it made when it agreed to the restructured Alabama State Medicaid plan.

***Regulatory Impact Analysis***

CMS estimates that the proposed rules will result in a $3.87 billion cut in Federal Medicaid spending over the next five years.[30] However, CMS fails to adequately explain how it reached this estimate, relying instead on ambiguous assertions regarding the agency's "recent reviews of state Medicaid spending" and "recent reports on spending on Disproportionate Share Hospitals (DSH) and Upper Payment Limit (UPL) spending . . . ."[31] By CMS's own admission, there is "uncertainty" in the agency's estimate of how large a financial impact the proposed rules will have on States. The uncertainty in CMS's estimate was underscored during a conference call with State Medicaid officials on January 25, 2007, in which CMS officials were asked whether they could provide State-specific estimates of the proposed rules' financial impact. CMS officials refused to provide these estimates and admitted that no such calculations had been conducted by the agency.

Also troubling are CMS's repeated assertions that the proposed rules will not negatively affect Medicaid beneficiaries or the providers who serve them (both public and private). For example, CMS proclaims that the proposed rules will actually have a "beneficial distributive impact on governmental providers because in many States there are a few selected governmental providers receiving payments in excess of cost, while other governmental providers receive a lower rate of reimbursement."[32] According to CMS, the proposed rules will "promote a more even distribution of funds among all governmental providers"[33] and "[p]rivate providers are generally

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[30] 72 Fed. Reg. at 2244.

[31] *Id.* at 2245.

[32] *Id.* at 2244.

[33] *Id.*

unaffected by this rule."[34] As for the quality of clinical care provided to Medicaid beneficiaries, CMS "anticipate[s] that this rule's effect on actual patient services to be minimal" and that despite the fact that States "may need to change reimbursement or financing methods, [CMS does] not anticipate that services delivered by governmentally operated providers or private providers will change."[35]

These commonsense-defying statements are the argument of an advocate determined to advance a position in disregard of the actual facts. CMS must understand that cuts in Federal spending of the magnitude proposed by the agency will almost certainly result in reduced services to beneficiaries and lower provider reimbursement. To suggest otherwise is insincere. At the very least, CMS should address the effects of its effort to completely overhaul the State-Federal relationship under the Medicaid program in an intellectually honest fashion.

The requirement that an agency prepare a regulatory impact analysis is not an invitation to engage in one-sided, fantasy-based, whimsical and self-justifying speculation; it is a requirement that the agency conduct a reasoned, balanced and fact-based analysis of the likely effects of a rule. The fact that CMS is uncertain about the true financial effects of its proposed rules counsels heavily against their implementation, especially when the agency is acting unilaterally and not at the behest of Congress. A "shoot first and ask questions later" approach is simply unacceptable when that approach jeopardizes the effective delivery of health care services to Alabama's most vulnerable citizens. For that reason alone the proposed rules should not be adopted.

Thank you for your attention to this vitally important matter.

Sincerely,

Carol A. Herrmann-Steckel

Carol A. Herrmann-Steckel
Commissioner

[34] *Id.* at 2244-45.

[35] *Id.* at 2245.

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# Cleveland County HealthCare System

Carolinas HealthCare System

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:

We are writing on behalf of Cleveland County HealthCare System, which includes Cleveland Regional Medical Center and Kings Mountain Hospital, to advise you that we 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 wiping out entire valuable programs that are otherwise fully consistent with all of the Medicaid statutes is unreasonable and objectionable. Cleveland County HealthCare System 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, because 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.

Cleveland County HealthCare System 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, Cleveland County HealthCare System 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 E. Young
President/CEO

Rose L. Coyne, CPA
Vice President/CFO

cc: The Honorable Elizabeth Dole
The Honorable Richard Burr
The Honorable Patrick McHenry
Ms. Martha Ann McConnell

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PITT COUNTY MEMORIAL HOSPITAL
*University Health Systems of Eastern Carolina*℠

OFFICE OF THE PRESIDENT

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:

Pitt County Memorial Hospital (PCMH) is appreciative of the opportunity to comment on the Centers for Medicare and Medicaid Services' proposed rule. We oppose this rule and will highlight the harm its proposed policy changes would cause to our hospital and patients we serve.

PCMH is a 755 bed referral center in Greenville, North Carolina providing acute, intermediate, rehabilitation and outpatient health services to more than 1.2 million people in 29 counties of eastern North Carolina. It is one of four academic medical centers in North Carolina. Pitt Memorial is the flagship hospital for University Health Systems of Eastern Carolina and serves as the teaching hospital for the Brody School of Medicine at East Carolina University. As the only academic tertiary hospital in this 29 county, eastern area of North Carolina, its revenues support extensive community benefit programs in the region. Programs designed to meet the needs of the indigent care population of the region have proven to be a cost savings to the Medicaid and Medicare programs.

It is estimated that the proposed rule would decrease PCMH's reimbursement by about $4.4 million. The elimination of services and a loss of jobs resulting from these decreases has been estimated to result in an economic loss of $8.7 million.

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.

2100 Stantonsburg Road P.O. Box 6028 Greenville, North Carolina 27835-6028 252.847.4398 Phone 252.847.5147 Fax

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.

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.

Sincerely,

Stephen J. Lawler
President

cc: Senator Elizabeth Dole
Senator Richard Burr
Congressman G. K. Butterfield
Congressman Walter B. Jones

# STATE OF CONNECTICUT

*DEPARTMENT OF SOCIAL SERVICES*

**OFFICE OF THE COMMISSIONER**

March 13, 2007

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2258-P
P.O. Box 8017
Baltimore, Maryland 21244-8017

**Re: Proposed Rule: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of the Federal-State Financial Partnership**

The State of Connecticut submits these comments in response to the proposed regulations, published January 18, 2007, that would transform, for the worse, the methods by which Medicaid services for the needy have been financed in Connecticut and throughout the nation. Connecticut has joined in Joint Comments, submitted on behalf of a group of states in opposition to the proposed rules. Those Comments set forth compelling reasons for CMS to abandon the proposal, which Connecticut urges CMS to do without further delay.

These comments are intended to record the particular impact that the proposed rules would have on the Connecticut Medicaid program. The primary impact can be summed up in two words--excessive burden. Connecticut relies heavily on certification as the means of reporting expenditures that qualify for Medicaid matching. Many different agencies of government utilize this time-honored means of financing Medicaid expenditures, including the Department of Mental Health and Substance Abuse, the Department of Mental Retardation, the Department of Children and Families, and the Department of Veterans Affairs. In the aggregate, these Departments certify Medicaid expenditures of close to one billion dollars annually. To the extent that services of these departments are reimbursed on a cost basis there are already in place cost reporting processes that have worked well and with which employees of the various departments are familiar. Any attempt to impose a new and different cost report regime on these departments would be extremely disruptive and would not lead to any improvement in the cost reporting process.

To the extent that these departments provide services that are reimbursed on a rate basis, the proposed rules would impose unnecessary cost reporting and reconciliation processes that would add enormously to the burden of program operations without adding any value to the services provided.

The insistence on cost reporting and reconciliation for all services of "units of government" is a reversion to the financing methods of bygone eras. Over the past several

decades Congress, DHHS and the states have moved steadily away from this method of payment in favor of prospective payment methodologies that have been shown to be more efficient and less cumbersome to implement. Mandating a return to the cost-based systems of old is bad policy, and is not necessary to deal with any perceived deficiencies in the present Medicaid financing system.

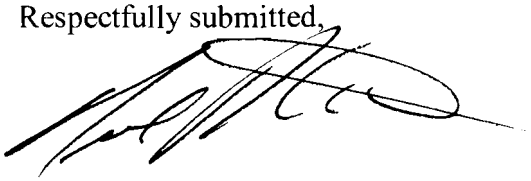
Connecticut is particularly concerned about the impact of the proposed rules on its home and community based waiver program, which is provided in substantial part through governmental agencies. The expensive and burdensome cost finding and reconciliation processes that the proposed rules would impose would be beyond the capacity of these agencies to bear. The home and community based services program helps keep elderly and disabled recipients from being institutionalized, and thus keeps the cost of Medicaid well below what it otherwise would be. Imposition of major new administrative burdens on the providers of these services, like those implicit in the proposed regulations, threatens to undermine the viability of one of the State's most important and successful program.

Finally, Connecticut is concerned about the narrowness of the proposed definition of "unit of government." There is substantial doubt whether the John Dempsey Hospital would meet the restrictive proposed federal definition of "unit of government." Yet Dempsey, while structured as a non-profit tax-exempt corporation, is a public entity in all material respects and organizationally is a component of the University of Connecticut medical school. Its mission is to serve the health care needs of the public, and to contribute to the medical education program of the State University. The University subsidizes its operations as necessary. Any definition that does not include Dempsey among those public entities entitled to certify its expenses for Medicaid matching purposes is unwarranted and should not be adopted.

## Conclusion

For the foregoing reasons, and for those set forth in more detail in the Joint Comments in which Connecticut has joined, the State of Connecticut respectfully urges that CMS not adopt the proposed regulations.

Respectfully submitted,

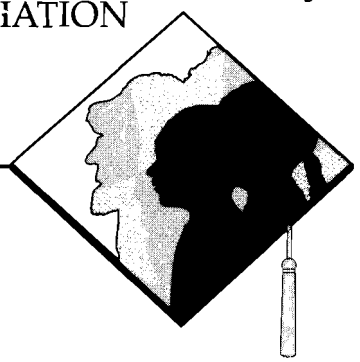


Michael P. Starkowski, Commissioner
Department of Social Services

cc: David Parrella
Lee Voghel
Gary Richter
Mark Schaefer
Steve Netkin, OPM
Dsp/Connecticutcomments.doc

# NEW HAMPSHIRE SCHOOL ADMINISTRATORS ASSOCIATION

CHAMPIONS FOR CHILDREN



**To:** **Centers for Medicaid and Medicare Services**
**Department of Health and Human Services**

**From:** **NH School Administrators Association**
**Dr. Mark Joyce, Executive Director**
mark@nhsaa.org

**NH Association of Special Education Administrators**
**Dr. P. Alan Pardy, Director**
alan@nhasea.org

**Date:** **3/9/07**

**Re:** **Public Comment File Code CMS-2258-P**

Please accept these comments to the proposed regulations at 72 Federal Register 2236, published on January 18, 2007. It is our position that these proposed regulations would be unduly burdensome in New Hampshire, because of the unique funding formula of education by local property taxes in our state. Since Medicaid reimbursement in NH is based upon actual expenditures on a per-unit, per-Medicaid eligible child basis, the cost reports proposed in these regulations are unnecessary to demonstrate the requisite "public expenditures." School districts in New Hampshire pay, "up front," 100% of the costs of delivering covered health related services via local property taxes, (not including monies available under the IDEA) and then seek Medicaid reimbursement via Federal Financial Participation. If requested in an audit, NH school districts could produce auditable financial statements demonstrating the cost to provide the services without having to justify the expenditure of local seed via the completion of proposed cost reports. The "one-size-fits-all" approach of these proposed regulations requiring cost report completion would unnecessarily burden school districts with reporting data that is already easily accessible and verifiable. Requiring the execution of the cost reports on a yearly basis would only add administrative burden to already overworked district staff with the revelation of no real new data. NH possesses a high level of justification of Medicaid Federal Financial Participation relative to the expenditure of local funds because of a direct and verifiable correlation between local expenditures and Medicaid reimbursement of those expenditures on a per unit, per Medicaid eligible child basis.

In addition, these proposed regulations would appear to negate some of the benefits that would be gained through the passage of the recently proposed bipartisan bill (SB 578) protecting the Medicaid to Schools Program. (Primary sponsor Senator Kennedy).

Our approach here will be to reproduce certain sections of the preamble and proposed regulations, and provide editorial comments in red font, where we attempt to raise questions that cause concern in our mind.

> "... the rule proposes to modify § 433.51(b) to require that a CPE must be supported by auditable documentation in a form approved by the Secretary that will minimally: (1) Identify the relevant category of expenditure under the State plan; (2) explain whether the contributing unit of

> government is within the scope of the exception to the statutory limitations on provider-related taxes and donations; (3) demonstrate the actual expenditures incurred by the contributing unit of government in providing services to Medicaid recipients or in administration of the State plan; and (4) be subject to periodic State audit and review.
> To implement this rule, the Secretary would issue a form (or forms) that would be required for governments using a CPE for certain types of Medicaid services where we have found improper claims (for example, schoolbased services). These forms will be published in the **Federal Register** using procedures consistent with the Paperwork Reduction Act requirements. In preparing the way for these forms, this rule would serve to enhance fiscal integrity and improve accountability with respect to CPE practices in the Medicaid program.
> Costs that are certified by units of government for purposes of CPE cannot include the costs of providing services to the non-Medicaid population or costs of services that are not covered by Medicaid...." [1]

We agree with the overall Certified Public Expenditure (CPE) requirement, although we think the requirement of a CPE in the school setting is unnecessary. School districts pay for 100% of total costs of providing health related services to children with IEPs "up front". While it is true that some of those costs are offset by Federal IDEA funds, the majority of the expenditures are out of the pocket of the local taxpayer in the first instance, with Medicaid claiming operating only to offset some of the costs through reimbursement at the FFP. In our state, the Medicaid reimbursement is driven exactly by the outlay to provide for the service on a per Medicaid child basis. School districts are not making money on Medicaid reimbursement relative to outlay of actual costs.

> *"Tool To Evaluate the Governmental Status of Providers*
> With the issuance of this proposed rule, we recognize the need to evaluate individual health care providers to determine whether or not they are units of government as prescribed by the rule. States will need to identify each health care provider purportedly operated by a unit of government to CMS and provide information needed for CMS to make a determination as to whether or not the provider is a unit of government. We have developed a form questionnaire to collect information necessary to make that determination. The questionnaire will be published in connection with this proposed rule. For new State plan amendments that will reimburse governmentally operated providers or rely on the participation of health care providers for the financing of the non-Federal share, States will be required to complete this questionnaire regarding each provider that is said to be

[1] 72 Fed. Reg. 2241 (2007) (to be codified at 42 C.F.R. §433.51) (proposed January 18, 2007)

> governmentally operated. For any existing arrangement that involves payment to governmentally operated providers or relies on the participation of health care providers for the non-Federal share, States will be required to provide the information requested on this form questionnaire relative to each applicable provider within three (3) months of the effective date of the final rule following this proposed rule."[2]

Our concern in relation to the "Tool to Evaluate the Governmental Status of Providers" is in the administration of "the questionnaire." It appears that all existing school districts that are enrolled as providers will need to execute this cumbersome four-page questionnaire within three months of the effective date of the final rule. It does not appear that the State Medicaid Agency will have the authority to review the questionnaire and deem the submitted school district qualified to execute a CPE. It appears rather, that only CMS will have the authority to review the questionnaire and determine whether or not a school is a "unit of government," qualified to execute a CPE. What is not clear is how long the review process by CMS will take and whether or not Medicaid reimbursements will be interrupted in any way during this period of review. Additionally, the execution of the questionnaire will create an unnecessary administrative burden on the school districts by requiring the districts to take the time to answer all of the questions. We think it obvious that a school meets the definition indicated in the regulations of a "unit of government," and should not have to be subject to this administrative burden and potential interruption of Medicaid reimbursement while CMS reviews the information submitted on the questionnaire. It would seem to us that CMS will have hundreds if not thousands of these documents to review nationwide, and without increased federal resources, these applications will not be processed in a timely manner. We find it interesting that CMS offers no comment on the time impact that the requirement of the filling out of the questionnaire will have on "units of government" under the analysis required under the "Paperwork Reduction Act of 1995," and we suspect it will involve increased time.

> *"Cost Limit for Providers Operated by Units of Government (§ 447.206)*
> Section 447.206(e) states that each provider must submit annually a cost report to the Medicaid agency which reflects the individual providers cost of serving Medicaid recipients during the year. The Medicaid Agency must review the cost report to determine that costs on the report were properly allocated to Medicaid and verify that Medicaid payments to the provider during the year did not exceed the providers cost. The burden associated with this requirement is the time and effort for the provider to report the cost information annually to the Medicaid Agency and the time and effort involved in the review and verification of the report by the Medicaid Agency. We estimate that it will take a provider 10 to 60 hours to prepare and submit the report annually to the Medicaid Agency. We estimate it will take the Medicaid Agency 1 to 10 hours to review and verify the information provided. We are unable to identify the total number of providers affected or the estimated total

[2] 72 Fed. Reg. 2242 (2007) (to be codified at 42 C.F.R. §433.50) (proposed January 18, 2007)

> aggregate hours of paperwork burden for all providers, as such figures will be a direct result of the number of providers that are determined to be governmentally operated."[3]

The excerpts listed above are the sections of the proposed rules that cause us the greatest concern. We believe the submission of a cost report by each school district on an annual basis to support a CPE is unduly burdensome and unnecessary. We think that the CMS estimate of time required to complete the cost reports is too optimistic as the amount of time to do cost reports on an annual basis will be substantial. School districts do not have the resources available to execute a cost report necessary to execute a CPE. The point is that they are spending 100% of the cost up front. In New Hampshire, the schools must calculate based on each individual practitioner, and major resources have to be committed to that task on an annual basis.

> "For purposes of Executive Order 13132, we also find that this rule will have a substantial effect on State or local governments."[4]

Ultimately, schools would need to hire highly qualified financial specialists, such as Certified Public Accountants, just to execute the cost reports each year and the State Medicaid Agencies would also have to employ such financial specialists to review all of the submitted cost reports to see if recoupments would be necessary because of a lack of balance between what was reimbursed and what was reflected on the cost report.

