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Hi-Line Retirement Center

"Providing professicnal, quality resident centered care in a home like environment to the people of Phillips County and surrounding areas."

March 6, 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:

Hi-Line Retirement Center appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our Nursing facility and ultimately the residents we serve and care for.

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 Nursing facilities. Montana's IGT program depends on county facilities being able to participate in the program. Capping Medicaid payments at the provider's cost will reduce participation by some counties whose facilities will not be able to receive any benefit from the IGT program. The other regulation that changes the definition of a government facility could cause further counties to decide not to participate and fewer counties means higher costs to those counties that remain, which could cause the program to collapse altogether. These changes would cause major disruptions to our state Medicaid program and hurt providers and beneficiaries alike.

We oppose this rule and strongly urge CMS to permanently withdraw it, based on our most significant concerns, which include: (1) the limitation on reimbursement of governmentally operated providers; (2) the narrowing of the definition of public hospital; (3) the restrictions on intergovernmental transfers and certified public expenditures; and (4) the absence of data or other factual support for CMS's estimate of savings.

If these policy changes are implemented, the nation's health safety net will unravel, and health care services for millions of our nation's most vulnerable people will be jeopardized.

Sincerely,

Ward C. VanWichen, Administrator

Foote Health System

We lead our community to better health and well being at every stage of life.

Foote Hospital

A Not-For-Profit Community-Owned Hospital

March 16, 2007

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

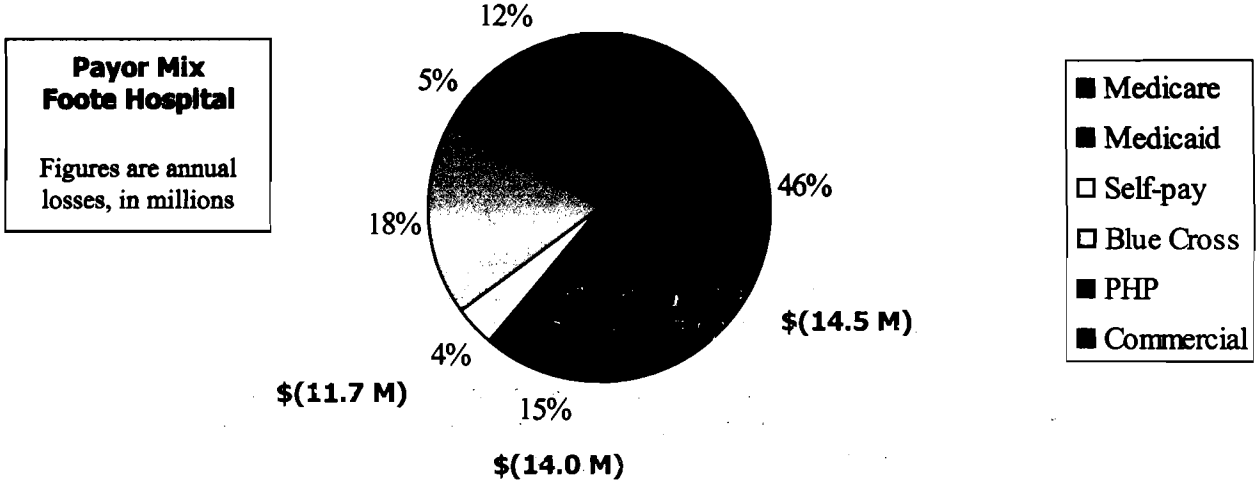
Re: (CMS-2258-P) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

I appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule, above. I will let the lobbyists tell you about the policy implications; I can tell you how it will affect Foote Hospital, our local economy and most of all, our most vulnerable citizens.

Let's start with the experience of a recent patient. This person's career has been spent in a service industry, where pay is close to the minimum wage. They do not have an option of affordable healthcare coverage. Last year they were sick and ended up with a short hospital stay. That brief stay resulted in a relatively small bill to the hospital but an impossible burden to them. Consequently it became a bad debt and is now a significant problem on their credit report. With the Medicaid program limiting access to this person, it has caused them significant financial hardship in an indirect way.

That is one just story, but is certainly not isolated. The chart below illustrates the payor mix at Foote Hospital, the sole hospital in Jackson County. You'll see that one out of five people that enter our hospital are either on Medicaid or have no coverage.



205 N. East Avenue, Jackson, MI 49201
517-796-6480; Fax: 517-789-5966

You'll also see that the annual loss to Foote Hospital, just for Medicaid, was $14 million last year. Interestingly, the loss for Medicare is roughly the same, yet the size of that population is three times larger. When the government pays less than the actual cost of care, much of that deficit is shifted to area employers and their employees in the form of a "stealth tax."

The rule change proposed would cause major disruptions to our state Medicaid program and hurt providers, beneficiaries, employers and those with health coverage. I respectfully ask that CMS permanently withdraw this rule. Thank you.

Sincerely,

Chad Noble, Director
Corporate Accounts and Governmental Affairs

205 N. East Avenue, Jackson, MI 49201
517-796-6480; Fax: 517-789-5966

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

March 19, 2007

Leslie V. Norwalk, Esq
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-2258-P

Dear Ms. Norwalk:

The Maryland Department of Health and Mental Hygiene (the Department) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' 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*" 72 Fed. Reg. 2236 (January 18, 2007). Although the Department understands the need to ensure the financial integrity of the Medicaid Program, we do not believe the regulations as written achieve this purpose. At the same time, we are very concerned that the regulations will greatly increase administrative burdens and costs to Maryland.

The regulations require the development of a cost-based rate for each public provider with cost-settlement after the fact. These two requirements will create a tremendous financial and administrative burden to Maryland. As an example, CMS currently allows states to develop statewide reimbursement methodologies for specific services delivered by public providers. Often states do this through the use of statewide time study methodologies. If the new regulations are approved, each provider will have to develop a cost-based rate for each service which will require individual provider time studies, necessitating much larger sample sizes and much more extensive data analysis.

The proposed regulations then require the State Medicaid agency to perform interim and final cost settlements for each governmentally operated provider to verify that actual payments did not exceed the provider's costs. This rule would significantly increase the administrative burdens for both providers and the State. These new administrative costs would be especially devastating for small providers such as local health departments that

provide community mental health and substance abuse services and school-based health centers. Unlike hospitals and nursing facilities, these providers have a very limited administrative infrastructure and are not accustomed to cost reporting. In addition, under the regulations, Maryland would be forced with the onerous task of completing annual cost settlements for these providers.

Finally, Maryland Medicaid is very concerned that these regulations have an effective date of September 1, 2007. 72 Fed. Reg. at 2247. This does not provide enough time to make necessary changes, especially since specific allowed cost definitions remain unclear.

Sincerely,

John M. Colmers
Secretary

cc: Mr. Charles Lehman
Ms. Audrey Richardson
Ms. Tricia Roddy
Ms. Susan Steinberg
Ms. Susan Tucker

EMORY UNIVERSITY

Michael M.E. Johns, MD
Executive Vice President for Health Affairs
CEO, Robert W. Woodruff Health Sciences Center
Chairman of the Board, Emory Healthcare

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,
(Vo. 72, N0. 11), January 18, 2007

Dear Ms. Norwalk:

The Woodruff Health Sciences Center at Emory University appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed Medicaid rule issued January 18, 2007. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospitals and the patients they serve.

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

The Woodruff Health Science Center has a long-standing relationship with the Grady Memorial Hospital. With a bed capacity of 953, Grady is among the largest hospitals in the Southeast. It is staffed primarily by Emory School of Medicine physicians and residents, in collaboration with Morehouse School of Medicine. Operated under the Fulton/DeKalb Hospital Authority, the Grady Health System includes ten comprehensive community centers, a regional perinatal center for high risk mothers and babies, a diabetes center, a teen center, the Georgia Poison Center, the Rape Crisis Center, a regional burn center, a sickle cell center, a comprehensive treatment program for HIV/AIDS, a level one trauma center, a long-term care facility, and the Hughes Spalding Children's Center. Currently, Grady is grappling with a severe budget deficit due, in large part, to the current reimbursement system. This proposed rule would further cripple a hospital that is critical to both serving Georgia's uninsured population and providing a unique teaching environment, which trains highly-skilled physicians throughout Georgia.

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The Robert W. Woodruff Health Sciences Center
An equal opportunity, affirmative action university

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

We urge CMS to permanently withdraw this rule, and we would like to outline our most significant concerns, which include: (1) the limitation on reimbursement of governmentally operated providers; (2) the narrowing of the definition of public hospital; (3) the restrictions on intergovernmental transfers and certified public expenditures; and (4) the absence of data or other factual support for CMS's estimate of savings.

Limiting Payments to Government Providers

The rule proposes to limit reimbursement for government hospitals to the cost of providing services to Medicaid patients, and restricts states from making supplemental payments to these safety net hospitals through Medicaid Upper Payment Limit (UPL) programs. Nearly 27 years ago, Congress moved away from cost-based reimbursement for the Medicaid program, arguing that the reasonable cost-based reimbursement formula contained no incentives for efficient performance. Since then, hospital reimbursement systems have evolved following the model of the Medicare program and its use of prospective payment systems. These reimbursement systems are intended to improve efficiency by rewarding hospitals that can keep costs below the amount paid. Many state Medicaid programs have adopted this method of hospital reimbursement, yet CMS is proposing to resurrect a cost-based limit that Congress long ago declared less efficient.

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. We are very concerned that, in CMS' quest to reduce federal Medicaid spending, important costs such as graduate medical education and physician on-call services or clinic services would not be recognized and therefore would no longer be reimbursed.

CMS also fails to explain why it is changing its position regarding the flexibility afforded to states under the UPL program. CMS, in 2002 court documents, described the UPL concept as setting aggregate payment amounts for specifically defined categories of health care providers and specifically defined groups of providers, but leaving to the states considerable flexibility to allocate payment rates within those categories. Those documents further note the flexibility to allow states to direct higher Medicaid payment to hospitals facing stressed financial circumstances. CMS reinforced this concept of state flexibility in its 2002 UPL final rule. But CMS, in this current proposed rule, is disregarding without explanation its previous decisions that grant states flexibility under the UPL system to address the special needs of hospitals through supplemental payments.

New Definition of "Unit of Government"

The proposed rule puts forward a new and restrictive definition of "unit of government," such as a public hospital. Public hospitals that meet this new definition must demonstrate they are operated by a unit of government or are an integral part of a unit of government that has taxing authority.

Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Contrary to CMS' assertion, the statutory definition of "unit of government" does not require "generally applicable taxing authority." This new restrictive definition would no longer permit many public hospitals that operate under public benefit corporations or many state universities from helping states finance their share of Medicaid funding. There is no basis in federal statute that supports this proposed change in definition.

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

The proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). There is no authority in the statute for CMS to restrict IGTs to funds generated from tax revenue. CMS has inexplicably attempted to use a provision in current law that limits the Secretary's authority to regulate IGTs as the source of authority that all IGTs must be made from state or local taxes. Not only is the proposed change inconsistent with historic CMS policy, but it is another instance in which CMS has inappropriately interpreted the federal statute.