**In summary, we appreciate very much your taking the time to review our thoughts and suggestions. We certainly believe that these proposed rules are going to have a substantial impact on schools nationwide relative to the administrative burden it will place on them as they move forward with executing their CPEs on an annual basis, especially when one considers the amount of reimbursement actually received from Medicaid is fractional when compared with the actual cost of delivering health related services to Medicaid eligible children with IEPs.**

Respectfully submitted,

Dr. Mark V. Joyce
Executive Director
NH School Administrators Association

Dr. P. Alan Pardy
Director
NH Association of Special Education Administrators

Cc: Senator Edward M. Kennedy
Senator Olympia Snowe
Senator John E. Sununu
Senator Judd Gregg
Representative Carol Shea-Porter
Representative Paul Hodes
Lyonel B. Tracy, Commissioner, Department of Education
John A. Stephen, Commissioner, Department of Health and Human Services
National Educational Agencies

[3] 72 Fed. Reg. 2243 (2007) (to be codified at 42 C.F.R. §§433.51, 447.206) (proposed January 18, 2007)
[4] 72 Fed. Reg. 2244 (2007) (to be codified at 42 C.F.R. §§433.51, 447.206) (proposed January 18, 2007)

Betty Hardwick Center
*A Community MH/MR Resource*
Independence, Dignity, Responsibility

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

Dear Sir or Madam:

My name is Jenny Goode and I represent Betty Hardwick Center, a Community Mental Health and Mental Retardation Center in the State of Texas. 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

2616 South Clack Street, Abilene, TX 79606
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An Equal Opportunity/Affirmative Action Employer

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, unallowed 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.**

I sincerely ask that you consider making these revisions. Thanks for your consideration.

Sincerely,

Jenny Goode
Chief Executive Officer

DELAWARE COUNTY MENTAL HEALTH CLINIC

Adult Services
1 Hospital Road
Walton, NY 13856
(607) 865-6522
FAX (607) 865-7424

Family & Children's Services
132 Delaware St., Suite 2A
Walton, NY 13856
(607) 865-8255
FAX (607) 865-7252

Patricia M. Thomson, CSW
Director of Community Services

March 13, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
P.O. Box 8017
Baltimore, Maryland 21244-8017

RE: Code #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 (42 CFR CFR Part 433, 447 and 457)

On behalf of the Delaware County Mental Health Department, I am commenting on the above-referenced proposed rule published in the Federal Register of January 18, 2007 on pages 2236 to 2248.

Our Department, representing consumers and providers is concerned that the proposed rule would seriously undermine mental hygiene services in two primary ways. First, new limitations proposed in the regulatory definition of allowable costs for providers which are units of government would be particularly harmful to the continuing viability of the range of services available to seriously mentally ill adults and children living in our community.

Also, new limitations on allowable services under the rehabilitation option would be particularly harmful to persons with mental retardation and currently receiving health-related specialty services which allow them to participate meaningfully and in a more mainstreamed manner in the public education system.

Additionally, more rural counties appear to be disproportionately disadvantaged/singled out by the proposed rule because (i) there are few if any alternative providers not subject to the costs limitation (not-for-profit agencies which are more available in more populous jurisdictions) which could substitute services previously provided by a rural county-operated clinic, and (ii) a county is particularly dependent on Medicaid transportation funding because of large travel distances for poor clients, so that proposed new limitations on Medicaid transportation could be disproportionately disadvantageous by isolating seriously mentally disabled clients living in the community.

We urge you to consider the potential harm to some of our most disenfranchised and disabled citizens that will result from promulgation of this rule, and withdraw it from further consideration.

Sincerely,

Patricia Thomson

Patricia Thomson, LCSW-R
Director of Community Services

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY

Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

March 15, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2258–P
P.O. Box 8017, Baltimore, MD 21244–8017

Re: Colorado Department of Health Care Policy and Financing's Comments on CMS–2258–P

To whom it may concern:

The Colorado Department of Health Care Policy and Financing (the Department) has prepared the following comments and questions to the proposed regulation [CMS-2258-p] by the Centers for Medicare and Medicaid Services (CMS) entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal State-Financial Partnership" (the Proposed Rule). Further, the attached analysis prepared by Department estimates the financial impact on the State of Colorado and safety-net providers.

The Proposed Rule which would make changes to public provider payment and financing arrangements with State Medicaid programs. As a result, the State of Colorado will experience significant negative impacts as the Department's ability to continue to fund public-owned hospital providers for serving low-income individuals would be greatly reduced. There are thirty-four (34) hospital providers that have been historically designated as public-owned in Colorado which are at risk under the Proposed Rule. The Proposed Rule is a Medicaid policy change that is expected to result in loss of federal revenue of approximately $142.2 million per year in Colorado. As such, the Proposed Rule puts the financial stability of the entire safety-net provider community in Colorado at risk.

The Departments requests that CMS formally respond to the following comments and questions:

1. Part 433. The Colorado Department of Health Care Policy and Financing drew $131.0 million in federal funds by using certification of public expenditures (CPE) under the upper payment limit for inpatient hospital services and Disproportionate Share Hospital (DSH) payments to fund the Colorado Indigent Care Program (CICP). It should be noted that Inpatient UPL payments are based upon services to the eligible Medicaid population, but providers are not eligible to receive these payments unless they agree to participate under the CICP. These funds allow the CICP to distribute federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to individuals living under 250% of the federal poverty level who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.

Approximately 180,000 individuals received care through the CICP in FY 05-06. Under the proposed rule, approximately $128.4 million of those federal funds could no longer be drawn using CPE. *To preserve the safety net, the Department recommends that the rule be revised to allow current definitions of public providers to apply. Please explain why CMS would place the safety-net provider community and those individuals who received care through this community at risk by implementing the proposed rule.*

2. Part 433. *If the safety-net hospital system became insolvent because of the proposed rule, please explain what contingency plans CMS has considered and what safeguards CMS has implemented to protect Medicaid and low-income populations.*

3. Part 433. By placing recent expanded financial controls on how the certification of public expenditure is calculated and requiring reconciliations to a cost report, there are already substantial controls over the certification process. The Colorado Department of Health Care Policy and Financing believes that these controls adequately protect the State's and CMS' funding for Medicaid and Disproportionate Share Hospital payments. *Please explain how converting ownership status to private-owned for those providers who have been historically considered as public-owned by CMS under the proposed rules increases these financial controls.*

4. Part 433. CMS is proposing a September 1, 2007 effective date with no transition period. Based on this effective date, many States will have an immediate Medicaid budget shortfall. *The Colorado Department of Health Care Policy and Financing requests that CMS extend the transition period to January 1, 2008 to implement these regulations to allow providers to adapt and allow states to adjust their budgets.*

5. Section 433.50. The proposed rule states that health care providers must demonstrate they are a unit of government by showing that: 1) the health care provider has generally applicable taxing authority; or 2) the health care provider is able to access funding as an integral part of a governmental unit with taxing authority and that this governmental unit is legally obligated to fund the governmental health care providers expenses, liabilities, and deficits. The proposed rule goes on to state that a contractual arrangement with the State or local government cannot be the primary or sole basis for the health care provider to receive tax revenues.

However, under the section titled Provisions of the Proposed Rule, CMS states that "In some cases, evidence that a health care provider is operated by a unit of government must be assessed by examining the relationship of the unit of government to the health care provider". CMS provides two situations where the health care provider would be considered governmentally operated. The first situation exists if the unit of government appropriates funding derived from taxes it collected to finance the health care providers operating budget, not to include special purpose grants, construction loans or similar funding arrangements. The second situation exists if the health care provider is included as a component unit on the government's consolidated annual financial report. CMS notes that this indicates the governmentally operated status of the health care provider.

*Will these two situations, described above, be considered separately from the actual language in the proposed rule or will they be considered in addition to the language in the proposed rule when determining if a health care provider is governmentally operated?*

6. Section 433.50. CMS noted that a tool, CMS Form 10172, to evaluate the government status of a provider would be required to be completed and submitted to CMS. However, it is unclear as to who is responsible for completing the form and what, if any, supporting documentation is required. In addition, this form in its current format does not require an official signature by an individual with that authority. *The Colorado Department of Health Care Policy and Financing requests that CMS provide more written guidance on the use of this form when final rules are presented.*

7. Section 447.206. The proposed rule establishes an initial rate, and then requires the Medicaid agency to perform two reconciliations on that rate – an interim to the "as filed" Medicaid Cost Report and a final to the "audited" Medicaid Cost Report. "As filed" cost reports are available six months after the close of the providers fiscal year and the "audited" cost reports may not be available for several years following the payment. Performing these reconciliations would be burdensome on the Medicaid agency and the providers. This draft rule forces all payments using certification of public expenditure to be retrospective, which many Medicaid agencies and Medicare have been attempting to eliminate over the years. *The Colorado Department of Health Care Policy and Financing requests that CMS modify this rule to allow a payment and corresponding CPE based on a current, inflated cost report without any reconciliation process. Any changes to costs will be captured in future cost reports, which is the philosophy behind a prospective payment system.*

8. Section 447.207. *Currently the Colorado Department of Health Care Policy and Financing offsets Medicaid expenditures using certification of public expenditures through the upper payment liming financing to outpatient hospitals, nursing facilities and home health agencies. The Department requests that this offset continue to be allowed, but only when applied to Medicaid expenditures.*

9. Section 447.271. The Provision of the Proposed Rule does not provide enough clarification on the modification of this rule and how it may impact providers who provide services at no charge, but are allowed to bill Medicaid for such services. *Does the modification of this regulation prevent a provider from billing Medicaid for those services the provider generally provides at no charge or generally provides to low-income populations at no charge? If that is CMS intent, please provide specific language to clarify.*

10. Sections 447.272 and 447.321. The Colorado Department of Health Care Policy and Financing has a concern that upper payment limit (UPL) calculations for inpatient hospital, outpatient hospital and nursing home providers will be different for public-owned and private-owned facilities under the proposed rule. *CMS should reconsider*

*requiring the State to have different calculations and allow the Medicaid agency the option to use the same calculation for private-owned providers as used for public-owned providers.*

11. Sections 447.272 and 447.321. *Will CMS define which provider costs and what specific Medicare/Medicaid 2552-96 worksheets and lines may be included in developing these new upper payment limits? Can costs for physicians and Graduate Medical Education be included when developing these upper payment limits?*

12. Section 447.207. *Is it allowable for the State to retain the federal share of a Supplemental Medicaid Payment when the federal share is used to support the Medicaid reimbursement, thus eliminating the need for a reduction in the Medicaid reimbursement?*

Sincerely,

Lisa M. Esgar
Senior Director, Operations and Finance Office

Attachment: Updated Impact Overview by Colorado Department of Health Care Policy and Financing, March 12, 2007

**Updated Impact Overview by Colorado Department of Health Care Policy and Financing**
**March 12, 2007**

***Draft Rules***
***Centers for Medicare & Medicaid Services***
***42 CFR Parts 433, 447, and 457***
***[CMS–2258–P] RIN 0938–A057***

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

**Summary Overview Analysis**

1. The proposed rule:
   - Adds specific limitations on those providers which are considered public-owned by stating they must be a unit of government and that unit of government must have generally applicable taxing authority.
   - Requires that entities using certified public expenditure (CPE) to draw the federal share of Medicaid and Disproportionate Share Hospital payments must fit within the new definition of a public-owned entity.
   - Clarifies the documentation, which must be defined using a specified cost report, and reconciliation required to support the certified public expenditure (CPE).
   - Limits reimbursement for health care providers that are operated by units of government to an amount that does not exceed the provider's cost, which must be defined using a specified cost report.
   - Requires providers to receive and retain the full amount of Medicaid, Supplemental Medicaid and Disproportionate Share Hospital payments.
   - Makes conforming changes to provisions governing State Child Health Insurance Program (SCHIP).

2. In FY 05-06, the Colorado Department of Health Care Policy and Financing drew $131.0 million in federal funds by using certification of public expenditures (CPE) under the upper payment limit for inpatient hospital services (Inpatient UPL) and Disproportionate Share Hospital (DSH) payments to fund the Colorado Indigent Care Program (CICP). Certification of public expenditure refers to a health care provider that is operated or owned by a unit of government certifying that local funds have already been spent. It should be noted that Inpatient UPL payments are based upon services to the eligible Medicaid population, but providers are not eligible to receive these payments unless they agree to participate under the CICP. Qualified health care providers who receive this funding render discounted health care services to individuals living under 250% of the federal poverty level who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan. Approximately 180,000 individuals received care through the CICP in FY 05-06.

3. Under the proposed rule, the Department believes that its ability to continue to fund hospital public-owned providers for serving low-income individuals through certification of public expenditures would be eliminated. As such, either the State would need to find an equivalent General Fund match to replace the current certification or the current federal funds distributed to providers would be eliminated. If the State could not provide the replacement General Fund match, the State and the hospital providers that receive these federal funds of approximately $128.4 million, would lose these federal funds.

4. Currently, there are thirty-four (34) hospital providers designated as public-owned in Colorado. Of those providers, three providers operate large facilities that provide integrated health care services (including primary, specialty, emergency, and inpatient hospital care) to Medicaid and low-income populations. Those three providers (Denver Health Medical Center, Memorial Hospital, and University Hospital) are an essential part of the State's safety-net and account for 92.3% of the federal funds distributed through certification of public expenditures. The remaining providers serve as a critical part of the State's safety-net provider community, mainly in rural areas.

   The Department believes that several of these providers, mainly those who are funded through a taxing district or county, would still be considered public-owned under the Proposed Rule, but because of the ambiguity in the Propose Rule and CMS' statement in the preamble to the Proposed Rule, the Department cannot state with complete certainty that any of these providers will still be considered public-owned under the Final Rule.

5. The proposed rule will also impact CICP payments to private-owned hospital providers, as there is fixed pool of General Fund available to fund current CICP payments. As more hospital providers are classified as private-owned, that fix pool of General Fund would be distributed over more providers. As large hospital providers, as Denver Health Medical Center, Memorial Hospital and University Hospital draw from that fix pool of General Fund, payments to other providers who currently classified as private-owned must significantly decrease. As such, payments to National Jewish Medical and Research Center, Parkview Medical Center, Platte Valley Medical Centers, San Luis Valley Medical Center, St Mary-Corwin Hospital, The Children's Hospital and all other private-owned hospital providers will decrease by an estimated 79.3%.

6. The Department is concerned about the timing of the rule. The proposed effective date of CMS' rule is September 1, 2007. The Department and public-owned providers have used certification to draw federal funds since FY 99-00. The abrupt end of this process would disrupt or even terminate the ability of low-income people to receive the necessary medical services offered through the CICP. Further, as public-owned hospitals have limited ability to cost-shift to other payers, the proposed rule puts the financial stability of the entire safety-net provider community at risk.

7. This rule would eliminate the Department's ability to retain the federal financial participation from the outpatient hospital, nursing facility, and home health agency public-owned upper payment limit payments. These federal funds are currently an offset to General Fund in Medical Services Premiums for Medicaid. The Department would need $13.8 million in General Fund per year, or would be required to reduce Medicaid payments to providers by $27.6 million, to offset the elimination of these financing mechanism.

**In summary, under the proposed rule, Colorado estimates that the loss in federal funds would be at least $142.2 million per year as providers who have historically been identified as public-owned would be reclassified as private-owned, and would be forced to stop utilizing certification of public expenditures to draw federal funds related to uncompensated costs for Medicaid and low-income populations. There is a significant risk that Denver Health Medical Center, Memorial Hospital, and University Hospital will no longer have the ability to use certification to draw the available federal funds. The proposed rule puts the financial stability of the entire safety-net provider community in Colorado at risk.**

**Proposed Questions/Comments to CMS Concerning the Proposed Rule**

1. Part 433. The Colorado Department of Health Care Policy and Financing drew $131.0 million in federal funds by using certification of public expenditures (CPE) under the upper payment limit for inpatient hospital services and Disproportionate Share Hospital (DSH) payments to fund the Colorado Indigent Care Program (CICP). It should be noted that Inpatient UPL payments are based upon services to the eligible Medicaid population, but providers are not eligible to receive these payments unless they agree to participate under the CICP. These funds allow the CICP to distribute federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to individuals living under 250% of the federal poverty level who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan. Approximately 180,000 individuals received care through the CICP in FY 05-06. Under the proposed rule, approximately $128.4 million of those federal funds could no longer be drawn using CPE. *To preserve the safety net, the Department recommends that the rule be revised to allow current definitions of public providers to apply. Please explain why CMS would place the safety-net provider community and those individuals who received care through this community at risk by implementing the proposed rule.*

2. Part 433. *If the safety-net hospital system became insolvent because of the proposed rule, please explain what contingency plans CMS has considered and what safeguards CMS has implemented to protect Medicaid and low-income populations.*

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5. Section 433.50. The proposed rule states that health care providers must demonstrate they are a unit of government by showing that: 1) the health care provider has generally applicable taxing authority; or 2) the health care provider is able to access funding as an integral part of a governmental unit with taxing authority and that this governmental unit is legally obligated to fund the governmental health care providers expenses, liabilities, and deficits. The proposed rule goes on to state that a contractual arrangement with the State or local government cannot be the primary or sole basis for the health care provider to receive tax revenues.

However, under the section titled Provisions of the Proposed Rule, CMS states that "In some cases, evidence that a health care provider is operated by a unit of government must be assessed by examining the relationship of the unit of government to the health care provider". CMS provides two situations where the health care provider would be considered governmentally operated. The first situation exists if the unit of government appropriates funding derived from taxes it collected to finance the health care providers operating budget, not to include special purpose grants, construction loans or similar funding arrangements. The second situation exists if the health care provider is included as a component unit on the government's consolidated annual financial report. CMS notes that this indicates the governmentally operated status of the health care provider. *Will these two situations, described above, be considered separately from the actual language in the proposed rule or will they be considered in addition to the language in the proposed rule when determining if a health care provider is governmentally operated?*

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7. Section 447.206. The proposed rule establishes an initial rate, and then requires the Medicaid agency to perform two reconciliations on that rate – an interim to the "as filed" Medicaid Cost Report and a final to the "audited" Medicaid Cost Report. "As filed" cost reports are available six months after the close of the providers fiscal year and the "audited" cost reports may not be available for several years following the payment. Performing these reconciliations would be burdensome on the Medicaid agency and the providers. This draft rule forces all payments using certification of public expenditure to be retrospective, which many Medicaid agencies and Medicare have been attempting to eliminate over the years. *The Colorado Department of Health Care Policy and Financing requests that CMS modify this rule to allow a payment and corresponding CPE based on a current, inflated cost report without any reconciliation process. Any changes to costs will be captured in future cost reports, which is the philosophy behind a prospective payment system.*

8. Section 447.207. *Currently the Colorado Department of Health Care Policy and Financing offsets Medicaid expenditures using certification of public expenditures through the upper payment liming financing to outpatient hospitals, nursing facilities and home health agencies. The Department requests that this offset continue to be allowed, but only when applied to Medicaid expenditures.*

9. Section 447.271. The Provision of the Propose Rule does not provide enough clarification on the modification of this rule and how it may impact providers who provide services at no charge, but are allowed to bill Medicaid for such services. *Does the modification of this regulation prevent a provider from billing Medicaid for those services the provider generally provides no charge or generally provides to low-income populations at no charge? If that is CMS intent, please provide specific language to clarify.*

10. Sections 447.272 and 447.321. The Colorado Department of Health Care Policy and Financing has a concern that upper payment limit (UPL) calculations for inpatient hospital, outpatient hospital and nursing home providers will be different for public-owned and private-owned facilities under the proposed rule. *CMS should reconsider requiring the State to have different calculations and allow the Medicaid agency the option to use the same calculation for private-owned providers as used for public-owned providers.*

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12. Section 447.207. *Is it allowable for the State to retain the federal share of a Supplemental Medicaid Payment when the federal share is used to support the Medicaid reimbursement, thus eliminating the need for a reduction in the Medicaid reimbursement?*

**Analysis by Component**

## *PART 433—STATE FISCAL ADMINISTRATION*

### *§433.50 is amended*

**Overview Analysis**: Section 1903(w)(7)(G) of the Social Security Act (the Act) identifies the four types of local entities that, in addition to the State itself, are considered a unit of government: a city, a county, a special purpose district, or other governmental units in the State. Currently, the interpretation of a "public-owned provider" is broad and not defined through rule. CMS has defined a public-owned provider, through correspondence and the State Medicaid Manual as: "Public Providers are those that are owned or operated by a State, county, city or other local government agency or instrumentality."

The Department considers a provider to be public-owned if the provider has a financial relationship with the governmental unit that may include one of the following: the provider receives operating revenues from the governmental unit, the governmental unit provides tax revenues to support bonds to construct the facility, the governmental unit has some financial obligation even if its daily operations of the facility have been assigned to private-owned company (such as Banner Health), and the liabilities and assets of the provider revert to the governmental unit upon bankruptcy.

As stated above, the Act identifies five types of entities that can be classified as a unit of government:

1. State
2. City
3. County
4. Special purpose district
5. Other governmental units within the state

Under the proposed rule, only these units of government may use CPE to draw the federal share of Medicaid expenditures. The proposed regulation seeks to place additional restrictions on the requirements under the Act by including the requirement that a unit of government have generally applicable taxing authority. Further, the funding for CPE must be directly derived from tax revenues. As such, for a provider to be considered public-owned, it must be operated by a unit of government with generally applicable taxing authority or have access to funding as an integral part of a government unit with taxing authority. As an integral part of a government unit, the governmental unit has a legal obligation to fund the 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.

Further, in the preamble to the Proposed Rule of the rule, CMS states: "*In recent reviews, we have found that health care providers asserting status as a '"special purpose district' or 'other' local government unit often do not meet this definition. Although the special purpose district or a unit of government with taxing authority may be required, either by law or contract, to provide limited support to the health care provider, the health care provider is an independent entity and not an integral part of the unit of government.* ***Typically, the independent entity will have liability for the operation of the health care provider and will not have access to the unit of***

***government's tax revenue without the express permission of the unit of government.*** *Some of these types of health care providers are organized and operated under a not-for-profit status. Under these circumstances, the independently operated health care provider cannot participate in the financing of the non-Federal share of Medicaid payments, whether by IGT or CPE, because of such arrangements."*

In Colorado, providers under the authority of a taxing district must request the funds from the district as they have separate Governing Boards; county facilities must request and be allocated moneys from their county's budget; Denver Health must request tax revenue from the City and County of Denver; University Hospital must request General Fund from the General Assembly. All providers must have the express permission of the unit of government prior to receiving any tax revenue - presumably on a yearly or as needed basis. Following the strict interpretation of these comments, it appears to be CMS' intent to dramatically reduce the number of safety-net providers from inclusion in the public-owned definition.

Currently, the Department considers thirty-four (34) providers to be public-owned. In reading of the regulations, the Department has prepared the following analysis based on the revised definitional of a public-own provider.

- Of these public-owned providers, eighteen (18) receive operating tax revenues from a special district: Aspen Valley Hospital, Delta County Memorial Hospital, Melissa Memorial Hospital, Grand River Hospital District, Haxtun Hospital District, Spanish Peaks Regional Health Center, Weisbrod Memorial County Hospital, Kit Carson County Memorial Hospital, Kremmling Memorial Hospital, Southwest Memorial Hospital, Estes Park Medical Center, Prowers Medical Center, Rangely District Hospital, Heart of the Rockies Regional Medical Center, Southeast Colorado Hospital and LTC, St. Vincent General Hospital District, Wray Community District Hospital, and Yuma District Hospital.

  The Department believes that these providers would still be considered public-owned under the Proposed Rule, but because of the ambiguity in the Proposed Rule and CMS' statement in the preamble to the Proposed Rule, the Department cannot state with complete certainly that these providers will still be considered public-owned under the Final Rule. In FY 05-06, these providers used CPE to draw $2.4 million in federal funds.

- Of these public-owned providers, four (4) receive operating tax revenues from a county: Lincoln Community Hospital and Nursing Home, The Memorial Hospital (located in Craig), Pioneers Hospital, and Sedgwick County Memorial Hospital.

  The Department believes that these providers may still be considered public-owned under the Proposed Rule, but because of the ambiguity in the Propose Rule and CMS' statement in the preamble to the Proposed Rule, the Department cannot be certain that these providers will be considered public-owned under the Final Rule. In FY 05-06, these providers used CPE to draw $150,000 in federal funds.

- Of these public-owned providers, two (2) receive operating tax revenues directly from the State, and the State is obligated to fund the expenses, liabilities and deficits of these providers: Colorado State Hospital in Pueblo and Ft. Logan in Denver.

  The Department believes that these providers would still be considered public-owned under the proposed rules. In FY 05-06, these providers did not use CPE to draw federal funds.

- Of these public-owned providers, ten (10) will probably be converted into a private-owned by this proposed rule: Arkansas Valley Regional Medical Center, Denver Health Medical Center, East Morgan County Hospital, Gunnison Valley Hospital, Keefe Memorial Hospital, Memorial Hospital (located in Colorado Springs), Montrose Memorial Hospital, North Colorado Medical Center, Poudre Valley Hospital, and University Hospital.

  The Department believes that these providers may no longer be considered public-owned under the proposed rules, but because of the ambiguity in the Propose Rule and CMS' statement in the preamble to the Proposed Rule, the Department cannot state with complete certainly that all of these providers will be considered private-owned under the Final Rule. In FY 05-06, these providers used CPE to draw $128.4 million in federal funds. The federal payments would either be eliminated causing substantial decreases to these providers' revenue or the CPE would need to be replaced with General Fund.

  The reason why the Department believes that some of these hospitals may be considered private-owned is due to the business relationship between the hospital, the management firm and the city/county. For some these hospitals, the management firm acts as an intermediary between the hospital and the city/county. In addition, for many of these hospitals, employees are no longer considered city/county employees but private sector employees.

  Denver Health Medical Center may receive some general operating funds from the City and County of Denver, but the Hospital Authority which operates Denver Health Medical Center does not have generally acceptable taxing authority nor is the city "legally obligated to fund the health care provider's expenses, liabilities, and deficits."

  The University Hospital is currently considered a unit of government through its relationship with the Board of Regents of the University of Colorado. Nevertheless, there is no statutory requirement that the State, through the Board of Regents, is "legally obligated to fund the health care provider's expenses, liabilities, and deficits" of the provider, nor does the Board of Regents has have generally acceptable taxing authority.

  There would be a significant impact to the safety-net health care system in Colorado if these providers were converted to private-owned under this proposed rule and they were no longer able to use CPE to draw the federal match. The chart below demonstrates the impact at the provider level using FY 05-06 payments.

| Facility Name | Inpatient UPL Payments | Disproportionate Share Hospital Payments | Total Payments (Federal Funds) |
|---|---|---|---|
| Arkansas Valley | $155,180 | $1,113,050 | $1,268,230 |
| Denver Health | $21,451,088 | $54,159,103 | $75,610,191 |
| East Morgan | $4,437 | $45,812 | $50,249 |
| Gunnison Valley | $5,064 | $12,785 | $17,849 |
| Memorial Hospital | $2,764,949 | $6,980,867 | $9,745,816 |
| Montrose Memorial | $151,015 | $381,277 | $532,292 |
| North Colorado Medical Center | $972,922 | $2,456,407 | $3,429,329 |
| Poudre Valley | $637,822 | $1,610,355 | $2,248,177 |
| University Hospital | $17,365,064 | $18,164,981 | $35,530,045 |
| **Total** | **$43,507,541** | **$84,924,637** | **$128,432,178** |

The proposed rule will also impact CICP payments to private-owned hospital providers, as there is fixed pool of General Fund available to fund current CICP payments. As more hospital providers are classified as private-owned, that fix pool of General Fund must be distributed over more providers. As large hospital providers, such as Denver Health Medical Center, Memorial Hospital, and University Hospital draw from that fix pool of General Fund, payments to other providers who are currently classified as private-owned must decrease. As such, payments to National Jewish Medical and Research Center, Parkview Medical Center, Platte Valley Medical Centers, San Luis Valley Medical Center, St Mary-Corwin Hospital, The Children's Hospital and all other private-owned hospital providers will decrease dramatically.

If all CICP providers were classified as private-owned and the entirety of $131.0 million in federal funds currently matched through CPE for was eliminated under the propose rule, payments to providers currently classified as public-owned would decease by an estimated 84.9% while payments to private-owned providers would decrease by an estimated 79.3%. The detail of this impact by provider using FY 05-06 payments as a proxy, is demonstrated in Table 1 of the attachment to this document.

***Section 433.51 is revised***

**Overview Analysis**: Basically, CMS is requiring that the Department have an approved form that documents the certification of public expenditures. There should be no fiscal impact. Any detail concerning the CPE process inferred from this regulation is provided in the analysis of another section of the rule.

## *PART 447 - PAYMENTS FOR SERVICES*

### ***Section 447.206 is added***

**Overview Analysis**:

- 447.206 (c)(1). This general principle has been in place for many years, and enforced through the five financing questions the Department submits with each State Plan Amendment (SPA).

- 447.206 (c)(1) – (4). Historically, the Department has interpreted this to mean "reasonable cost" and has loosely provided a calculation of reasonable cost relative to the provider group. The Department has not based "reasonable cost" on information from the provider's Medicaid Cost Report in the past. CFR 92.22 defines Applicable Cost Principles. The new rule would limit the Department's ability to define "reasonable cost" and force the definition of cost to match the Medicaid Cost Report. The Department expects this portion of the rule to have any indeterminate impact, as the definition of cost using the Medicaid Cost Report is expected to be higher than the Department's current definition of "reasonable cost" but the result may vary by provider. However, the Department was already planning this action based on a recent CMS audit.

- 447.206 (c)(4). This would have an impact on School Based Providers. These providers currently use CPE, but no "Medicaid Cost Report" has been developed for this provider group. Even without this rule, the Department has been told by CMS that CPE for School Based Providers must reconcile to a cost report and the Department has been working on achieving this goal.

- 447.206 (d). Any payment that utilizes CPE must be based on a specific Cost Report. Historically, this has not been true for all of the Department's CPE payments. The Department believes that it may be prevented from using the CPE from one provider to support the payment of another provider (that is, pooling and redistributing upper payment limit funds). Overall, this requirement will not impact the aggregate of payments, but payments to some providers would decrease, as payments to others would increase.

  The Department would need to establish an initial rate, and then perform two reconciliations on that rate – an interim to the "as filed" Medicaid Cost Report and a final to the "audited" Medicaid Cost Report. "As filed" cost reports are available 6 months after the close of the providers fiscal year and the "audited" cost reports may not be available for several years following the payment. Performing these reconciliations would be burdensome on the Department and the providers. CMS should modify this rule and allow a payment and CPE based on a current, inflated cost report without any reconciliation process. Any changes to costs will be captured in future cost reports, which is the philosophy behind a prospective payment system. This draft rule forces all CPE payments to be retrospective, which the Department and Medicare have been attempting to eliminate over the years.

  The Department would need to submit a State Plan Amendment to change all the CPE payments to a cost-based payment methodology. Further, the payment methodologies for private-owned providers do not need to be cost based, so those calculations can remain the same but will now be different than the public-owned providers.

The Department submitted a CPE protocol and reconciliation process to CMS on October 2, 2006. The CPE protocol utilizes the health care provider's Medicare/Medicaid 2552-96 cost report for hospital providers and home health agencies and the Med-13 cost report for nursing facilities as supporting documentation for the CPE claimed by public-owned providers. The Department is currently responding to questions from CMS regarding this protocol and reconciliation process through a CMS request for additional information (RAI) for State Plan Amendment (SPA) TN 06-012.

The Department is working on developing a cost-based reimbursement for School Based Providers under the direction of CMS.

- 447.206 (e). This is a broad rule, and applies to ALL public-owned providers participating in Medicaid. Currently, not all public-owned providers participating in Medicaid have a "Medicaid Cost Report." Currently, the Department has identified that hospitals, nursing facilities, and home health agencies can provide a standardized Medicaid Cost Report. This rule will cause a burden on providers who may be considered public-owned, but do not produce a Medicaid Cost Report. Further, the Department has the responsibility to audit these cost reports. At this time, it is unknown what providers or groups of providers may be considered public-owned that will be impacted by this rule.

- 447.206 (f) and (g). Any payment over the provider's "cost" must be refunded to CMS. Historically, the Department has not refunded any FFP because the payment exceeded the provider's cost. There is a concern that the providers will need to start issuing refunds to the Department for overpayments, which will create additional accounting duties.

***Section 447.207 is added***

**Overview Analysis**: This proposed rule would eliminate the Department's ability to retain the federal match from the outpatient hospital, nursing facility, and home health public-owned upper payment limit (UPL) payments. The Department would need $13.8 million in General Fund to offset the elimination of this financing mechanism. The $13.8 million in federal funds could only be directed to hospital, nursing facility, and home health providers. This is no net gain to CMS under this rule, but a cost to the State and a potential gain to the providers.

Further, this rule may eliminate the Department's ability to retain 10% of the federal match in the School Based Program for administration. Under the Proposed Rule, all federal funds would have to be paid to the provider, so the Department's administration would need General Fund and a statute change to administer the program. The Department will analyze this further.

***Section §447.271 is revised***

The current rules states:

*447.271 Upper limits based on customary charges.*

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

*customary charges to the general public for the services.*

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

**Overview Analysis**: The elimination of (b) will have an impact on School Based Providers. It appears that CMS does not like that the Department reimburses providers for services provided at no charge if those services are provided to a Medicaid client. CMS lost a decision before the Department of Health and Human Services' Departmental Appeal Board concerning "free care." This rule seems to be an attempt to reverse that DAB decision. This would cause a decrease to the federal payment to School Based Providers.

***Section 447.272 is amended***

**Overview Analysis**: The Department's current inpatient hospital and nursing facilities upper payment limit (UPL) calculations would need to revised for public-owned facilities and replaced with a UPL calculation that is provider specific and cost based. The Department expects this change to have an indeterminate impact, but have a positive impact on some specific providers. There is a concern that the UPL calculation will be different for public-owned and private-owned facilities.

Historically, the Department has not based "reasonable cost" on information from the provider's Medicare/Medicaid 2552-96 Cost Report. The proposed rule requires the UPL calculation for public-owned facilities and the calculation of CPE to be based on the provider's actual cost as reported in the Medicaid Cost Report. The proposed rule requires that in aggregate, Medicaid payments cannot exceed the UPL calculation or for a specific provider, the calculation of reasonable cost. As such, Denver Health Medical Center would not be able to receive a federal match on the SB 06-044 moneys through the Inpatient UPL (Major Teaching payment) as is being considered by the Department.

As shown in the table below, the Department expects this change to have an indeterminate impact, but have a positive impact on some specific providers.

| Facility (FY 05-06 Data) | Uncompensated Inpatient UPL – Current Methodology | Uncompensated Inpatient UPL – Provider Costs, based on proposed rules |
|---|---|---|
| Denver Health Medical Center | $31,278,539 | $46,484,439 |
| University Hospital | $34,730,127 | $27,367,670 |

***Section 447.321 is amended***

**Overview Analysis**: Same as Section 447.272. The Department's outpatient hospital UPL calculation will need to be revised for public-owned facilities and replaced with a UPL calculation that is provider specific and cost based. There is a concern that the UPL calculation will be different for public-owned and private-owned facilities. As shown in the table below, the Department expects this change to have an indeterminate impact, but have a positive impact on some specific providers.

| Facility (FY 05-06 Data) | Uncompensated Outpatient UPL – Current Methodology | Uncompensated Outpatient UPL – Provider Costs, based on proposed rules |
|---|---|---|
| Denver Health Medical Center | $6,438,654 | $7,454,247 |
| University Hospital | $4,301,401 | $6,901,745 |

***PART 457- ALLOTMENTS AND GRANTS TO STATES***

***Section 457.220 is revised***

**Overview Analysis**: Same as Section 433.51.

***§457.628 is revised***

***Other regulations applicable to SCHIP programs include the following:***

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

**Overview Analysis**: The Department does not use CPE under its SCHIP program (CHP+); therefore, there is no fiscal impact.