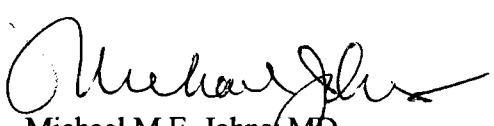
CPEs are restricted as well, so only hospitals that meet the new definition of public hospital and are reimbursed on a cost basis would be eligible to use CPEs to help states fund their programs. These restrictions would result in fewer dollars available to pay for needed care for the nation's most vulnerable people.

Insufficient Data Supporting CMS's Estimate of Spending Cuts

CMS is required to examine relevant data to support the need to change current policy. The proposed rule estimates that the policy changes will result in $3.87 billion in spending cuts over the next five years. However, CMS fails to provide any relevant data or facts to support this conclusion. CMS claims to have examined Medicaid financing arrangements across the country and has identified state financing practices that do not comport with the Medicaid statute. CMS, however, provides no information on which states or how many states are employing questionable financing practices. The public, without access to such data, has not been given the opportunity to meaningfully review CMS' proposed changes, calling into question CMS' adherence to administrative procedure.

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

Sincerely,



Michael M.E. Johns, MD
Executive Vice-President for Health Affairs, Emory University
CEO, Woodruff Health Sciences Center
Chairman of the Board, Emory Healthcare

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NORTHEAST
MEDICAL CENTER

March 15, 2007

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

Re: (CMS-2258-P) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

NorthEast Medical Center is a not-for-profit hospital comprised of an extensive inpatient and outpatient network that services the residents of multiple counties in the Piedmont region of North Carolina. Through this network, we provide 447 general acute care beds, 10 psych beds, a comprehensive mix of outpatient services and 26 clinics that provide excellent healthcare to our residents. In addition, we have approximately 350 physicians that are members of NorthEast's medical staff, and the medical center employs greater than 4,200 individuals. We are the safety net provider for the citizens of our region, and as such in 2006, we provided uncompensated care of more than $49 million on a cost basis. The purpose of this letter is in regard to the regulations that were published on January 18, 2007 (as referenced above) involving the Medicaid Program. NorthEast Medical Center would like to state for the record that we are strongly opposed to the promulgation of these regulations.

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.

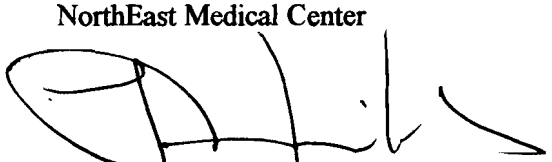
Yet, under the proposed new definition requiring all units of government to have generally applicable taxing authority or to be an integral part of an entity that has generally applicable taxing authority, virtually none of these truly public hospitals will be able to certify their expenditures. Imposing 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. NorthEast Medical Center 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.

NorthEast Medical Center 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, NorthEast Medical Center 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,

NorthEast Medical Center



Laurence Hinsdale
Chief Executive Officer

LH/jfy

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Central Georgia Health System

March 14, 2007

Rhonda S. Perry, CPA
Senior Vice President/CFO

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
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 the Medical Center of Central Georgia ("MCCG"), I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes $14,950,335 in critical Medicaid support payments for MCCG, funding that has been essential to our ability to serve as major safety net health care system in Georgia.

MCCG is owned by Macon-Bibb County Hospital Authority ("the Authority") and operated pursuant to a lease with the Authority to provide health care services to our community. MCCG is a Non Profit, 603 bed full service, acute care hospital located in Macon, Georgia. It is the second largest hospital in the state, is the only Level One Trauma Center and Level III Neonatal Center in Central Georgia. Also, MCCG is a Disproportionate Share Hospital (DSH). Last year our inpatient charges were 47.9% Medicare and 18.1% Medicaid. Outpatient charges were 32.3% Medicare and 16.2% Medicaid.

MCCG is the largest provider of care for indigent patients in Central Georgia. In addition to acute care, MCCG also provides care through an integrated network of hospital based and community based clinics.

The W.T. Anderson Clinic on the MCCG campus provides care in 27 clinics. The larger clinics include general medicine, obstetrics, oncology and orthopedic services. The clinics see 35,000 patients annually from six Central Georgia counties. Patients are eligible for charity clinic care when their income is less than 200% of Federal Poverty Level. Care is also provided at community-based centers. In fiscal year 2005, more than 21,000 patients were seen in the two largest "Neighborhood Health" clinics. The W. T. Anderson Clinic also provides pharmacy services to eligible patients without prescription insurance.

As a key safety net provider in our community, and as a member of the Georgia Coalition of Safety Net Hospitals, we strongly oppose the Proposed Rule, and respectfully request you to withdraw it immediately. 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.

Defining a Unit of Government (§ 433.50)

The Proposed Rule would impose a new definition of a "unit of government" on states that would require an entity to have generally applicable taxing authority in order to be considered governmental. Entities that are not units of government (or providers operated by units of government) would be prohibited from contributing funding to the non-federal share of Medicaid expenditures through intergovernmental transfers ("IGTs"). The Medical Center opposes this restrictive new definition and urges the Centers for Medicare and Medicaid Services ("CMS") to allow states to determine which entities are units of government pursuant to state law.

Georgia Medicaid has recognized our key role as a safety net provider for years, and has provided crucial financial support for this role through Georgia's Indigent Care Trust Fund and through supplemental "upper payment limit" ("UPL") payments, totaling $14,950,335 in FY 2006. The Hospital Authority, a public entity under Georgia law, has provided the non-federal share of these support payments through IGTs. In 2005, we were asked by the Georgia Department of Community Health to complete a questionnaire describing in detail the governmental structure of the hospital, the relationship between the Medical Center and the Hospital Authority, the Hospital Authority's access to tax revenues and the community services we provide. It is our understanding that based on our survey responses, CMS approved the Hospital Authority's governmental status and ability to provide intergovernmental transfers to help fund the Medicaid program. At the same time, Georgia restructured its IGT program in response to CMS concerns so that now none of the transfers exceed the non-federal share of the supplemental payments they support. Despite the "clean bill of health" that Georgia's IGTs have received, the Proposed Rule would nevertheless upend our system, calling into question a fact that has never been doubted under Georgia law – that hospital authorities such as ours are units of government.

As a result of this sharp change of course, the Hospital Authority would no longer be able to support our Medicaid payments through IGTs, and we stand to lose the very payments that have allowed us to so successfully serve as the safety net provider in our community. Our Indigent Care Trust Fund and UPL payments provide the financial backbone for so many of the services we provide that are unreimbursed or under-reimbursed. For example, in SFY 2006 we provided $29,771,936 in care to the uninsured, providing access to those who often have nowhere else to turn.

None of this would have been possible without supplemental Medicaid payments funded through Hospital Authority IGTs. The impact to our facility of the loss of these payments is unthinkable. More importantly, however, our patients – especially those on Medicaid or who are uninsured – are most likely to suffer from the loss of access to care that will result from this new policy. Georgia's IGTs are not abusive and have been approved by

CMS. There is no justification for adopting a restrictive definition of "unit of government" that will simply deprive Georgia Medicaid of an important and legitimate source of local public funding. We urge you to defer to state law in the determination of "units of government."

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

We are equally opposed to the Proposed Rule's new cost limit on Medicaid payments to governmental providers. This limit puts us in a box – either we are considered to be a private entity and therefore the Hospital Authority will be unable to provide IGTs to fund our supplemental payments, or we are considered to be governmental but are then subject to a limit to cost. This is an untenable "Catch-22" that again is unwarranted by the existence of any inappropriate financing mechanisms in Georgia – Georgia's IGTs have been deemed by CMS to be appropriate. Instead, the limit would impose a $6,169,157 cut to our Medicaid payments (which currently are based on Medicare rates). This cut, while not as substantial as the loss of all of the supplemental payments funded by IGTs that would result from a determination that the Hospital Authority is no longer governmental, would nevertheless be substantial. This aspect of the rule should be withdrawn as well.

Direct Payments for Medicaid Managed Care Patients

Georgia recently established Georgia Families, a program to enroll Medicaid recipients into private care management organizations ("CMOs"). As CMO enrollment grows, it has a direct impact on our supplemental UPL payments, as CMS regulations prohibit states from providing supplemental payments for Medicaid patients who are enrolled in private plans. Based on preliminary projections of SFY 2007 UPL payments, we expect to lose approximately $5,250,323 because of the loss of UPL payments associated with CMO enrollees. One way to temper the cut that is being imposed by the Proposed Rule is to relax your regulatory prohibition on direct payments to providers for managed care enrollees (42 C.F.R. §438.6; 438.60). We urge you to consider this refinement to the regulation.

* * *

In sum, we are deeply concerned about the impact that the Proposed Rule will have on our institution and the essential services we provide to our community. The impact on our patients will be very swift and very severe. We urge you to withdraw the regulation immediately.

If you have any questions about this letter, please feel free to contact Rhonda Perry, Senior Vice President/CFO at 478-633-1452.

Sincerely,

Rhonda S Perry

Rhonda S. Perry, CPA
Senior Vice President/CFO

Memorial
HEALTH

March 16, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
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 Memorial Health University Medical Center, Inc. ("Memorial"), I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes $17,659,778 in critical Medicaid support payments for Memorial, funding that has been essential to our ability to serve as a major safety net health care system in Georgia.

Memorial is owned by the Chatham County Hospital Authority ("the Authority") and operated pursuant to a lease with the Authority to provide health care services to our community. Memorial is a 530 bed Level I Trauma Center and Southeast Georgia's only Teaching Institution. In addition, we are the sole provider of other extraordinarily high cost services in our region such as Neonatal Intensive Care, Pediatric Nephrology, High Risk Obstetrics, Pediatric Cardiology, Rehab, Psych, and an around the clock Stroke Team. As the region's only Teaching Hospital, we provide the medical education experience for more than 100 residents in 6 different programs: Internal Medicine, Family Practice, Pediatrics, Surgery, OB/GYN, and Radiology. These residents play a vital role in our ability to meet the healthcare needs of our region's underserved population.

As the region's only safety net hospital, we treat a disproportionate share of Medicaid and uninsured patients. Medicaid, Indigent, and the Uninsured account for nearly 30% of Memorial's revenue base. While 15.8% of all Americans and 17.5% of all Georgians are uninsured, approximately 25% of Chatham County residents have no health insurance. Studies show that most of those uninsured individuals seek help in Memorial's emergency department. To help meet the need of primary and preventive care to the uninsured in our county, Memorial started an innovative program of strategic investment in and partnership with the community. Over the past 10 years, Memorial has invested in the development of two new community clinics—one that focuses on the homeless and one that focuses on the working poor. Both provide primary and preventive care to county residents. Together these two new clinics have been able to provide access to 16% of the county's uninsured. Without ICTF and UPL funding, Memorial's support of and partnership with these community assets would necessarily cease.