**Attachment**

**Table 1**

**FY 2005-06 CICP Provider Payments**

| CICP Provider | FY 05-06 Total Payment Under Current Rules | FY 05-06 Total Payment Under Proposed Rules | Expected Actual Change in Total Payment | Expected Percent Change in Total Payment |
|---|---|---|---|---|
| Denver Health Medical Center | $75,698,495 | $12,393,468 | ($63,305,027) | -83.6% |
| University Hospital | $35,551,623 | $4,156,772 | ($31,394,851) | -88.3% |
| Arkansas Valley Regional Medical Center | $1,270,002 | $207,878 | ($1,062,124) | -83.6% |
| Aspen Valley Hospital | $267,272 | $43,808 | ($223,464) | -83.6% |
| Delta County Memorial Hospital | $353,596 | $57,960 | ($295,636) | -83.6% |
| East Morgan County Hospital | $50,249 | $8,236 | ($42,013) | -83.6% |
| Estes Park Medical Center | $158,248 | $25,940 | ($132,308) | -83.6% |
| Gunnison Valley Hospital | $17,849 | $2,926 | ($14,923) | -83.6% |
| Heart of the Rockies Regional Medical Center | $179,191 | $29,372 | ($149,819) | -83.6% |
| Kremmling Memorial Hospital | $33,316 | $5,462 | ($27,854) | -83.6% |
| Melissa Memorial Hospital | $21,275 | $3,486 | ($17,789) | -83.6% |
| Memorial Hospital | $9,745,816 | $1,597,462 | ($8,148,354) | -83.6% |
| Montrose Memorial Hospital | $532,292 | $87,250 | ($445,042) | -83.6% |
| North Colorado Medical Center | $3,429,329 | $562,110 | ($2,867,219) | -83.6% |
| Poudre Valley Hospital | $2,248,177 | $368,504 | ($1,879,673) | -83.6% |
| Prowers Medical Center | $318,193 | $52,158 | ($266,035) | -83.6% |
| Sedgwick County Memorial Hospital | $21,345 | $3,498 | ($17,847) | -83.6% |
| Southeast Colorado Hospital and LTC | $42,136 | $6,908 | ($35,228) | -83.6% |
| Southwest Memorial Hospital | $284,259 | $46,596 | ($237,663) | -83.6% |
| Spanish Peaks Regional Health Center | $500,989 | $104,982 | ($396,007) | -79.0% |
| St. Vincent General Hospital District | $39,349 | $6,448 | ($32,901) | -83.6% |
| The Memorial Hospital | $129,139 | $21,168 | ($107,971) | -83.6% |
| Wray Community District Hospital | $53,449 | $8,762 | ($44,687) | -83.6% |
| Yuma District Hospital | $97,961 | $16,058 | ($81,903) | -83.6% |
| **Public Hospitals Total** | **$131,043,550** | **$19,817,212** | **($111,226,338)** | **-84.9%** |
| Boulder Community Hospital | $867,186 | $179,992 | ($687,194) | -79.2% |
| Colorado Plains Medical Center | $150,362 | $31,210 | ($119,152) | -79.2% |
| Community Hospital | $96,714 | $20,074 | ($76,640) | -79.2% |
| Conejos County Hospital | $111,704 | $23,090 | ($88,614) | -79.3% |
| Exempla Lutheran Medical Center | $462,832 | $96,064 | ($366,768) | -79.2% |
| Longmont United Hospital | $828,948 | $172,056 | ($656,892) | -79.2% |
| McKee Medical Center | $1,390,956 | $288,706 | ($1,102,250) | -79.2% |
| Mercy Medical Center | $519,774 | $107,884 | ($411,890) | -79.2% |
| Mount San Rafael Hospital | $97,468 | $20,228 | ($77,240) | -79.2% |
| National Jewish Medical and Research Center | $1,362,472 | $282,452 | ($1,080,020) | -79.3% |
| Parkview Medical Center | $5,724,807 | $1,187,222 | ($4,537,585) | -79.3% |
| Penrose-St. Francis HealthCare Systems | $2,156,552 | $447,614 | ($1,708,938) | -79.2% |
| Platte Valley Medical Center | $2,105,606 | $436,352 | ($1,669,254) | -79.3% |
| Rio Grande Hospital | $55,750 | $11,574 | ($44,176) | -79.2% |
| San Luis Valley Regional Medical Center | $1,191,922 | $246,678 | ($945,244) | -79.3% |
| St. Mary-Corwin Hospital | $3,547,650 | $736,348 | ($2,811,302) | -79.2% |
| St. Mary's Hospital and Medical Center | $621,088 | $128,912 | ($492,176) | -79.2% |
| St. Thomas More Hospital | $641,766 | $133,202 | ($508,564) | -79.2% |
| Sterling Regional Medical Center | $272,414 | $56,542 | ($215,872) | -79.2% |
| The Children's Hospital | $2,241,867 | $463,174 | ($1,778,693) | -79.3% |
| Valley View Hospital | $451,063 | $92,842 | ($358,221) | -79.4% |
| Yampa Valley Medical Center | $136,762 | $28,386 | ($108,376) | -79.2% |
| **Private Hospitals Total** | **$25,035,663** | **$5,190,602** | **($19,845,061)** | **-79.3%** |
| **All CICP Providers** | **$156,079,213** | **$25,007,814** | **($131,071,399)** | **-84.0%** |

**CAPE FEAR VALLEY**
TRANSFORMING HEALTHCARE

Richard H. Parks, Chief Executive Officer
Rueben N. Rivers, MD, Chief of Staff

BEHAVIORAL HEALTH CARE
CAPE FEAR VALLEY MEDICAL CENTER
CAPE FEAR VALLEY REHABILITATION CENTER
HEALTH PAVILION NORTH
HIGHSMITH-RAINEY SPECIALTY HOSPITAL

BLOOD DONOR CENTER
CANCER CENTER
CARELINK
CAPE FEAR VALLEY HOME HEALTH & HOSPICE
CUMBERLAND COUNTY EMS
FAMILY BIRTH CENTER
HEART & VASCULAR CENTER
HEALTHPLEX
LIFELINK CRITICAL CARE TRANSPORT
PRIMARY CARE PRACTICES
SLEEP CENTER

March 14, 2007

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

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

Dear Ms. Norwalk:

Cape Fear Valley Health System appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule. We vehemently 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 which in turn would raise the healthcare costs overall. The second would eliminate needed services, not just for Medicaid patients but also for the entire community. Eliminating those services would result in reduced spending and lost jobs and an estimated economic loss to the State of North Carolina of more than $600 million and 11,000 jobs.

Cape Fear Valley Health System operates Cape Fear Valley Medical Center (a 397-acute care bed regional medical center), Behavioral Health Care (a 32-bed psychiatric care facility and outpatient clinic), Cape Fear Valley Rehabilitation Center (a 78-bed rehabilitation facility), Cumberland County Emergency Medical Services, Cape Fear Valley Home Health & Hospice, Highsmith-Rainey Memorial Hospital (a 112-bed long-term acute care facility), Health Pavilion North (a multi-specialty outpatient facility), 16 primary care and specialty practices, and the Healthplex) a medically oriented wellness center to provide cardiovascular conditioning and strength training). The Health System provides the healthcare services for all of the residents of Cumberland County, North Carolina.

The Health System will receive through the current MRI program in excess of $18 million dollars annually. These program dollars have been the lifeline for the Health System since the inception of the MRI program. In fact, with the exception of two years, the program dollars received have been greater than the health system's excess of revenues over expenses. Without these MRI program payments, the health system will surely have to reduce services and layoff employees.

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,

Torrey M. Johnson
Chief Financial Officer

cc: Senator Elizabeth Dole
Senator Richard Burr
Congressman Mike McIntyre
Congressman Robin Hayes

WESTCARE
HEALTH SYSTEM

Carolina West Sports Medicine
Hospital Hill Pharmacy
Mountain Regional Cancer Center / Murphy
Mountain Regional Cancer Center / Sylva
Mountain Trace Nursing Center
Occupational Health Management
WestCare Emergency Medical Service
WestCare Home Health & Hospice Service
WestCare Medical Park of Bryson City
WestCare Medical Park of Franklin
WestCare Medical Park of Sylva

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March 14, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8017
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, (Vol. 72, No. 11), January 18, 2006

Dear Ms. Norwalk:

I am writing on behalf of WestCare Health System to comment on the above-referenced proposed changes to the Medicaid Program. WestCare is opposed to the proposed changes due to the significant negative impact on our community and patients.

The WestCare Board of Trustees passed the attached resolution during its meeting of March 13, 2007. The WestCare Trustees consist of local business leaders and physicians. They are concerned that our small, rural health system received over $614,000 supplemental payments in fiscal year 2006. Our system has experienced an increased dependency on these supplemental payments in order to continue the provision of services to our community. The negative economic impact of this proposed change for our region is almost $2.0 million.

WestCare Health System opposes the rule, and we strongly urge CMS to permanently withdraw it.

Sincerely,

Mark T. Leonard, FACHE
President & CEO

cc Senator Elizabeth Dole
Senator Richard Burr
Congressman Heath Shuler
Mr. Bill Pully, N.C. Hospital Association
Mr. Hugh Tilson, N.C. Hospital Association
WestCare Trustees

**Harris Regional Hospital**
68 Hospital Road
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828/586-7000
Fax 828/586-7467

**Swain County Hospital**
45 Plateau Street
Bryson City, NC 28713
828/488-2155
Fax 828/488-4039

**RESOLUTION OF THE BOARD OF TRUSTEES**
**WESTCARE HEALTH SYSTEM**
**Sylva, North Carolina**

WHEREAS, North Carolina hospitals have participated in the North Carolina Medicaid Reimbursement Initiative Supplemental Payment Program for several years, allowing over $300 million dollars annually to supplement hospital losses for Medicaid patient recipients, with small and rural hospitals experiencing increased volumes and increased dependancy on supplemental payments (for WestCare Health System over $614,000 in supplemental payments in fiscal year 2006); and

WHEREAS, the increasing costs of providing for the uninsured and underinsured threaten the financial viability of hospitals and elimination of one piece of Medicaid reimbursement will increase losses and potentially undermine patients' access to health care. Existing federal Medicaid regulations allow North Carolina hospitals to receive payments to offset a portion of the costs incurred when caring for Medicaid patients. Medicaid revenues for most NC hospitals still fall significantly short of allowable Medicaid costs, and

WHEREAS, the proposed federal regulation that would eliminate the NC Medicaid Reimbursement Initiative through the certified public expenditure program will represent a substantial departure from long-standing Medicaid policy and cause major disruption to our state Medicaid program, hurting both providers and beneficiaries. The rule further restricts how states reimburse hospitals. The new restrictive definition of "unit of government" and "generally applicable taxing authority" 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.

WHEREAS, hospitals would be forced to either raise charges to insured patients or reduce costs by eliminating costly but under-reimbursed services. Those choices would lead to increases in health insurance costs by an estimated four percent or elimination of almost 3,000 jobs if services are eliminated. That reduced spending and those lost jobs would be felt in local economies and the resulting economic loss to the State of NC has been estimated at over $600 million and almost 11,000 jobs. Specifically for our hospital, the loss of these supplemental dollars would mean a total economic impact of over $1,861,000 including economic impact on output and labor income for the areas served by WestCare Health System, and

WHEREAS, the proposed effective date for this rule is Sept. 1, 2007, and if this rule is not withdrawn, North Carolina hospitals will lose approximately $340 million immediately. The immediate implementation of this rule would result in major disruption of hospital services in our state;

NOW THEREFORE, the WestCare Health System Board of Trustees resolves to offer these comments opposing the proposed Medicaid rule (CMS-2258-P) Medicaid Program: Cost Limits for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership.

Chairman

Vice Chairman

Secretary

Treasurer

Mary Jane Letts

Fred Alexander

25

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

*Kathleen Sebelius, Governor*
*Don Jordan, Secretary*

www.srskansas.org

March 15, 2007 *[Sent via Federal Express overnight delivery]*

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

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

These comments are submitted on behalf of the State of Kansas Department of Social and Rehabilitation Services (SRS). SRS is charged by Kansas statute with primary program responsibility for significant portions of Medicaid health services for Kansans, including those with mental health, developmental disability, physical disability, traumatic brain injury, and/or substance abuse treatment needs.

Kansas has had a history of strong partnership with CMS to increase the stability of, access to, and viability of basic health services for our citizens in the deepest shadows of society. SRS encourages our federal policy partners to fully consider, and work with states to mitigate, the impact of these major rule changes upon the functional ability of states and localities to continue meeting those needs.

At this hour in America's health care history, we should all be building public policies that ease barriers to access and promote early, effective and on-the-ground integrated interventions. The proposed rules have an overly restrictive and narrow definition of what is a government entity. This restrictive definition will result in the limitation of the use of money from county taxes that have long been established within the state of Kansas through legislative actions. The proposed changes will:

- Dramatically change longstanding practices of states and other units and instrumentalities of government regarding the use of certified public expenditures to fund the non-federal portion of Medicaid costs.
- Acutely limit the spirit of building effective and efficient coalitions to flexibly utilize local funding options for enhancing access to critical services for people who are uninsured and have deeply challenging life circumstances.

- Impose accounting and reporting requirements that will functionally decrease access, decrease functionality, and decrease efficiency in Medicaid services.

If CMS elects to proceed with these new rules, as written or if amended, we respectfully request that consideration be given to effective transition time for implementation. As noted in the "Costs and Benefits" section, this proposed rule is a "major rule" because it has an estimated financial impact (which would fall directly upon state and local governments) of $120 million in the first year and $3.87 billion over five years.

In order to prepare for the striking effect of this change, to stabilize the shifting targets related to the use of certified public expenditures, and to make any legislative changes needed, we recommend:

- The changes proposed in this rule, and all related changes CMS is currently pressing in interactions with states, be applied only prospectively from the effective date of the rule.
- The effective date of the rule be set only after states are given a reasonable opportunity to prepare for the implementation of these proposed changes. A transition time for these changes should allow for the completion of a full state fiscal year before the changes take effect. Fundamental fairness dictates that funding decisions which have already been made by states and other units of government, and which consumers and other stakeholders have relied upon, not be required to absorb this type of "major" change mid-stride.

We appreciate the opportunity to provide comment regarding the substantial changes associated with this proposed rule. Thank you for considering our perspective and recommendations.

Respectfully,

Don Jordan
Secretary

cc: Governor Kathleen Sebelius
Marcia Nielsen, Executive Director, Kansas Health Policy Authority

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MISSISSIPPI HOSPITAL ASSOCIATION

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March 15, 2007

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

***Via Overnight Mail to:***

*Centers for Medicare & Medicaid Services*
*Department of Health and Human 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:

The Mississippi Hospital Association ("MHA" or the "Association"), representing over 100 public, non-profit and private hospitals in the State of Mississippi, appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS") proposed rule. Our comments detail specific concerns with the proposed rule and highlight the harm it would cause to our hospitals and the patients they serve, including over 600,000 persons who are enrolled in the State's Medicaid Program. However, our primary recommendation is that CMS withdraw the proposed rule and work with Congress and with state and local stakeholders to develop policy alternatives that would strengthen- not undermine- the nation's health safety net.

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. Not only would these changes cause major disruptions to our state Medicaid program, it would also 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 (5) years. The rule will drastically reduce reimbursement for Mississippi'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. Mississippi's Medicaid financing arrangement employs none of these characteristics.

This Rule 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. This delegation included Mississippi Senator Cochran and Mississippi Congressmen Wicker and Taylor.

We urge CMS to permanently withdraw this rule, and we would like to outline our most significant concerns to the proposed Rule that particularly impact our hospitals and the State of Mississippi's Medicaid program. These concerns include: (1) the limitation on reimbursement of governmentally operated providers; (2) the narrowing of the definition of public hospital; (3) the restrictions on intergovernmental transfers (referred to herein as "IGTs"); and (4) the September 2007 effective date is not achievable.

**Limiting Payments to Government Providers**

We are opposed to this rule that 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 Medicare Upper Payment Limit (UPL) programs. Limiting a public hospital's Medicaid payment to the undefined "cost" of its services merely punishes those hospitals have struggled to reduce their cost. In addition, since the proposed rules impose these cost limits only on public hospitals, they have the insidious effect of paying government hospitals less than private hospitals. There has been no articulated justification for this policy change.

Mississippi hospitals (which are reimbursed by Medicaid on a per-diem system) do not receive per-diem payments from Medicaid that exceed their average actual costs of providing such services. While our public hospitals receive DSH payments in addition to the Medicaid per-diems which help to reimburse them for providing uncompensated charity care, many of them still only break even or even lose money on their actual costs of providing services to all patients. Therefore reductions in payments to government hospitals as proposed by this rule will cause serious financial harm to many public hospitals in Mississippi.

As you have already heard before in other comment letters you have received, hospitals that do not have profits do not have money to replace obsolete equipment, replace and/or expand infrastructure, invest in information technology and emergency preparedness, or pay for workforce. In addition, implementation of this proposed rule may cause hospitals to reduce services and/or workforce, which would directly negatively impact its employees, its community and the economy of the surrounding area, as well as the State which depend on the hospitals as an important contribution to our economy.

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable and non-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 as allowable costs 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. Hospitals that do not meet this new definition would not be allowed to help finance the state portion of the Medicaid Program.

We understand that some states have created hospitals that are organized separately from local governments, such as public benefit corporations or non-profit corporations engaged in public-private partnerships with their local governments, and that such hospitals in other states are permitted in their states to help finance the non-federal share of the program. However, the 45 public hospitals in Mississippi that help to finance the state match are traditional public hospitals that are owned by the State or by counties or local governments. As has been explained to you in other comment letters, these hospitals (with a few limited exceptions) were structured to have separate budgets and separate governing boards, etc. from their local government-owners to provide them with more autonomy and to equip them to better control costs.

This proposed rule is so restrictive that only the state's teaching hospital University of Mississippi Medical Center (UMMC)) would potentially qualify as a "unit of government." Furthermore, it is questionable that UMMC (the source of over 46% of the total IGTs made in 2006) would meet the definition as it currently does not meet all of the criteria set forth in the proposed rule.

Contrary to CMS' assertion, the statutory definition of "unit of government" does not require "generally applicable taxing authority." There is no basis in federal statute that supports this proposed change in definition.

**Restrictions on Intergovernmental Transfers**

The proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through IGTs. 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. In 2006 only $18,000,000 in IGTs from UMMC of the $82,000,000 total IGTs made by our 45 public hospitals would meet this restriction.

**The Financial Impact of the Proposed Rules**

**The result of the proposed rules would be a deficit of at least a quarter of a billion dollars to the State's Medicaid program!**

The restrictions placed on funding from providers and the resulting loss of federal matching funds will leave the state's Medicaid program (including the DSH and UPL program and other supplemental Medicaid payment programs that support the state's health care safety net) with a gaping funding hole of approximately

$266 Million Dollars. Other more profitable states may find ways to fill these gaps, but with Mississippi's economy being the worst in the nation, it is very likely that the state would address the shortfall by leaving potential federal match dollars of 76% (the highest match in the nation) on the table and instead making cuts in services, beneficiaries and/or reimbursement.