As a key safety net provider in our community, and as a member of the Georgia Coalition of Safety Net Hospitals, we strongly oppose the Proposed Rule, and respectfully request you to withdraw it immediately. 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.

Defining a Unit of Government (§ 433.50)

The Proposed Rule would impose a new definition of a "unit of government" on states that would require an entity to have generally applicable taxing authority in order to be considered governmental. Entities that are not units of government (or providers operated by units of government) would be prohibited from contributing funding to the non-federal share of Medicaid expenditures through intergovernmental transfers ("IGTs"). Memorial opposes this restrictive new definition and urges the Centers for Medicare and Medicaid Services ("CMS") to allow states to determine which entities are units of government pursuant to state law.

Georgia Medicaid has recognized our key role as a safety net provider for years, and has provided crucial financial support for this role through Georgia's Indigent Care Trust Fund and through supplemental "upper payment limit" ("UPL") payments, totaling $17,659,778 in FY 2006. The Hospital Authority, a public entity under Georgia law, has provided the non-federal share of these support payments through IGTs. In 2005, we were asked by the Georgia Department of Community Health to complete a questionnaire describing in detail the governmental structure of the hospital, the relationship between Memorial and the Hospital Authority, the Hospital Authority's access to tax revenues and the community services we provide. It is our understanding that, based on our survey responses, CMS approved the Hospital Authority's governmental status and ability to provide intergovernmental transfers to help fund the Medicaid program. At the same time, Georgia restructured its IGT program in response to CMS concerns so that now none of the transfers exceeds the non-federal share of the supplemental payments it supports. Despite the "clean bill of health" that Georgia's IGTs have received, the Proposed Rule would nevertheless upend our system, calling into question a fact that has never been doubted under Georgia law – that hospital authorities such as ours are units of government.

As a result of this sharp change of course, the Hospital Authority would no longer be able to support our Medicaid payments through IGTs, and we stand to lose the very payments that have allowed us to so successfully serve as the safety net provider in our community. Our Indigent Care Trust Fund and UPL payments provide the financial backbone for so many of the services we provide that are not reimbursed or under-reimbursed. For example, in SFY 2006 we incurred $46,900,732 in costs to care for the uninsured, providing access to those who often have nowhere else to turn. In addition, because leadership within Memorial understands that primary care is best delivered in a clinic or doctor's office rather than in an ED, Memorial has partnered with the Chatham County community to develop additional points of access to primary care for the uninsured. These new points of access are able to provide high quality care to the uninsured at a fraction of the cost of an ED visit. Memorial has supported these new points of access through advice, in-kind contributions, and strategic investment dollars to improve health care for low-income populations in our community.

One partnership is with the J. C. Lewis Health Complex located within the local homeless shelter, Union Mission. Research shows that homeless people stay in hospitals 4.1 days longer than most people, mainly because of lack of respite care. Memorial invested in the development of a respite program within Union Mission. Shortly after, Memorial supported the development of a homeless clinic within the shelter, which provides primary and preventive care—including oral health services—to homeless people. By tracking the services provided, this program shows that Memorial's 10 year $4 million investment has facilitated the provision of $93 million of services that would otherwise been sought in Memorial's ED. This partnership works well for the community because it provides high quality care in the most cost-efficient manner.

None of this would have been possible without supplemental Medicaid payments funded through Hospital Authority IGTs. The impact to our facility of the loss of these payments is unthinkable. More importantly, however, our patients – especially those on Medicaid or who are uninsured – are most likely to suffer from the loss of access to care that will result from this new policy. Georgia's IGTs are not abusive and have been approved by CMS. There is no justification for adopting a restrictive definition of "unit of government" that will simply deprive Georgia Medicaid of an important and legitimate source of local public funding. We urge you to defer to state law in the determination of "units of government."

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

We are equally opposed to the Proposed Rule's new cost limit on Medicaid payments to governmental providers. This limit puts us in a box – either we are considered to be a private entity and therefore the Hospital Authority will be unable to provide IGTs to fund our supplemental payments, or we are considered to be governmental but are then subject to a limit to cost. This is an untenable "Catch-22" that again is unwarranted by the existence of any inappropriate financing mechanisms in Georgia – Georgia's IGTs have been deemed by CMS to be appropriate. Instead, the limit would impose an $18,116,805 cut to our Medicaid payments (which currently are based on Medicare rates). This cut is as substantial as the loss of all of the supplemental payments funded by IGTs that would result from a determination that the Hospital Authority is no longer governmental. This aspect of the rule should be withdrawn as well.

Direct Payments for Medicaid Managed Care Patients

Georgia recently established Georgia Families, a program to enroll Medicaid recipients into private care management organizations ("CMOs"). As CMO enrollment grows, it has a direct impact on our supplemental UPL payments, as CMS regulations prohibit states from providing supplemental payments for Medicaid patients who are enrolled in private plans. Based on preliminary projections of SFY 2007 UPL payments, we expect to lose approximately $7,603,704 because of the loss of UPL payments associated with CMO enrollees. One way to temper the cut that is being imposed by the Proposed Rule is to relax your regulatory prohibition on direct payments to providers for managed care enrollees (42 C.F.R. §438.6; 438.60). We urge you to consider this refinement to the regulation.

In summary, we are deeply concerned about the impact that the Proposed Rule will have on our institution and the essential services we provide to our community. The impact on our patients will be very swift and very severe. We urge you to withdraw the regulation immediately.
If you have any questions about this letter, please feel free to contact Hans Schermerhorn at 912-350-5160.

Sincerely,

Mike Thompson

Mike Thompson
Reimbursement Manager

CC: Robert A. Colvin, President and CEO
Margaret Gill, Senior VP of Operations and Interim CFO
Darcy Davis, VP of Finance
Amy Hughes, VP of Government Affairs
Tracy Thompson, Senior Communications Officer

RIVERSIDE COUNTY
REGIONAL MEDICAL CENTER

OFFICE OF THE DIRECTOR

March 15, 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

Medicaid Rule Comment Letter

On behalf of Riverside County Regional Medical Center (RCRMC), I am writing to express our opposition to CMS' Proposed Rule CMS 2258-P, which imposes cost limits on Medicaid payments to public providers. RCRMC 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, RCRMC anticipates that it will lose $21 million in Federal funding. Loss of this funding would impact approximately 10,500 inpatient days from our overall census. RCRMC is the only County hospital serving the residents of Riverside County.

We are concerned about a number of troubling provisions contained in the rule.

First, it will limit our 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 (who make up 21% of our patient population) 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.

RCRMC provides a full range of services to vulnerable populations, and specialty services to both the uninsured and insured that are not provided elsewhere in our communities. If the rule is applied to the waiver, RCRMC could be forced to limit critical services to our patients, including care for the uninsured, trauma care, specialty

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services, acute psychiatric services, and 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.

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 we are 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.

RCRMC opposes the Medicaid rule and strongly urges CMS to withdraw it. If the rule goes into effect, we will suffer extremely harmful effects that will affect our 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,

Douglas Bagley

Douglas Bagley
Chief Executive Officer

DB:DR:rjm

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR

HALEY BARBOUR
GOVERNOR

March 19, 2007

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

Dear Ms. Norwalk:

I am writing to express my concerns regarding the Center for Medicare and Medicaid Services (CMS) proposed rule change to the Medicaid program as proposed in rule (CMS- 2258-P). This rule will seriously impair the ability of states to maintain their Medicaid programs and will cause financial injury to many hospitals. The proposed changes will also have an impact on 650,000 Mississippians and will result in cuts of approximately $90 million in federal funds.

The language in the proposed rule as promulgated will have a negative impact upon Mississippi's ability to continue to classify many non-profit hospitals as "public" and only allows states to reimburse a narrow set of costs incurred by public providers. Narrowing the definition of a "public" hospital will leave many states with holes in their Medicaid budgets. This will require diverting resources from other state priorities, finding new sources of revenue or ultimately cutting Medicaid. In addition, limiting payments to cost would cripple Mississippi's ability to offer incentives to governmental providers to operate more efficiently.

In order to continue the successful state-federal partnership in the Medicaid program, this rule change must be revisited. CMS's commitment to working constructively with states has led to the implementation of thoughtful program reforms that are in the best interest of Medicaid recipients and state and federal governments. Shifting the cost burden to states will leave many no choice but to cut services which is neither in the best interest of recipients nor government.

I look forward to working with CMS on this important issue. Please contact me if you would like to discuss this matter further at 601-576-2001.

Sincerely,

Haley Barbour

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

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:

For more than four decades, the most vulnerable residents of our State, indeed the Nation, have benefited from receiving health care financed by an open, yet often complex, Medicaid system. The State of Mississippi has, in good faith, relied upon the Centers for Medicare and Medicaid Services' (CMS) historic and ongoing interpretations of Federal law in order to craft a state Medicaid program which best utilized scarce resources in the most advantageous, legal, and approved manner benefiting low-income, medically underserved residents.

As the level of resources required to maintain essential health services has soared, Congress has remained vigilant in preserving states' abilities to build upon local investments in health care. Congress addressed and codified governmental finance parameters associated with Medicaid in 1991 when it addressed both provider taxes and donations. All the while, states have rightfully utilized local investments in health care by public entities in order to aggregate dollars within individual states to match Federal dollars.

Congress has repeatedly rejected prior attempts to confuse and alter the long-standing, equitable, federal-state partnership that is the basis for funding the Medicaid program in all states. In fact, the proposed rule, if adopted in its current form, would serve to disallow practices in Mississippi that the State has openly conveyed to CMS and its agents (including the Office of Inspector General). The State has never misrepresented its financing practices and, in fact, Federal regulators have repeatedly audited the State, reviewed Medicaid State Plan Amendments (SPA's), discussed financing practices with State leaders, and received cost reports from Mississippi's Medicaid/Medicare providers without ever raising any questions regarding financing practices such as those addressed in this rule.

With this proposed rule, the Administration would reverse the precedents that have been established through decades of CMS actions. The Administration would have the public believe that it has heretofore assumed that all of the providers participating in approved Intergovernmental Transfers (IGT) and Certified Public Expenditures (CPE) activities within all states were meeting the new found definition of "local government" and not the definition of "non-state, public" that has, in fact, been used as a standard by countless states and CMS for decades. CMS need only look at the Medicare cost reports submitted by the providers that has audited related to Medicare, Upper Payment Limit (UPL), Disproportionate Share Hospital (DSH), and Medicaid payments in the State of Mississippi to see that most of the public hospitals that voluntarily assisted the State to meet Federal matching requirements defined themselves as "private, nonprofit." This proposed rule makes no effort to address any deceptive practices. To the contrary, the proposed rule, as promulgated, seeks to provide short-term budget relief to the Federal Government at the expense of states that have, in good faith, used CMS' historic and ongoing practices to craft policy which affords the most vulnerable populations with health care.