With respect to the prospect of reducing coverage, Mississippi has already reduced the rolls by over 60,000 persons in FYE 2006. Another reduction coming so soon on the heels of the previous one would have a devastating effect in the health care needs of the 490,000 citizens in Mississippi (17.4% of the state's population) who do not have and cannot afford health insurance. Furthermore, Mississippi's Medicaid patients are already the most vulnerable and sickest patients in the nation, requiring longer hospital stays than patients in other states. Therefore reducing coverage of services is not a viable option because any services reduction would jeopardize our state's already vulnerable patients and result in even sicker patients.

Regardless of what route the State takes all of these alternatives will have a negative impact on the care the Medicaid beneficiaries receive and would increase the number of uninsured persons in the State rather than help to improve our state's health care system.

**The September 1, 2007 Effective Date is not Achievable**

The State of Mississippi does not have the time nor the financial and staffing resources in place to overhaul its provider payment system and plug the large budgetary gap (assuming it will even do so) resulting from the required changes in non-federal share financing by September 1, 2007. Our state legislative session ends in less than two weeks at which time the State's budget for fiscal year 2008 will be finalized, long before the final rule is published. Elimination of federal funding of the magnitude proposed in this rule cannot possibly be incorporated and absorbed at this late date.

Further, the State is not obligated to modify the program based on the provisions of a proposed regulation that does not have the force and effect of law. It would not be prudent for the State to undertake restructuring of the program at this time, given that the regulation may undergo a significant change.

* * * * *

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

Sincerely,

Sam Cameron
President

Enclosures (2 copies of letter)

# TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

March 16, 2007

Michael O. Leavitt, Secretary
Department of Health and Human Services
Attention: CMS-2258-P
Mail Stop C4-26-05
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Leavitt:

Attached please find comments from the Texas Health and Human Services Commission on the Centers for Medicare and Medicaid Services proposed rule, CMS-2258-P: *Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership.*

This rule, if implemented, will have serious consequences for public hospitals and safety net providers in Texas. The State does not support the changes proposed in this rule and requests that CMS withdraw the proposed regulation in order to protect the fiscal integrity of the State's Medicaid program and ensure that critical healthcare services continue to be available to the State's most needy citizens.

Please let me know if you have any questions or need additional information. Olga Oralia Rodriguez, Deputy Director for Policy Development in the Medicaid and CHIP Division, serves as the lead staff person on this matter and may be reached at (512) 491-1805 or by e-mail at Olgaoralia.rodriguez@hhsc.state.tx.us.

Sincerely,

Chris Traylor

Chris Traylor
State Medicaid Director

CT:OOR:dn

Attachments

cc: Andrew Fredrickson, CMS

Proposed Rule; CMS-2258-P
42 CFR Parts 433, 447, and 457
Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership

**Overall Impact to Texas Medicaid Program**

**This rule, if implemented, will have serious consequences for public hospitals and safety net providers in Texas and could drastically cut access to healthcare for the State's most vulnerable citizens. The rule would place additional undue and costly administrative burdens on the Texas' Medicaid program without additional federal funding, further limiting the funds available to provide needed medical services. The State estimates a potential impact to hospitals and other Medicaid providers of more than $480 million in lost federal revenue ($788 million all funds) due to the provisions in this proposed rule. Therefore the State does not support the changes proposed in this rule and requests that CMS halt the implementation of this regulation to protect the fiscal integrity of the State's Medicaid program and the wellbeing of the clients it serves.**

**Please find additional comments by rule provision below:**

**Rule Provisions:**

Unit of Government; §433.50

CMS proposes to limit participation in the non-federal portion of medical assistance expenditures to "units of government," defined as a State, city, county, special purpose district, or other governmental unit in the State (including Indian tribes) that have generally applicable taxing authority. A health care provider cannot be considered a "unit a government" simply because of a contractual arrangement with the State or local government to receive tax revenues. More specifically, in order to participate in intergovernmental transfers (IGTs) or certified public expenditures (CPEs), the health care provider must be an integral part of a unit of government, evidenced by the unit of government's responsibility in funding the health care provider's expenses, liabilities and deficits.

In addition, the rule preamble states that local or state tax dollars used as the state share "cannot be committed or earmarked for non-Medicaid activities. Tax revenue that is contractually obligated between a unit of State or local government and health care providers to provide indigent care is not considered a permissible source of non-Federal share funding for purposes of Medicaid payments."

**Texas Comment**

***Legal Basis for Change in CMS Definition*: Notwithstanding the significant and harmful impact this rule would have, CMS is unable to articulate a sound legal basis for its new definition of a "unit of government." Section 1903(w)(7)(G) of the Social Security Act already defines "unit of local government":**

> **The term "unit of local government" means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.**

**Nowhere in this definition can be found the new and substantial requirement that the entity must have taxing authority or be a part of a unit of government with taxing authority. Health care authorities not having this authority have long been recognized as legitimate "units of government" for these purposes.**

**Moreover, this artificially narrow construction of "unit of local government" does not coincide with the context in which it is used in section 1903 (w)(6)(A) which recognizes a health care authority as such:**

> **6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.**

***Significant and Programmatic Impact in Texas*: This provision establishes a more narrow definition of entities that can fund the state share portion of Medicaid expenditures. By restricting the source of IGTs, Texas may have to find alternate revenue sources to fund the state share, serve fewer individuals, or reduce benefits because of limited funds. Also, the restriction on using federal match for non-Medicaid expenditures (such as public health activities or indigent care) may limit the use of IGT match for Texas' hospitals participating in the Medicaid program.**

**In addition, this change appears to disallow Texas' Community Mental Health and Mental Retardation (MHMR) Centers as "units of government" and makes them incapable of financing the non-Federal share. Community MHMR Centers are currently using CPEs as the state match for certain Medicaid services provided by the community centers. Under the proposed rule they will no longer be allowed to do so. Texas will likely incur administrative costs to change the payment method from a CPE to a direct payment of the full rate. Consideration should be given in the rules to recognize other units of government created by state statute and identified by the State as governmental.**

**Texas' MHMR Centers will also no longer be able to obtain Federal Financial Participation (FFP) dollars to reimburse some of the costs they incur performing required authority functions such as intake, operating the crisis hotlines, authorizing services, and assisting clients in becoming Medicaid eligible, because these are currently reimbursed through Medicaid Administrative Claiming (MAC) and participation in MAC is restricted to governmental entities. The costs of transporting clients to and from Medicaid services will also not be able to be reimbursed through MAC.**

**CMS should carefully reconsider this proposal in order to calculate the effect it will have on health care providers such as public hospitals in Texas as well as in other states in which so many Medicaid services are provided in these entities.**

Certified Public Expenditures (CPEs); §433.51

This provision states that funds from a unit of government may be used as the non-Federal share if the funds are: 1) appropriated directly to the State or local Medicaid agency, 2) transferred from other units of government to the State or local agency and are under its administrative control (IGT), or 3) certified by the contributing unit of government as representing the expenditures eligible for FFP (CPE). The rule proposes a requirement that CPEs must be appropriately documented – i.e. the governmental entity using a CPE must submit a certification statement to the State Medicaid agency attesting to the validity of the claimed expenditure. The certification must be submitted within two years from the date of the expenditure.

**Texas Comment**

**Texas currently uses CPEs for several programs in Medicaid (e.g. School Health Related Services, Rehabilitative Services, Early Childhood Intervention, Targeted Case Management). The proposed rule requires changes in the way that CPEs are processed, documented, and certified and requires that the certifications undergo periodic audit. Instituting these provisions is time intensive and costly, and may result in rule changes, staff costs of auditing the documents, process changes and provider education. Texas recommends CMS provide states enough time to implement these changes as well as to make enhanced funding available for these costly activities.**

**By limiting CPEs to their new definition of "units of government," only state and local taxes will be eligible for certification. This operates as a severe restriction because many traditional health care authorities that have certified matching funds will now be outside the purview of the rule. Thus, the impact to Texas will considerably exceed the procedural and administrative costs referenced above.**

**CMS's justification for only allowing state and local tax revenues as federal match is, in large part, a strained interpretation of the Medicaid Voluntary Contribution & Provider Specific Tax Amendments of 1992. This is a major change in the funding relationship between the states and the federal government and CMS has not offered justification nor states a reason for having interpreted the SSA in a contrary fashion for all these years. To the contrary, section 1902(a)(2) in no way limits the funds authorized to match federal dollars to tax revenues.**

Cost Limit for Governmental Providers; §447.206

This provision states that all providers operated by a unit of government are limited to reimbursement at the cost of services provided. For hospital and nursing facility services, Medicaid costs would have to be determined using information from standard Medicare cost

reports. For non-hospital, non-nursing facility services, a standard cost report does not exist, therefore the Medicaid costs must be reported in a form approved by the Secretary. The proposed rule requires that the state Medicaid agency review annual cost reports for all providers operated by a unit of government to verify that actual payments did not exceed a provider's costs. This rule applies to all providers operated by a unit of government including those currently reimbursed under a community-wide uniform prospective payment method. There is no distinction made between situations involving CPEs or IGTs and situations where there are no CPEs or IGTs. The State may utilize the most recent cost reports to develop interim rates; and both interim and final (annual) payment reconciliations must be made. The cost limit would be effective for all services provided as of September 1,2007. Medicaid managed care and SCHIP providers are not subject to the cost limit provision.

**Texas Comment**

**This provision would affect reimbursement to certain government providers in Texas. This rule change would lower the amount of Medicaid payments to some governmental providers by limiting their reimbursement to costs, thereby decreasing Medicaid expenditures.**

**The requirement to complete and review annual cost reports and reconcile payments to costs annually for governmental providers would place an additional administrative burden on the Medicaid program and would require the allocation of additional staff time and other resources. If the rule becomes final, CMS should allow each state enough time to implement the provisions of the rule given significant system changes and education efforts to providers that will be required.**

**The proposed rule requires government operated hospitals and nursing facilities to use a "standard, auditable, nationally recognized cost report." Currently the nursing facility program has a Medicaid specific cost report and allowable cost guidelines that are used to set statewide rates for all nursing facilities. If these rules were to move forward, government nursing facilities will be required to submit two cost reports, one based on Medicare for cost settlement and one based on Medicaid for rate determination. The rule should clarify that annually submitted State cost reports can be used as the basis for the cost settlement of government providers to be used in lieu of the Medicare cost report. In addition, the rule should clarify that State cost principles may be used in the settlement determination.**

**Given that there are no standard nationally recognized cost reports for non-hospital and non-nursing home facilities, the rule requires additional documentation to support the cost report of non-hospital and non-nursing home government operated facilities. If this rule extends to programs that currently do not have a cost report (some of these programs may use Medicare rates) the State may need to develop a new cost report that applies only to government providers solely to determine their cost for cost settlement. Medicare rates used by states as payments for their Medicaid programs should be exempt from the cost settlement process.**

**The rules should clarify if Federally Qualified Health Centers and Rural Health Clinics are exempt from the settlement provision.**

**These rules state that when CPEs are used that an interim and final settlement is required. Currently only final settlements are conducted, therefore, an additional interim settlement would need to be conducted and rates adjusted based on the settlement. States should be allowed the option of having a single settlement and forgo the interim settlement process.**

**By limiting Medicaid payments to costs by way of retroactive settlement, this process loses the savings built into a prospective payment system whereby healthcare providers have an incentive to keep costs below the prospective rate set by the state.**

**It is important to mention that this constraint on matching funds is contrary to the history of the relevant part of the SSC, section 1902(a) (13), which has always been interpreted to support rate setting flexibility on the part of the states.**

**The effective date of September 1, 2007 does not allow adequate time to modify processes, agency rules and get approval of amendments to the state plan.**

Retention of Payments; Add §447.207

This provision requires that providers receive and retain the full amount of Medicaid payments. Compliance will be monitored by CMS and states may be required to demonstrate that the source of an IGT originates from an account that is funded by taxes, the IGT occurs before the Medicaid payment is made, and the IGT originates from a separate account from which the health care provider receives Medicaid payment. The provider may not repay any portion of the payment to the State, and any IGT made by a provider after receiving a Medicaid payment would be considered an improper donation with a corresponding reduction in FFP.

**Texas Comment**

**Currently in Texas only public hospitals utilize IGTs and the public hospital provider retains the full amount of Medicaid payments. However because the IGT may be provided by only a few public providers, some IGTs will originate from taxes collected from a hospital other than the hospital that is receiving the Medicaid payment. If this rule requires that all government hospitals provide their own IGT in return for the Medicaid payment, then the IGT structure would need to be changed. Some government providers may not have the funds to pay their own IGT and general revenue would need to be secured to replace the IGT to draw down the same level of funding, or their payments would be reduced. The rule should be clarified to state that an IGT from a single governmental entity can be the basis of the state match for multiple hospitals in the eligible payment group.**

UPL for Government Providers; §447.272 and §447.321

This provision modifies the upper payment limit (UPL) rules for inpatient hospital and nursing facilities (447.272) and outpatient hospital and clinic services (447.321) to incorporate by reference the new cost limit and to make the defined UPL facility groups consistent with the new rule. This provision limits UPL to cost for both state- and non-state government operated facilities. Additionally, it appears that for these facilities, UPL would be limited to an individual facility's costs, rather than the current aggregate facility group cost determination. The UPL rules for private facilities and Indian/tribal facilities are unchanged. States must comply with the proposed upper payment limit by September 1, 2007.

**Texas Comment**

**UPL payments in Texas are currently limited to hospitals and physician plans operated by academic health systems. This provision would decrease UPL payments to certain hospital and health system physician plan providers in Texas and could impact the ability of those providers to serve Medicaid clients. Additionally, there is a concern that the practice Texas uses in their public hospital UPL programs where a group of governmental entities provide the IGTs for other public hospitals may not be acceptable under the new rules. The state requests CMS provide additional guidance on this practice.**

**CMS has stated that the cost limitation applies to disproportionate share hospitals but does not affect them. However, there is concern that the cost limit could affect current DSH calculations, therefore additional clarification is requested. In addition, the effective date does not allow much time to modify processes, agency rules, or get approval of amendments to the state plan if needed.**

Tool to Evaluate the Governmental Status of Providers

In order to verify that a provider is a "unit of government," states will be required to submit information on each health care provider that is said to be governmentally operated through a questionnaire developed by CMS. For existing providers, states will be required to submit this information within three months of the effective date of the final rule.

**Texas Comment**

**This provision will require additional administrative and staff resources to identify relevant providers and collect the appropriate information to send to CMS.**

# Indiana Council of Community Mental Health Centers, Inc.

*Supporting . . . Representing . . . Serving*

**James F. Jones, M.S.**
*Executive Director*

March 16, 2007

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

RE: File Code: CMS - 2258 - P

Dear Sir/Madam:

Please consider this response on behalf of the 30 Indiana Community Mental Health Centers to the proposed Medicaid rule File Code: CMS – 2258 – P, Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, regarding the Medicaid program.

On June 14, 2000, the State of Indiana's Office of the Attorney General issued an opinion letter declaring that Indiana's Community Mental Health Centers were public entities. This opinion was rendered upon consideration of tests developed by the Indiana appellate courts. This public entity designation is further supported by numerous Indiana Codes such as IC 12-7-2-38 and IC 12-21-2-3 that statutorily define the centers and requires the Indiana Division of Mental Health and Addictions Director to certify them as providers for public supported mental health care. These statutes also require the Director to designate the centers to serve a defined geographic service area which assures that public mental health services are available in each of Indiana's 92 counties. Within these assigned geographic service areas, IC 12-29-2-2 authorizes the centers to receive a specific county property tax levy for the purpose helping to offset their general operations costs. And IC 12-26-7-3 requires that all individuals must be evaluated by a community mental health center before being committed to a state operated mental health facility. Indiana clearly is dependent upon the 30 community mental health centers to assure that at risk mentally ill Hoosiers have access to the state's public mental health system.

For the Fiscal Year 2006, Indiana's community mental health centers served 115,993 mentally ill consumers in the state's public mental health program. All consumers in this

program must meet a financial eligibility of less than 200% of federal poverty and the clinical assessment for seriously mentally ill adults, seriously emotionally disturbed children, or a chronic substance abuse dependency. Of this total 72,705 were covered by Medicaid Rehabilitation Services with the Federal Funding Participation share for these services totaling $179,624,389. The state matching share of $108,697,618 was covered by Inter-Governmental Transfers (IGTs) from the Division of Mental Health and Addictions and County Property Tax funds from the Community Mental Health Centers in their role as Public entities.

In addition to the above, Indiana's community mental health centers have been participants in the Medicaid Administrative Claiming program. Their status as Public entities has allowed them to certify the Medicaid Match from their County Property Tax funds. The claims for this program have totaled just over $30 million in FY 2006.

With direction and oversight from Indiana's Division of Mental Health and Addictions and the Office of Medicaid Policy and Planning, community mental health centers have built an excellent system of care for those mentally ill residents who are poor and at-risk. For those who are Medicaid eligible this system of care has been based on access to payment for services under the Medicaid Rehabilitation Option program. The Medicaid Rehabilitation Program has been operated by the state with our collective understanding, that the community mental health centers were a qualified Public entity for the purposes of Medicaid Inter-Governmental Transfers.

As we review, the proposed Medicaid rules, which narrows the definitions for a unit of government and a governmentally operated health care provider, we fear there is a possibility they may be interpreted in a way that would disqualify the mental health centers from their status as Public entities. If this were the case and resulted in the centers losing their status as Public agencies, they would no longer be able to Certify Public Expenditures (CPE), or to participate in the Inter-Governmental Transfer (IGT) process, for the purpose of Medicaid participation. This would prohibit the use of some $31 million in County Property Tax funds that have been available to meet the Federal Matching requirements for the Medicaid Administrative Claiming Program and the Medicaid Rehabilitation Option services delivered to the 72,705 Medicaid eligible seriously mentally ill consumers in Indiana's public mental health program. **Considering Indiana's matching percentage, this would result in a loss in Federal funds to our system of care for those Medicaid eligible and seriously mentally ill of approximately $50 million.**

If the proposed rules were to be implemented and interpreted in a way that disqualified Indiana's community mental health centers from their current state designated as Public entities, our public mental health system could be devastated. The loss of this much Medicaid revenue would force many of our providers to close and literally thousands of seriously mentally ill Hoosiers will be left with no option for care.