CMS has stated that this proposed rule simply clarifies existing language. To the contrary, this proposed rule contradicts practices that CMS has knowingly approved and endorsed for decades. At this time to use the term "clarify" is to mislead the state leaders and CMS officials that have operated in a manner consistent with the language in the rule and in the best interest of the Nation.

This proposed rule is contrary to the letter and spirit of the laws that have been the foundation for state Medicaid programs since their inception. The attempt by the Administration to introduce such a change in interpretation and practice in a timeframe that would not afford states with the time necessary to identify, evaluate, and adopt financing methods different than those that have long been openly communicated, approved, and utilized demonstrates a disregard for the partnership between the states and CMS.

The proposed rule's language ranges from the questionable (e.g. this is an effort to "clarify") to the impractical (e.g. those governmental entities must retain every cent of reimbursement). CMS repeatedly demonstrates that it lacks an appreciation for the various methods of financing that are necessary to establish the foundation for funding local health care facilities using state, county, and municipal funds. The fact that states and units of local government have seen fit to build upon public, nonprofit entities investments and to leverage their resources in caring for the poor and underserved would seem to be a model for the very public/private partnerships that the Administration has sought to foster elsewhere.

More specifically:

1. The proposed rule does not clarify anything. Rather, it contradicts CMS' long standing practices and seeks to unjustifiably alter the Federal Government's role and authority in financing state Medicaid programs.

2. CMS's requirement that an entity must have "generally applicable taxing authority" would restrict the use of funds at the local levels within states beyond what Congress has intended.

3. CMS's current adherence to applicable Federal regulations pertaining to the three pool categories for upper payment limits (state owned or operated, non-state government-owned or operated, and privately owned and operated) adequately serve to address any concerns regarding unnecessary spending while maintaining an appropriate balance between state flexibility and the integrity of the partnership between states and the Federal Government.

4. As promulgated, the proposed rule would serve to impose cost limits on government providers in a manner inconsistent with the clear, ongoing intent of Congress to migrate away from cost-based limits on rates. Further, it would impose an undue administrative burden on states and providers to ensure that payments to government providers were settled. The proposed rule would impact many provider types in addition to hospitals (NFs, ICF-MR's, schools, etc.) and the administrative burden would serve to provide CMS with savings in an unspoken, implicit manner - - making the administrative burden so great that states and non-state government providers would simply cease to provide services through the Medicaid program.

The State of Mississippi respectfully suggests that CMS withdraw this overly prescriptive proposed rule which clearly fails to consider Congress' intent in crafting Medicaid law and certainly demonstrates a degradation of the permissible, long-standing funding mechanisms that exist within states as a result of good faith communication with CMS and adherence to practices and principles demonstrated by the Administration. The proposed rule does not represent an effort to clarify; rather, it represents a reversal of clearly demonstrated CMS policy and practice that has been in place for decades.

If, in the end, CMS promulgates and enforces this final rule commensurate with the draft, the State of Mississippi implores CMS to give due consideration to the time that it will take for the State to undo a complex financing system designed and implemented under scrutiny from CMS and utilized only to benefit the most vulnerable residents of the State in an open, honest, allowable manner. Again, the State of Mississippi strongly encourages CMS to abandon this effort; however, if adopted, CMS simply must afford states with a reasonable time frame to adjust to this drastic shift.

Sincerely,

Robert L. Robinson
Executive Director

Enlcosures

STATE OF MISSISSIPPI

HOUSE CONCURRENT RESOLUTION NO. 88

A CONCURRENT RESOLUTION REQUESTING AND ENCOURAGING THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) TO CEASE AND DESIST IN THEIR EFFORTS TO CHANGE THE RULES REGARDING MEDICAID FINANCING TO THE DETRIMENT OF THE HOSPITALS AND OTHER HEALTH CARE BUSINESSES AND PROFESSIONALS THAT PROVIDE ESSENTIAL HEALTH CARE SERVICES TO THE ELDERLY, THE DISABLED AND OTHER NEEDY POPULATIONS IN OUR STATE.

WHEREAS, the federal Medicaid agency, the Centers for Medicare and Medicaid Services (CMS), has proposed to change the Medicaid program rules in ways that will seriously injure the ability of states to maintain their Medicaid program, and will cause substantial financial injury to the hospitals and other health care businesses and professionals that provide essential health care services to the elderly, the disabled and other needy populations in our state; and

WHEREAS, although CMS says that its proposals are consistent with and required by current law, they go far beyond any reasonable construction of the agency's authority, disrupt long-standing practices, and impose new and onerous administrative and fiscal burdens on the states; and

WHEREAS, the principal elements of the CMS proposals, each of which would impair state programs, are: (1) the prohibition of the use of various sources of revenue of public entities that, along with funds appropriated from tax collections, have always been considered to be legitimate sources for the expenditures that they certify as the basis for federal matching funds for Medicaid, (2) the restriction on the use of certification of public expenditures (CPEs) to a narrow category of governmental units, which excludes public bodies that have long been allowed to certify expenditures as the basis for federal Medicaid funding, (3) the limitation on payments to governmental providers to their cost, which would undermine the use of payment methodologies widely used, in Medicare as well as Medicaid, to encourage cost efficiency, and (4) the requirement that all payments made to Medicaid providers be retained by them, which would both be unenforceable and certain to be a constant source of disputes and intrusion into the operation of state governmental entities; and

WHEREAS, in the realm of hospital services, the proposed rules would allow federal Medicaid payments only where the non-federal share of expenditures could be traced directly to an appropriation of tax dollars from some governmental body – the state, a county, or another entity with taxing authority - which would bar the use of unquestionably legitimate sources, such as foundation grants, earnings from other hospital operations, including ancillary lines of business such as gift shops or parking lots, and charitable contributions, as well as state sources such as tobacco payments, university tuition and other fees; and