Given the potential magnitude of this financial impact, and the short notice of the proposed implementation of the final rules Indiana would likely need to make substantial changes in our legislation and appropriate significant funding for these programs in order to prevent the loss of its public mental health system. Since Indiana has a part-time legislature and due to the complexity of this issue, our state legislature and state policy makers would need at least two years to construct a plan to salvage its public mental health system.

We therefore, recommend that these rules be tabled until the true state and national impact on Public Mental Health Systems can be adequately defined. It would be irresponsible for any change with this level of potential impact to be implemented without sufficient notice for states and providers to evaluate the changes they must make for compliance.

We sincerely hope you will consider these comments and concerns in your final deliberations.

Please feel free to contact me for additional information you may need in your deliberations at (317) 684-3684.

Sincerely,

James F. Jones
Executive Director

cc:
Senator Richard G. Lugar
Senator Evan Bayh
Representative Pete Visclosky
Representative Chris Chocola
Representative Mark Souder
Representative Steve Buyer
Representative Dan Burton
Representative Mike Pence
Representative Julia Carson
Representative John Hostettler
Representative Michael E. Sodrel
Secretary Mitchell Roob, Family Social Services Administration
Indiana Council of Community Mental Health Centers, Inc. Membership
National Council of Community Behavioral Health
Mental Health of American in Indiana
National Alliance on Mental Illness Indiana, Inc.

BOARD OF SUPERVISORS
COUNTY OF SANTA CLARA
COUNTY GOVERNMENT CENTER, EAST WING
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DONALD F. GAGE
CHAIRPERSON
SUPERVISOR FIRST DISTRICT

March 15, 2007

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

**RE: COUNTY OF SANTA CLARA MEDICAID RULE COMMENT LETTER**

Dear Ms. Norwalk:

On behalf of the Board of Supervisors of the County of Santa Clara, I am writing to express our opposition to CMS' Proposed Rule CMS 2258-P, which imposes cost limits on Medicaid payments to public providers. The County of Santa Clara urges CMS to withdraw this proposed rule.

We are highly concerned that the proposed rule would have a severe negative impact on California's public hospital safety net and the patients and communities they serve. If the rule is implemented, our County's public hospital, Valley Medical Center, anticipates that it will lose nearly $32 million a year.

Valley Medical Center is the largest provider of medical services to residents of Silicon Valley. VMC provides a wide range of primary through tertiary inpatient services to a very large and diverse population. In 2006, nearly 200,000 people (or 1 in 10 residents of Santa Clara County) received care at VMC. Looking back over the past four years, VMC's unduplicated patient count was 410,000, meaning that 1 in 5 residents of Santa Clara County receives care at VMC.

Valley Medical Center is the only disproportionate share hospital remaining in Santa Clara County. We provided 50% of care to Medicaid patients and over 90% of the care provided to the uninsured in calendar year 2005. In addition, VMC is the only burn

center in the region and one of only two burn trauma centers in California north of Los Angeles. VMC provides spinal cord and traumatic brain injury rehabilitation, pediatric intensive care, regional Level III neonatal intensive care, and is the county's only psychiatric emergency service. VMC's outpatient department and community clinic partners provide over 1 million outpatient clinic visits each year. VMC also works with Stanford University to offer a top-notch physician training program.

We are concerned about a number of troubling provisions contained in the rule.

First, it will limit our Medicaid (in California, Medi-Cal) reimbursements to the costs of providing Medi-Cal services to our Medi-Cal patients. This will eliminate funding for our Medi-Cal and uninsured patients, whose costs are currently covered under the Safety Net Care Pool. The pool exists under California's CMS-approved hospital financing waiver specifically for the purpose of providing financial assistance to safety net hospitals that incur significant costs in treating uninsured patients.

If the proposed rule is applied to the waiver, Valley Medical Center could be forced to limit critical services to our patients, including care for the uninsured, trauma and burn care, specialty services, acute psychiatric services, outpatient services. These limitations also could result in an increased number of uninsured patients seeking care in private hospitals, creating a domino effect that could be harmful to California's entire health care system.

Though we understand that staff from CMS verbally has advised the State that the regulation will not affect California's waiver, the potential harmful effects on our hospital are such that we cannot rely on these verbal assurances, particularly given the plain language of the rule. The proposed rule explicitly states in the preamble that all Medicaid payments "made under the authority of the State plan and under Medicaid waiver and demonstration authorities are subject to all provisions of this regulation." 72 *Fed. Reg.* 2236, 2240. Moreover, the Special Terms and Conditions that govern the Hospital Waiver require that the State comply with any regulatory changes. Hence, we and California's other public hospitals are highly concerned that, when the rule's limit to Medicaid costs is applied to our state's hospital financing waiver, funding will be eliminated for indigent non-Medicaid patients whose costs are currently covered under the Safety Net Care Pool.

Second, the rule imposes a very restrictive definition of public providers who can participate in Medicaid funding programs. Under the proposed provision, the University of California Medical Centers and Alameda County Medical Center will likely be unable to meet CMS' stringent definition; consequently, those public hospitals stand to lose millions of federal dollars a year. These additional losses would also contribute to reduced access and services to our patients and our communities.

Finally, there are a number of legal and technical issues raised in the comment letter submitted by the California Association of Public Hospitals (CAPH), an organization of which Valley Medical Center is a member. These include a provision that narrows which

sources of funds may be used as non-federal Medicaid matching funds, and a requirement that public providers retain federal funds upon receipt. We support these comments of opposition and incorporate them by reference in this comment letter.

The County of Santa Clara opposes the proposed Medicaid rule and strongly urges CMS to withdraw it. If the proposed rule goes into effect, we will suffer extremely harmful effects that will affect our County's ability to care for our patients and communities. CMS should recognize the damage that this rule will have to our community's health care system and stop its efforts to move forward with the rule.

Sincerely,

Donald F. Gage
Chairperson, Board of Supervisors

c: Santa Clara County Congressional Delegation
Santa Clara County Board of Supervisors
Peter Kutras, Jr., County Executive

SINAI
Sinai Health System

- Mount Sinai Hospital
- Schwab Rehabilitation Hospital and Care Network
- Sinai Community Institute
- Sinai Medical Group
- Sinai HealthFirst
- Affiliate: Access Community Health Network

*Sinai Health System is an affiliate of the Jewish Federation of Metropolitan Chicago*

**Alan H. Channing**
President and CEO

March 15, 2007

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

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

Dear Ms. Norwalk:

On behalf of Sinai Health System, I am writing to express our strong opposition to the proposed regulation published on January 18, CMS-2258-P. The Jewish Federation of Metropolitan Chicago, of which we are an affiliate, joins Sinai in its opposition to this proposed rule. We believe that the proposed rule could be devastating for the safety net health care system in the communities we serve.

Sinai Health System is the largest private provider of health care for low-income patients in Illinois. We are located on the west side of Chicago and provide services to patients throughout the metropolitan area. Sinai Health System includes Mount Sinai Hospital, a tertiary care hospital; Schwab Rehabilitation Hospital, Sinai Medical Group, and Sinai Community Institute, the social service entity of our system. In addition, Mount Sinai Hospital has been designated as a children's hospital by the State of Illinois. Over 60% of the patients served by Sinai are covered by the Medicaid program. Approximately 12% of the patients we see are without any insurance. We are one of the largest providers of maternity care in Chicago with our annual births approaching 4,000 per year. Mount Sinai Hospital is one of four trauma centers serving Chicago. We provide over $20 million a year in uncompensated care. Sinai is also affiliated with and serves as the major specialty care and inpatient resource for over 50 federally qualified health centers (fqhc) sites in the metropolitan area, including Access Community Health Network, Erie Family Health Centers, and Lawndale Christian Health Center. In cooperation with our affiliated fqhc sites, we provide outpatient services to approximately 250,000 individuals annually.

As the major private safety-net provider in our community, we respectfully request that you immediately withdraw the proposed rule. Moreover, we would like to endorse the comments on

SINAI

the proposed rule that have been offered by the National Association of Public Hospitals and Health Systems and the Illinois Hospital Association.

The State of Illinois has estimated that the impact of the proposed rule on the State's Medicaid program could exceed $600 million. Such a loss would have a tremendous negative effect on safety net hospitals in Illinois. This proposed rule is coming at a time when the public hospital serving our community is experiencing cuts in service, private hospitals have closed their acute care services in our community, and the number of uninsured patients has steadily risen. In the past year, we have seen the numbers of uninsured inpatients rise by over 30%. Over 20% of our outpatient services are provided to patients without insurance. Years of low reimbursement coupled with the rising burden of caring for the uninsured have left us unable to deal with pressing capital needs. We are very concerned that if the proposed rule further weakens our public hospital, we will see the number of uninsured patients rise again while we simultaneously experience inevitable cuts in Medicaid reimbursement from the State. Currently, Sinai Health System is experiencing a $5 million loss from operations. Even an impact of an additional $5 million loss of revenues annually will jeopardize our ability to sustain our programs.

As I know you are aware, there has been considerable congressional opposition to this plan. Last year, 300 members of the House of Representatives and 55 senators expressed their opposition to Secretary Leavitt. Recently, Congress has again expressed its opposition with 226 members of the House and 43 Senators formally signing letters to urge congressional leadership to stop the proposed rule from moving forward. Much of the Illinois delegation and both of our senators have led or joined this opposition.

There are three significant concerns we have with the proposed rule. These include the limitation on reimbursement of governmentally operated providers; the restriction on intergovernmental transfers and certified public expenditures; and the absence of data or other factual support for CMS's estimate of savings. The Illinois Hospital Association and the National Association of Public Hospitals and Health Systems have submitted extensive comments on these specific areas of the proposed regulation, and we endorse their positions.

The safety net of health care for low-income patients in our community is already in crisis. We believe that this proposed rule will devastate a fragile system of care. We join with our associations, other safety net providers and numerous other organizations in opposition to this rule and ask that it be permanently withdrawn.

Sincerely,

Alan H. Channing
President/Chief Executive Officer

Pamela Seubert
Vice President
Jewish Federation of Metropolitan Chicago

cc: Illinois Hospital Association
Jewish Federation of Metropolitan Chicago
National Association of Public Hospitals and Health Systems


TEXAS HOSPITAL ASSOCIATION

March 13, 2007

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

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

Dear Ms. Norwalk:

On behalf of its more than 500 member hospitals, the Texas Hospital Association appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule restricting how Texas currently funds the state's Medicaid program and reimburses its public hospitals. **The THA respectfully opposes this proposed rule and is very concerned by the harm the proposed rule will have to low-income Texans and the hospital safety-net infrastructure now in place.**

As proposed, the rule severely limits how Texas may reimburse its safety-net hospitals. The rule will dramatically jeopardize the long-standing Medicaid financing mechanisms that have operated in Texas for nearly two decades and THA estimates that Texas safety-net hospitals will lose approximately $400 million annually in federal Medicaid funds if these proposals are implemented. In addition to directly harming the state's state-owned and public hospitals, the rule has peripheral cascading implications extending beyond public hospitals and will ultimately harm privately-owned hospitals and the low-income Texans they provide much-needed care for.

It's our organization's understanding that the American Hospital Association, the National Association of Public Hospitals and Health Systems and other national organizations have submitted well detailed comments on the proposed rule. Therefore, our association will limit our discussion to three major topics included in the proposed rule:

- Limiting reimbursement to governmentally-operated providers;
- Narrowing the definition of to a "unit of government" standard for Medicaid payment and transfer purposes; and
- Restricting the use of intergovernmental transfers.

**Limiting reimbursement to governmentally-operated providers**

The proposed rule limits reimbursement for government hospitals to the cost of providing services to Medicaid patients, and therefore severely restricts Texas from making supplemental payments to these safety net hospitals through our Medicaid Upper Payment Limit (UPL) programs.

Almost three decades ago, Congress abandoned 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. Texas' Medicaid program has adopted a similar prospective payment model, and CMS is proposing to resurrect a cost-based limit that Congress long ago declared less efficient.

As referred to in the rule, section 1902(a)(30)(A) of the Social Security Act states, in part, that a state Medicaid plan must:

> *"assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area"*

There is no explanation provided in the proposed rule as to why the 100 percent aggregate upper payment limit for governmentally operated hospitals is now insufficient to meet the efficiency and economy requirements of this section, and must be replaced with a limit based on each individual provider's costs and a cost-based reimbursement limit.

Limiting reimbursement to each specific hospital's cost is *severely more restrictive than implementing an overall, aggregate upper limit.* Furthermore, there is no explanation in the proposed rule why the agency is disregarding without explanation its previous decisions that allows Texas greater flexibility and adaptability in addressing the special needs of specific hospitals in establishing the upper payment limit.

**Redefining "Unit of Government"**

As proposed, the rule puts forth a new and restrictive definition of organizations that may assist in financing the state share of Medicaid. CMS has proposed narrowly redefining these facilities as a "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.

The THA is concerned that hospitals that do not meet this new definition will not be allowed to make intergovernmental transfers to the Texas Medicaid program. It's our association's position that the statutory definition of "unit of government" does not require "generally applicable taxing authority."

Texas hospitals are concerned that this new, more restrictive definition could possibly limit some of our public hospitals that operate as public taxing entities or as local taxing districts from helping in financing the state share of Texas Medicaid funding. Furthermore, the THA is unable to find any basis in federal statute supporting the proposed change in definition.

**Restricting the use of intergovernmental transfers**

The proposed rule imposes new restrictions on a state's ability to fund the non-federal share of Medicaid payments through IGTs and CPEs, including limiting the source of IGTs to funds generated from tax revenue. **While THA acknowledges that the discussion does not apply to public hospital intergovernmental transfers operating in Texas,** our association encourages CMS to adopt broad based principles in certifying and permitting the state share of Medicaid funds.

Our association is concerned that restrictions on IGTs may adversely impact Texas Medicaid funding in the future, especially as public and privately-owned hospitals consolidate their operations to achieve higher quality while increasing efficiency and lowering their costs of treatment.

Finally, a table included in the rule illustrates that CMS estimates the proposed rule will save approximately $3.9 billion in federal funds over five years. This reduction is, in fact, a budget cut for Texas safety-net hospitals, and will have devastating effects on the Texas health care safety net. Respectfully, THA opposes the rule and strongly urge that CMS permanently withdraw the rule from future consideration. If you have any questions, or need additional information, please e-mail jberta@tha.org, or contact me at 512-465-1556.

Sincerely,

John Berta

John Berta
Director, Policy Analysis

APHSA
American Public Human Services Association

NASMD
National Association of State Medicaid Directors
an affiliate of the American Public Human Services Association

March 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Attention: **CMS–2258-P**

**Re: Proposed Rule: 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:

The American Public Human Services Association (APHSA) and its affiliate, the National Association of State Medicaid Directors (NASMD), respectfully submit this comment letter on the provider cost limit regulation published in the January 18, 2007 Federal Register (72 FR 2236) for the Centers for Medicare and Medicaid Services (CMS).

Please be assured that the state Medicaid agencies share the federal government's strong commitment to protecting the fiscal integrity of the Medicaid program and are prepared to do so through federal-state initiatives and state-specific efforts. However, we respectfully submit that the agency's proposed rule is a fundamentally flawed approach to achieve this stated goal.

The analysis that states have conducted thus far indicates that the proposed regulation could reverse much of the progress that they have made to strengthen the efficiency and accuracy of their reimbursement and financing systems. State initiatives have helped to ensure the sustainability of their evolving Medicaid programs and the health care system more broadly. Such changes were pursued in accordance with statutory requirements, and, in many cases, through the explicit guidance and approval of CMS. They also reflect CMS' and federal policymakers' philosophy for facilitating cost-effective market principles into federally funded health care programs and are likely to impede ongoing efforts to move towards so-called "pay-for-performance" payment models that align

payment and desire outcomes. The proposed payment limit on costs is contrary to these federal and state policy decisions.

In addition, APHSA and NASMD believe this rule could cause significant upheaval and have a far-reaching impact on states' Medicaid programs and public health care delivery systems as they were developed without first considering the unique and complex reimbursement processes employed in each state. At a minimum, the agency has failed in its responsibility to communicate the proposed rule's impact on specific policies, systems, and entities throughout the states. For example, states believe CMS has failed to account for the magnitude of effort and new resources that will be required to undertake cost-based reporting and reconciliation.

Although states believe that the proposed rule could have a significant impact on their Medicaid programs, it is difficult to quantify this impact due to the lack of clarity and specificity in the rule itself. APHSA has convened a number of calls with states during which several fundamental questions have arisen. Although we appreciate that CMS has attempted to provide clarification to the extent possible given the constraints of the federal rulemaking process, states believe it is inappropriate for CMS to move forward on the rule without a more comprehensive understanding of the state-by-state impact. Specifically, CMS staff on a number of occasions has indicated that they lack data and other relevant information on the fiscal impact the proposed changes would have.

For these reasons, we ask that CMS not move forward with this new regulation without first obtaining and communicating additional information on the proposed rule's impact on the various state reimbursement practices and providing a more comprehensive regulatory analysis.

APHSA and NASMD also wish to take this opportunity to note that a bipartisan majority of Members of Congress previously have contacted Secretary Leavitt regarding their opposition to the changes contained within this proposed rule. States have significant concerns with CMS' decision to move forward with the rulemaking process without further consideration by Congress.

The six major areas of concern identified by states include:

- Dismantling, or at a minimum significant disruption of, the current financing and reimbursement systems in many states;
- Creating an arbitrary distinction in reimbursement policies for providers based solely on whether they are public or private entities;
- Imposing a state mandate to comply with far reaching audit and review programs merely to demonstrate that they do not employ certain financing mechanisms that CMS now characterizes as inappropriate;
- Arbitrarily overturning principles that grant states the unique authority to define and create standards for entities classified as "units of government;"
- Proposing an unfeasible implementation timeframe; and

- Underestimating the regulatory impact in terms of scope, time, and resources at both the state and federal level.

We appreciate the opportunity to provide you with the following comments.

**§ 433.51 Funds from units of government as the state share of financial participation**

*Defining unit of government*
In § 433.50(a)(1)(i), CMS proposes to define "unit of government" as a "city, county, special purpose district, or other governmental unit in the State with generally applicable taxing authority." States respectfully submit that CMS has exceeded its authority in defining "unit of government" in this proposed regulation.

There are a number of long-standing provisions and discussions regarding the Medicaid program that have sanctioned public entities not funded by state appropriations to contribute to the non-federal share of Medicaid expenditures. Section 1902(a)(2) authorizes a state plan to provide for local participation in as much as 60 percent of the non-Federal share of total Medicaid expenditures, as long as the lack of adequate "funds" from "local sources" does not result in lowering the amount, duration, scope of quality of care and services under the plan. There is no requirement in this section of the law that such "funds" come from tax revenues or that the "sources" be federally determined to be "units of government." Further, congressional intent regarding permissible sources for the state share is indicated at section 1903(d)(1). This provision makes clear that sources of funds in addition to amounts appropriate by the State or its political subdivisions may supply the non-Federal share.

We are concerned that CMS is newly determining states that it must substitute "units of government" for "public agencies" as the only entities qualified to put up the non-Federal share through transfer or certification in order "to be consistent with" and "to conform the language to" Sections 1903(w)(6)(A), which was added to Title XIX as part of the Provider Tax Amendments of 1991 (72 Fed. Reg. at 2240). We submit that section 1903(w)(6)(A) is not a limitation on the nature of public entities contributing to the non-federal share of financial participation. Rather, it was a limitation on CMS's authority to regulate in this area. It states that notwithstanding any other provision:

States also ask that CMS consider that this overly restrictive approach would exclude the "governmental entities" approved by CMS in some states' existing section 1115 demonstrations. We strongly believe CMS has failed to consider that there is a broad range of mechanisms and relationships beyond taxing authority, including contractual arrangements, grants, sale or lease of land, litigation funds, and many other sources beyond taxing authority, that link government entities to the Medicaid program.

For these reasons, APHSA and NASMD urge CMS to reconsider the overly restrictive and complex language defining a "unit of government."

*Differentiating between public and private entities*
States request that CMS refrain from imposing an arbitrary distinction between public and private entities participating in the Medicaid program. States strongly disagree with the proposed regulation's sanctioning of higher reimbursements for private entities than for public entities simply because they are private. This differential treatment fails to consider the actual services delivered. In reality, services are not likely to differ based on the public or private nature of the facility or provider, but rather on their specialization and expertise. For example, many states design their reimbursement systems to differentiate payments between an acute care hospital and a psychiatric care facility. Public and private entities in the acute care hospital category would be paid the same rate based on the services they provide. States would develop a separate rate for a psychiatric care facility and apply it to the public and private entities in this group. The proposed regulation would essentially force states to dismantle this reasonable payment methodology.

Despite the clear national trend across the entire health care system to improve transparency and build pay-for-performance reimbursement models, this regulation impedes the ability of state Medicaid programs to do so by restricting reimbursement systems for Medicaid providers. States believe a more rational approach is to retain the current state flexibility to set rates based on service delivery categories and other models that reward high performance, quality care. States urge CMS to reconsider the rule as it would result in a differential treatment between public and private providers thereby driving the federal government and states further from their goal of ensuring the integrity of the program.

The proposed rule indicates that hospitals and nursing facilities are accustomed to using Medicare cost report forms to document costs. States believe this is a flawed approach as the Medicare cost report cannot be easily adapted for Medicaid purposes. States also note that there is no cost report for most other types of "public" providers, for example schools, universities, and other entities within state and local education systems. States are particularly concerned about how to interpret this rule with regard to higher education and university systems. In addition, states have long-standing partnerships with school systems due to the fundamental overlap between school-aged children who are simultaneously enrolled in the Medicaid program. The proposed rule could be a barrier to compliance with 42 USC 1396b(c) with respect to the Secretary of Health and Human Service's obligation to make federal financial participation (FFP) available for Medicaid services provided in schools where the Medical assistance is included in an Individual Education Plan or Individualized Family Service Plan under IDEA. In addition, it will create a new documentation and reporting structure for schools and school-based providers and clinics that could strain and eventually result in the severing of this important relationship.

*Treatment of Tribal entities*
In section 433.50(i), the proposed regulation indicates that a governmental unit will include Indian tribes. States request clarification as to how CMS can propose this language as it seems to directly conflict with the unique government-to-government relationship the United States has with Tribal governments. Specifically, the State Medicaid Director Letter (#05-004) issued on October 18, 2005 responds to questions about using expenditures certified by Tribal organizations to fulfill the state matching requirements for activities under the Medicaid program. The letter described CMS's policy regarding the conditions and criteria under which tribal organizations can certify expenditures as the non-federal share of Medicaid expenditures for administrative functions. On June 9, 2006, CMS issued a clarifying letter to state Medicaid directors (#06-014) that stated that federal funds awarded under the Indian Self-Determination and Education Assistance Act (ISDEAA) (P.L. 93-638) may be used to meet matching requirements. We believe this proposed regulation reverses those decisions by suggesting that CMS would only allow this federal matching if the tribe has generally applicable taxing authority.

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

*Approval and oversight of reimbursement systems*
On behalf of all states, we strongly oppose the restrictions the proposed rule imposes on current state flexibility to develop appropriate and reasonable Medicaid reimbursement systems. Specifically, we believe the cost limit could violate Section 1902(a)(30)(A) of the Social Security Act (SSA) by preventing states from adopting payment methodologies that are economic and efficient and that promote quality and access. It could also violate Section 705(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 by implementing upper payment limits that are not based on the proposed rule announced on October 5, 2000.

We also respectfully disagree with CMS' assertions in the proposed rule that states operate inappropriate financing structures. We submit to you that states have worked with CMS to ensure that their financing policies do not denigrate the integrity of the Medicaid program and have received approval by CMS for these systems. Further, states have been subject to significant state and federal audit reviews. These auditing practices occur on an ongoing basis. We believe these audits and other oversight mechanisms are completely capable of identifying any potential threats to the integrity of the program that could occur at some future point and oppose the duplicative and overly burdensome administrative procedures proposed by CMS.

We wish to emphasize that Medicaid reimbursement formulas are established by each state with the approval of the federal government and in accordance with federal guidelines. As such we believe it is irrational to implement this proposed rule since it

would overturn the approved systems currently in place. The proposed rule also does not accurately account for the fact that such actions must be undertaken on an ongoing basis.

*State flexibility in reimbursement system design*
Based on the proposed rule as currently written, many states believe they would have to undertake significant restructuring of their current reimbursement systems that would force them to revert to cost-based reimbursement systems. Reports from state Medicaid officials' indicate that such systems are nearly impossible to operationalize. In the past, cost-based systems also forced states to make excessive payments for services at the expense of other aspects of their Medicaid programs. Depending on the state-specific design of such cost-based systems, states also were compelled to reconcile payments with providers, another inefficient and administratively burdensome aspect of such systems.

In response to the new reimbursement requirements and desire to phase-out cost-based systems, states have developed a range of different approaches to provider reimbursement. Such variation is fundamental to the Medicaid program's flexibility in adapting to state and local needs and policies. States have implemented reimbursement systems that are well researched and audited to ensure Medicaid provides the most appropriate reimbursement to providers. Such flexibility also allows states to respond to the demand and supply at each level within the state and local health care marketplace. It also provides states with the tools necessary to develop adequate provider networks to meet the needs of their residents.

As an example, some states use Medicare rates that may reflect an "above-cost" Medicaid payment. A number of states report that this payment structure has helped to equalize payments to providers regardless of the specific payer. In turn, this has helped to minimize traditional bias against the Medicaid program and allowed states to sustain adequate provider networks. Other states have developed prospective payment systems (PPS) based on Medicare's diagnosis-related groups (DRGs). States then periodically rebase their systems. States' current payment structures seek to reflect the actual costs of providing services in today's healthcare marketplace within the fiscal parameters of the state budgets.

As noted above, these reimbursement systems were developed in light of inefficiencies identified within cost-based reimbursement systems. State Medicaid programs, similar to other payers, have adopted more rational reimbursement systems that encourage desired behaviors and have helped to contain costs. States overwhelmingly report that such systems and policies have improved overall efficiency in the Medicaid program. Regrettably, we believe it is reasonable to conclude that the proposed rule would force states to revert to inefficient cost-based systems. As such, we request that CMS continue to allow states to utilize prospective payment systems and that such systems not require states to reconcile payments.

States also are concerned with one of the underlying premises of the proposed rule – that paying the Medicare rate to Medicaid providers is excessive. We request that CMS provide clarification as to why states would not be able to use this rate methodology. States also offer for CMS' consideration that if the agency is concerned that Medicare payments are excessive, then the agency should address this issue through the Medicare program rather than overturning approved financing systems in Medicaid that have not proven to be a problem.

*Additional payments to providers*
On behalf of states we request that CMS provide further clarification on the treatment of graduate medical education (GME) payments to providers and that such payments be considered outside of the currently proposed cost limit. GME payments are an option that state Medicaid programs may choose to provide, subject to approval by CMS. States have the flexibility to determine how to best use available GME funds. GME payments are one tool that has allowed states to become more prudent, farsighted purchasers of care. Many states recognize that support for GME is a valuable tool for meeting the future health care provider needs of Medicaid beneficiaries and the public in general. For example, states increasingly are requiring that some or all Medicaid GME payments be directly linked to state policy goals intended to vary the distribution of, or limit, the health care workforce.

We also request that CMS clarify that the proposed rule's language at § 447.206(c)(1) that states, "[a]ll health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider's cost of providing covered Medicaid services to eligible Medicaid recipients." States request CMS clarify that the payment limit based on the cost of providing services to eligible Medicaid recipients does not exclude costs for disproportionate share hospital payments. In addition, several states have or evaluating proposals for state plan amendments that would pay for services provided to the non-Medicaid eligibles that are uninsured. States are unable to fully analyze the impact of the proposed rule on their Section 1115 demonstration programs without further clarification. States submit to CMS that restricting Section 1115 demonstration projects will stifle innovation in federal-state efforts to address the health care needs of low-income uninsured individuals.

States ask that CMS provide clarification on the proposed rule's applicability to managed care organizations (MCOs). States increasingly are contracting with MCOs because they have demonstrated cost-efficiencies in delivering services and managing care and they frequently offer a more choices with their expansive provider networks. The rule fails to address how the cost limit would apply to such entities and the negotiated capitated payments states pay. CMS also should provide clarification on how the cost limit applies to government providers participating in an MCO network. States submit that it is unreasonable to segment out public and private providers in such arrangements and, as noted above, this would disrupt the system of incentives for quality and cost-efficiency.

**§ 447.271 Upper limits based on customary charges**

As noted above, states respectfully request that CMS refrain from implementing a rule that would limit state flexibility to design reimbursement policies. Specifically, we believe that CMS has exceeded its authority by proposing to eliminate the aggregate nature of the payment limit. The proposed rule appears to impact existing state plan amendments in which CMS has approved an Upper Payment Limit calculation which is based on an aggregate cost limit for privately owned/operated facilities, government owned/operated facilities, and state teaching hospital facilities.

**§ 457.628 Other applicable Federal regulations**

CMS states in section 457.628(a) of the proposed regulation that the proposed cost limit provisions at section 447.206 do not apply to states' State Children's Health Insurance Programs (SCHIP). States request that CMS provide further clarification of this provision. Specifically, it is unclear if CMS is creating a new definition for what will be considered an "SCHIP provider." We note that in states that have chosen to design their SCHIP program as a Medicaid expansion, there is no distinction made between those providers who provide services to the SCHIP population and those who provide services to Medicaid enrollees. We request that CMS address whether there are different qualifications for SCHIP versus Medicaid providers. In addition, we ask CMS to provider further clarification whether, if a state's Medicaid providers are considered to be SCHIP providers, they are exempt from the cost limit provisions of 447.206 for that unit of government. Alternatively, if a state's Medicaid providers are not considered to be SCHIP providers and are required to meet the cost limit provisions of 447.206 for that unit of government, we ask that CMS address whether the state should exclude SCHIP costs and reimbursements when making the Medicaid cost limit and overpayment determination. We note for your consideration that if CMS does not allow exclusion of the SCHIP costs and reimbursements in the cost limit determination the result may be a cost shift from the Federal government to the state Medicaid Agency for the difference between the states' regular FMAP and the enhanced SCHIP FMAP.

**Implementation Timeframe**

We respectfully urge CMS to revise the effective date of the proposed rule for two main reasons. First, we submit to CMS that there is tremendous confusion among state Medicaid officials as to the interpretation of the proposed rule and in seeking clarifications from CMS staff, we note that there has been disagreement among the CMS staff themselves as to how to interpret certain provisions of the proposed rule. For example, at this time, many states have reported that they are still unclear as to who CMS will determine to be a government operated provider. We believe it is unreasonable to expect states to meet the proposed effective deadline if CMS staff is still working to

understand and clarify the proposed rule. In addition, CMS has indicated that it would take a team of individuals working with states on an individual basis to determine the specific state impact and application. We believe that CMS cannot in good faith ensure that it will be able to accomplish such a significant task within the proposed timeframe.

Second, states also have reported that they - and the Medicaid providers in their respective states - will need significant time to adapt systems, methodologies, change state plans, etc. Developing a process for reconciliation necessary to comply with the cost-based provisions of the proposed rule would itself take considerable time and would not be available before proposed effective date. Many states have reported that they would need to work with their state legislatures to address the impact of implementing the proposed regulation. They would need at least a year from the date of issuance of the final rule in order to have an opportunity to convene their legislatures. In some states, implementation may require additional funding, and, in turn, this may require the involvement of state legislatures.

In addition, some states are reporting that they have identified several hundred potential government provides that would need to be reviewed and reported to CMS. Many governmental provider types do not have individual Medicaid cost reports which will need to be developed and approved by CMS. As a result, CMS should provide states with transition periods leading to more reasonable time period for implementation.

**Regulatory Impact Analysis**

On behalf of states, we ask that CMS reevaluate its regulatory impact analysis. We believe there are three general aspects in which it fails to provide an adequate assessment: (1) the federal revenues generated; (2) the cost of implementation to the federal government; and (3) the absence of any state fiscal impact.

In its Regulatory Impact Analysis, CMS estimates $3.9 billion in federal savings from the proposed rule over five years. We request that CMS provide additional information on its analysis and methodologies used in producing this estimate. States are perplexed that CMS to date has refused requests for further information on its methodology for deriving this number that could otherwise assist states in determining CMS' assumptions and how states should interpret the provisions of the proposed regulation.

Second, CMS fails to account for the initial and ongoing *costs* of implementation and compliance with the proposed regulation to the federal government and to states. The estimated federal revenues generated does not appear to include offsets for new needs, including additional staff that states and the federal government will hire, the information technology and infrastructure development and changes, and educational efforts among states, providers and other stakeholders that will be required of the federal government. Notably, the proposed regulation understates the tremendous administrative burden on

providers and the indirect impact that additional provider mandates could have on states' ability to develop adequate provider networks. We also request that CMS indicate if and how it accounted for these costs as they relate to states that do not use the financing mechanisms that the agency wishes to limit.

Finally, as noted previously in our comments, there will be a significant increase in administrative costs for all states to comply with the proposed rule. We believe CMS is disingenuous in its portrayal of the regulatory impact by providing estimates solely for federal revenues while failing to account for the fiscal impact on states. In addition to the limitations placed on states' financing policies, states will face an unprecedented administrative burden that will result from various new requirements including staff time and resources to develop cost reports, collect, analyze and report the information to and from providers and CMS, undertaking policy changes to comply with the proposed rule, implementing systems updates to comply with the proposed rule, educating and fielding questions from public providers who will newly have to comply with cost reporting requirements among other issues. For example, some of the tasks associated with implementation may include:

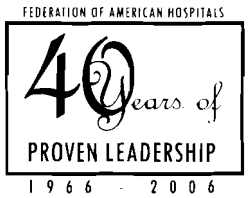
- Reviewing all documents, including inter-state agreements and other agreements, to ensure consistency with proposed regulations.
- Reviewing financial documents and other documentation of all entities that contribute certified public expenditures (CPEs) to ensure that they meet the definition of a 'unit of government.'
- Reviewing all providers who may be considered a 'unit of government' to see if they meet this definition, in order to identify if reimbursement to a given provider must be limited to costs.
- Creating and implementing methods for collecting expenditure data for all units of government, including creating new cost reporting mechanisms and imposing additional cost-related documentation requirements.
- Reviewing all reimbursement methodologies for all services across all providers that meet the definition 'units of government.'
- In cases where services are reimbursed through CPEs, (1) ensuring that reporting requirements are consistent with proposed regulations; (2) reviewing and, if necessary, amending state plan methodologies to reflect new payment structure; and (3) negotiating approval with CMS as needed.
- In cases where services are not reimbursed through CPEs, (but where the provider is a 'unit of government:'), states will need to (1) review and, if necessary, amend state plan methodologies to reflect limit of payment to costs; (2) review and, if necessary, amend regulations and state statutes to ensure that they reflect that payments to these providers are limited to costs; and (3) negotiate approval with CMS as needed..

We would be happy to provide you with additional information on our comments as you go forward. Please contact Martha Roherty, Directory of NASMD, at (202) 682-0100 if we can be of further assistance.

Sincerely,

Jerry Friedman
Executive Director
American Public Human Services Association

David Parrella
Chair
NASMD Executive Committee


Charles N. Kahn III
President

March 19, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2558-P, MS C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-18500

Re: **CMS Proposed Rule Concerning Cost Limit For Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership**
**File Code CMS-2258-P**

Dear Ms. Norwalk:

The Federation of American Hospitals ("FAH") is the national representative of privately owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, and provide a wide range of acute and post-acute services. Our members provide significant services to Medicaid and uninsured patients and are an important part of the health care safety net in the communities they serve. We appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS") proposed rule (the "Proposed Rule") regarding cost limits for governmental providers and other provisions concerning Medicaid funding.

FAH strongly opposes the adoption of the Proposed Rule. The Proposed Rule would constitute a dramatic departure from customary and accepted methodologies that have been used to fund state Medicaid programs. We are concerned that implementation of the Proposed Rule would impede the functioning of many state Medicaid programs, and would result in irreparable harm to the health care safety net, limiting access to care for the vulnerable patients it serves.

The Proposed Rule would cause a large reduction in federal funding for state Medicaid programs. CMS' own regulatory impact analysis estimates that the rule would result in $3.9 billion in federal savings over five years. The elimination of this amount of funding from the health care safety net would be cause for significant concern. However, we believe that the reduction in federal funding will likely be much greater than CMS has estimated.



801 Pennsylvania Ave., NW, Suite 245 • Washington, DC 20004-2604 • 202-624-1500 • Fax: 202-737-6832

Significantly, CMS has not offered an alternative funding mechanism to replace the lost funding that will result in the implementation of the Proposed Rule. It cannot be reasonably anticipated that cash-strapped states will be in a position to replace the funding shortfall with state monies. This will necessarily result in the diminution of services available to Medicaid beneficiaries and the uninsured, and further weaken the financial viability of hospitals and other health care providers which serve these vulnerable populations.

We are particularly disappointed that CMS is proposing a rule which will inescapably have an adverse impact on the health care safety net at a time when both the federal and state governments are working hard to develop new and innovative approaches to financing health care, improving access to services, and addressing the problems presented by the uninsured. The Proposed Rule would appear to be fundamentally at odds with these efforts.

We appreciate CMS' concern to ensure accountability with respect to federal Medicaid funding and to protect the fiscal integrity of the Medicaid program. Congress and CMS have implemented various measures in furtherance of this objective in recent years, including restrictions on provider taxes and donations, limitations on disproportionate share hospital payments, and modifications to regulatory upper payment limits. The Proposed Rule will go well beyond these initiatives, and we believe would further shred the health care safety net.

In addition to the policy concerns expressed above, we believe that the Proposed Rule is legally defective. Various aspects of the Proposed Rule are inconsistent with the Medicaid provisions of the Social Security Act and go beyond the authority afforded CMS. Unlike CMS' recent efforts to address accountability and fiscal integrity in the Medicaid program, discussed above, Congress has not enacted legislation requiring the adoption of the Proposed Rule, or indicated its approval of the concepts contained in the Proposed Rule.

We will address briefly below our specific concerns with several provisions of the Proposed Rule.

## I. DEFINITION OF UNIT OF GOVERNMENT – 42 C.F.R. § 433.50

The Proposed Rule defines a "unit of government" as "a state, a city, a county, a special purpose district, or other government unit in the state (including Indian tribes) that has generally applicable taxing authority." This definition will significantly narrow the entities that will be permitted to make intergovernmental transfers or certify public expenditures which will be subject to federal participation. The limitation of the unit of government to entities who have taxing authority is inconsistent with the statutory definition contained in § 1903(w)(7)(G) of the Social Security Act. It is also inconsistent with the manner in which state and local governments organize themselves to deliver health care service in an effective and efficient manner, and impermissibly intrudes on the power of the states to organize themselves in the manner they see fit.

## II. SOURCES OF THE STATE SHARE OF FINANCIAL PARTICIPATION – 42 C.F.R. § 433.51.

The preamble of the Proposed Rule states that the sources of intergovernmental transfers must be tax revenue in order to qualify for federal financial participation. We note that this restriction is not set forth in the regulation. Such a restriction would be both inconsistent with the current practice and with federal law. Section 1902(a)(2) of the Social Security Act allows states to rely on local sources for up to 60% of the non-federal share of program expenditures, and does not limit the types of local sources that may be used.

## III. COST LIMIT FOR PROVIDERS OPERATED BY UNITS OF GOVERNMENT – 42 C.F.R. § 447.206.

This provision would limit the Medicaid reimbursement of providers that are operated by units of government to the individual provider's costs of providing covered services.

This provision appears to have been written more broadly than intended. As written, the provision would preclude public providers from receiving any reimbursement under a Medicaid program in excess of that provider's cost of providing covered Medicaid services to eligible recipients. However, it is common and accepted for public providers to receive disproportionate share funds to providers to reimburse them for the cost of services furnished to uninsured patients. Additionally, several states have the authority to make payments to public providers for services to the uninsured through § 1115 Demonstration Projects.

The Proposed Rule cites § 1902(a)(30)(A) of the Social Security Act as the statute authorizing the adoption of the cost limit. This provision requires that Medicaid payments be consistent with efficiency, economy, and quality of care, and ensure access to services. A reimbursement limit based on Medicare reasonable costs, however, is not consistent with efficiency, economy, and quality of care. For example, the Medicare program has departed from cost reimbursement, and has adopted prospective payment methodologies for most services furnished by providers. This is a recognition that cost reimbursement is not consistent with efficiency, economy, and quality of care, but may reward inefficient providers and penalize efficient providers.

The proposed cost based limit is also inconsistent with § 705(a) of the Budget Improvement and Protection Act of 2000, which authorized the adoption of Medicaid payment limits for categories of hospital in the aggregate but did not authorize the adoption of provider-specific limits. Section 705(a) evidences Congress' intent that the limitations should be adopted on an aggregate basis, not on a provider specific basis.

## IV. RETENTION OF PAYMENTS: 42 C.F.R. § 447.207.

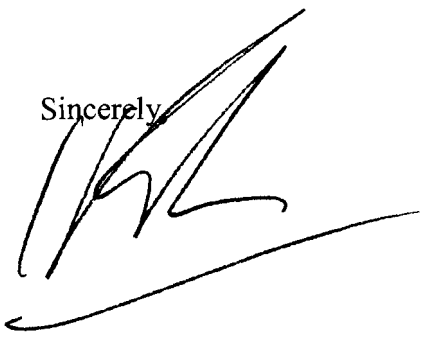
The proposed § 447.207(a) would require all providers "to receive and retain the full amount of the total computable payment provided to them for services furnished under the approved State plan (or the approved provisions of a waiver or demonstration, if applicable)." We are uncertain as to the meaning of this provision. Taken literally, it could require providers to segregate all Medicaid funding into separate accounts and to retain such funding permanently. It is unclear whether Medicaid funding could be used to pay a provider's expenses or other expenses of the organization to which the provider belongs, commingled with other funding of the organization for investment purposes, or in a case of a proprietary organization, to commingle with other funds, a small part of which may ultimately be distributed to investors.

Health care providers are often components of larger organizations which may include other providers, as well as non-provider entities. It is common for organizations to commingle funding, and to shift funds from one component of the organization to another component as they are needed to meet the health care needs of the patients they serve, including the uninsured and seniors. Proposed § 447.207(a) could be read as prohibiting this practice with respect to Medicaid funds.

We are aware of no statutory authority for CMS to control the use of Medicaid funds in the manner suggested by proposed § 447.207(a). Rather, once Medicaid funding is properly received by a provider in return for rendering services, the provider should be free to use the funds as it deems appropriate.

Again, we want to thank you for the opportunity to comment, and urge you to withdraw this proposed rule. If you have any questions, please do not hesitate to contact me or Steven Speil, Senior Vice President at (202) 624-1529 or sspeil@fah.

Sincerely,



America's Health
Insurance Plans

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Washington, DC 20004

202 778.3200
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March 19, 2007

Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-2258-P

Dear Sir or Madam:

I am writing on behalf of America's Health Insurance Plans (AHIP) to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed rule, "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership"( 72 FR 2236, January 18, 2007). AHIP is the national association representing nearly 1,300 member companies providing health coverage to more than 200 million Americans. These regulations have the potential to impact the funds available to carry out State Medicaid programs and are therefore of significant interest to AHIP's member organizations many of which serve beneficiaries under State Medicaid managed care programs and State Children's Health Insurance Programs (SCHIPs).

**OVERVIEW OF AHIP COMMENTS**

AHIP's member organizations have demonstrated their commitment to meeting the health care needs of Medicaid beneficiaries through their longstanding participation in State Medicaid programs. We are concerned that the proposed rule retains a barrier to expansion of State Medicaid managed care programs that are an important part of State strategies to provide quality, cost effective health care to a broad spectrum of Medicaid beneficiaries. As discussed in greater detail below, we recommend that this barrier be removed.

Further, we believe strongly in the importance of a Medicaid funding stream that is sufficient to promote the availability and accessibility of services for Medicaid beneficiaries whether they are enrolled in Medicaid health plans or receiving services through Medicaid fee-for-service programs. We are concerned that the proposed rule has the potential to disrupt funding to State Medicaid programs, particularly funding for safety net providers, through the manner and timing of the proposed changes to the rules regarding new limits and the sources of the State dollars that may permissibly be used to generate federal matching funds. We are recommending that if any such changes are made, CMS ensure that they do not undermine the availability of services

to beneficiaries through State Medicaid programs and their participating providers. AHIP's detailed comments appear below.

**AHIP COMMENTS**

- **Removal from the UPL calculation of a barrier to expansion of State Medicaid managed care programs**

As CMS notes in the preamble summary on page 2236, expenditures under Medicaid managed care programs are not included in the upper payment limit (UPL) calculation under the existing regulations, and CMS is retaining this exclusion in the proposed rule. AHIP believes that the exclusion has had the unintended effect of creating a significant impediment to State consideration of the initiation or expansion of Medicaid managed care programs. Because the payments to Medicaid health plans are not included in the UPL calculation, growth in the availability of these plans to beneficiaries under new State initiatives would have the effect of reducing the aggregate potential Federal financial participation (FFP) that a State would be eligible to receive under the UPL rules. The proposed changes to the UPL requirements that are included in the proposed rule would not alter this situation.

To address this issue and provide greater opportunities for States interested in increasing the availability of Medicaid health plans to their beneficiaries, AHIP recommends that CMS amend its regulations to allow for the inclusion of the costs associated with all Medicaid recipients (including those enrolled in Medicaid health plans and those covered under Medicaid fee-for-service programs) in the UPL calculation. This recommendation would apply to costs for inpatient services, as specified in §447.272, and outpatient and clinic services, as specified in §447.321.

- **Promoting accessibility of health care services for beneficiaries under State Medicaid programs**

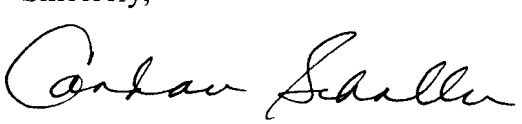
While AHIP fully supports the Administration's efforts to ensure that expenditures of Federal matching funds are used to fund health care services and are not inappropriately increased through impermissible practices, AHIP is concerned about the potential adverse financial impact the proposed rule could have on the efforts of States to maintain the accessibility of health care services through providers participating under their Medicaid programs. The financial viability of Medicaid program participation for providers under both Medicaid fee-for-service and Medicaid managed care programs is critically important to core program goals such as providing a medical home, promoting use of preventive services, and promoting continuity of care for Medicaid beneficiaries.

We are concerned that implementation of revisions to the regulations as proposed by CMS could result in reduction in overall funding available for State Medicaid programs that would place at risk the ability of providers, including safety net providers and particularly hospitals, to continue their current level of service to Medicaid recipients. In the preamble (page 2245) to the proposed rule, CMS projects that the proposal would cut Federal Medicaid funding by $120 million the first year and $3.87 billion in federal expenditures over five years. We believe that these projections significantly under-represent the impact on Medicaid beneficiaries, because this proposal also would result in reduced non-federal funding.

AHIP strongly urges CMS to reconsider the impact of these changes on the States, beneficiaries, and affected government operated facilities and to reevaluate the approach reflected in the proposed rule. If changes are made to the UPL requirements, we recommend that implementation include a transition period that is structured to avoid undermining the integrity of established provider participation, particularly in the States that would be most affected, to ensure continued access to services for beneficiaries. Similarly, we recommend that CMS ensure that programs operating under Section 1115 waivers and services for beneficiaries under those programs are not disrupted by a change to the UPL rules.

We appreciate the opportunity to provide comments. If you would like to discuss any of the issues we have raised or would like additional information, please contact me at (202) 778-3209 or at cschaller@ahip.org.

Sincerely,



Candace Schaller
Senior Vice President, Federal Programs

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PROVIDENCE
Health & Services

March 13, 2007

MAR 19

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

**REF: CMS-2258-P**

RE: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership; Proposed Rule, *Federal Register*, Vol. 72, No. 11, January 18, 2007.

On behalf of Providence Health & Services, I want to thank you for the opportunity to provide our comments on the changes proposed by the Centers for Medicare and Medicaid Services (CMS) which were published in the *Federal Register* on January 18, 2007. Providence Health & Services is a faith-based, non-profit health system that operates acute care hospitals, physician groups, skilled nursing facilities, home health agencies, assisted living, senior housing, PACE programs, and a health plan in Washington State, Oregon, California and Montana.

As a Catholic health care system striving to meet the health needs of people as they journey through life, Providence would like to express our strong opposition to the 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" published in the *Federal Register* (Vol. 72, No. 11, pages 2236-2248) on January 18, 2007. This proposed regulation, if implemented, will have a devastating effect on safety-net providers.

Providence is committed to its mission of caring for the poor and vulnerable; we provide crucial health care services for many who have no other place to turn. Our hospitals, clinics, nursing homes, home health agencies, assisted living, senior housing and PACE programs provide a broad range of services to communities, including those who are Medicaid recipients and the uninsured.

The Proposed Rule is an attempt by CMS to ensure the fiscal integrity of the Medicaid program. While Providence supports the overall goal of a fiscally sound and balanced Medicaid program, we are greatly concerned about the impact this proposed regulation will have on our ability to maintain the scope of services we offer. Although, as private providers, the Proposed Rule would have no direct effect on Providence health care entities, the potential indirect effects are enormous.

First, this rule would create a new definition of "unit of government" that is more narrow than the existing definition found in statute under Title XIX. Units of government would be those only with general taxing authority, thus reducing the numbers of public providers eligible to contribute to the non-federal share of Medicaid expenditures. By limiting the number of contributors to the states' share of Medicaid expenditures, the Proposed Rule may have the unintended consequence of forcing states to limit the scope of services provided under this entitlement program. With fewer dollars flowing into the pool of Medicaid resources, states may no longer be able to offer the current level of services to recipients. During a time when the nation is focused on ensuring every American has basic health insurance, this rule which will likely increase the number of uninsured is counterproductive.

In addition, the Proposed Rule would limit payments to providers operated by units of government to the costs of providing Medicaid services to eligible Medicaid recipients. Over the last three decades, the health care system has moved away from cost-based reimbursement mechanisms, in large part because such systems have no incentives for performing efficiently. Also, no health care provider can effectively operate with a zero margin – building improvements, equipment expenditures, graduate medical education and other expenses must be considered in order for the provider to maintain community services. Whether such expenses would be permitted under the proposed rule is uncertain as CMS has failed to define allowable costs. The potential for providers operated by units of government to decrease the current level of services offered, or even to cease operation, would cause private providers in the community to become overwhelmed. The delicate balance of providing care to a community's Medicaid recipients and uninsured could be severely strained.

Limiting the use of certified public expenditures (CPE) to cost-based reimbursement and inter-governmental transfers (IGT) to those funds derived from tax revenue further compound the problem of creating huge shortfalls in state Medicaid funds. States have relied on previously approved long-standing, legitimate mechanisms to fund expanded services under Medicaid programs and to support community safety-net providers. Without these resources, essential services may not be reimbursed or private insurers, through increased costs, may be required to compensate for the lack of state support. Rising insurance costs and lack of providers able to meet the needs of the community will strain an already overburdened health care system – especially in rural communities where the numbers of providers are already dangerously low.

States operating Section 1115 waiver programs will also see a significant impact to the viability of these programs under the Proposed Rule. Many states may face a mandatory revision of expenditure caps negotiated in connection with their waivers and demonstrations. If budget-neutral expenditure cap calculations included funds made

available by eliminating certain above-cost payments to public providers, the impact of revisions to these expenditure caps will be dramatic. At a time when states are experimenting to find creative solutions to this nation's current health care crisis, CMS should be encouraging, not stifling, such innovation.

Generally speaking, the Proposed Rule would shift many Medicaid costs to the states. While this process will lower the federal share of Medicaid costs in the short term, it does little to address the underlying cost drivers in the overall Medicaid program. Providence supports the goal of ensuring the integrity of the Medicaid program, but we are also urging CMS to design meaningful reform that will strengthen the delivery of services as well as achieve program efficiencies for both federal and state governments. The significant impacts to Medicaid funding proposed in the regulation will strain already fragile state programs and could result in the closure of many Medicaid health care providers. The Proposed rule states that "[p]rivate providers are predominantly unaffected by the rule, and the effect on actual patient services should be minimal." *Federal Register*, Vol. 72, No. 11, pg. 2246. Providence, as a private provider, strongly disagrees with this statement and urges CMS to consider the above-mentioned consequences that this Proposed Rule will have on private providers.

For the last several years, CMS has been working aggressively with states to end potential financing abuses. Through these efforts, the agency has eliminated most of what it had previously identified as abuse in regards to the use of IGT and CPE. States have successfully worked with CMS to restructure their financing programs, including using waivers and demonstrations. To implement this proposed regulation in light of the success CMS has had is punitive to State Medicaid programs that have worked so hard to be compliant with new financing policies. While Providence believes that transparency of CMS policies and procedures is valuable, the Proposed Rule goes much further than policies and procedures that CMS has used with the states over the last several years.

The nation is currently focused on expanding health care coverage for the un- and underinsured; this Proposed Rule would weaken an already fragile safety net providing services to those very same individuals. The Medicaid program is a shared responsibility between federal and state government – attempts to shift the cost burden to states will leave them with no choice but to cut benefits or eliminate coverage. These results would be devastating and will likely increase the number of un- and underinsured Americans rather than improve the health care system. As attempts are made to strengthen the integrity and accountability in the Medicaid program, care must be taken to do so in a way that does not jeopardize any benefits the program brings to low-income Americans, states, the local health care safety net, and the nation's health care system as a whole.

**Recommendation:**

**Providence opposes the Proposed Rule, "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership," and we strongly urge that CMS permanently withdraw it.**

In closing, thank you for the opportunity to review and comment on the Proposed Rule. Please contact Beth Schultz, System Manager, Regulatory Affairs, at (206) 464-4738 or via e-mail at Elizabeth.Schultz@providence.org if you have questions about any of the material in this letter.

Sincerely,

John Koster MD

John Koster, M.D.
President/Chief Executive Officer
Providence Health & Services