WHEREAS, the proposed rules would not only bar the use of the sources listed above, the proposed rules would even limit some categories of tax-based appropriations; and

WHEREAS, the CMS proposals would do great damage to the Medicaid program, the continued vitality of which is crucial to attaining the goal, now generally regarded as among the most important domestic policy objectives, of broadening health care coverage throughout the nation:

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE STATE OF MISSISSIPPI, THE SENATE CONCURRING THEREIN, That we request and encourage the Centers for Medicare and Medicaid Services (CMS) to cease and desist in their efforts to change the rules regarding Medicaid financing to the detriment of the hospitals and other health care businesses and professionals that provide essential health care services to the elderly, the disabled and other needy populations in our state.

BE IT FURTHER RESOLVED, That copies of this resolution be furnished to the President of the United States Senate, the Speaker of the United States House of Representatives, members of the Mississippi congressional delegation, and members of the Capitol Press Corps.

ADOPTED BY THE HOUSE OF REPRESENTATIVES
March 14, 2007

WILLIAM J. MCCOY
SPEAKER OF THE HOUSE OF REPRESENTATIVES

ADOPTED BY THE SENATE
March 15, 2007

LIEUTENANT GOVERNOR AMY TUCK
PRESIDENT OF THE SENATE

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
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Alan D. Aviles
President

March 18, 2007

Ms. Leslie V. Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Room 314G
200 Independence Ave., SW
Washington, DC 20201

Dear Ms. Norwalk:

On behalf of the New York City Health and Hospitals Corporation (NYCHHC), the public hospital system of New York City, I urge the Centers for Medicare and Medicaid Services (CMS) to withdraw Proposed Rule CMS-2258-P (the Proposed Rule). The Proposed Rule would seriously undermine the existing system of Medicaid-based support for New York City's health care safety net, thereby compromising access for Medicaid and uninsured patients.

In New York, the proposed cost limitations contained in the Proposed Rule would significantly reduce annual Medicaid funding to New York State, resulting in an estimated $350 million reduction to NYCHHC. Loss of these supplemental Medicaid funds would put a severe financial strain on the NYCHHC system which encompasses eleven public hospitals, six trauma centers, four long term care facilities and an extensive primary care network. We provide health care to 1.3 million New Yorkers, of whom 400,000 are uninsured. Additionally, supplemental Medicaid funds have played a major role in ensuring that communities throughout the United States are protected with adequate emergency response capabilities, highly specialized tertiary services (such as trauma care, neonatal intensive care, burn units and psychiatric emergency care), and trained medical professionals.

The Proposed Rule would eliminate the long-standing regulatory exception that allows payments to public providers in excess of cost (42 CFR § 447.271(b)). The basis for this exception is rooted in the Medicaid statute, which specifically directs regulations permitting an exception "if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public." 42 U.S.C. § 1396b(i)(3). Therefore, we question whether CMS has the legal authority to eliminate this exception. In addition, we believe that the elimination of the nominal charge exception is inappropriate, since the exception properly recognizes the special situation of public providers that have substantially reduced charges. Public providers with substantially reduced charges should not be penalized because of these reduced charges.

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 and allow states appropriate flexibility to target support to communities and providers where it is most needed.

Over the last three years, CMS has significantly increased its oversight of payment methodologies and financing arrangements in states, including New York, to restructure their programs to eliminate inappropriate federal matching arrangements. We share CMS' goal of ensuring that Medicaid dollars be spent properly and applaud past efforts to rein in the misuse of such funds. 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. However, as there is no evidence that the legislative, regulatory and administrative steps already taken have been insufficient to eliminate the financing practices about which CMS is concerned, one wonders how the restrictive policies in the Proposed Rule will further its stated goals. Rather, the Proposed Rule imposes payment and financing policies that have nothing to do with institutionalizing the oversight procedures that CMS has used successfully. Instead, the proposed rule seems designed to cut deeply into the heart of Medicaid as a safety net support program with no measurable increase in fiscal integrity.

Additionally, it is ill-considered that providers, such as NYCHHC, that disproportionately serve uninsured patients, should be subject to a more restrictive limit on Medicaid Reimbursements than private providers. Furthermore, imposing a restrictive cost limit only on Government Providers would undermine their capacity to actualize important public policy goals related to quality, patient safety, emergency preparedness, enhancing access to primary and preventive care, reducing costly and inappropriate use of hospital emergency departments, and reducing disparities.

We are also unclear if the Proposed Rule's limitations on reimbursement not in excess of the individual providers' cost of providing "covered Medicaid services to eligible residents" impact payments made to public hospitals through the Disproportionate Share Hospital (DSH) program or through Section 1115 Waivers. A clarification clearly exempting DSH payments and 1115 demonstration program funds is needed.

It is also unclear which "costs" would be allowed for the purpose of the cost limit. Would graduate medical education, capital costs necessary to maintain an adequate physical infrastructure, investments in health information technologies, investments in community-based clinics, and Medicaid's fair share, beyond DSH, of the costs of treating the growing number of uninsured Americans be included? It is imperative that any definition of Medicaid "costs" include these vital items.

Finally, we believe that the cost limit would 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; and 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. CMS should not modify the current upper payment limits.

In response to President Bush's FFY 2007 budget, which first announced the intent to restrict Medicaid Payments via regulation (foreshadowing the Proposed Rule), 300 Members of the House of Representatives and 55 Senators in the 109th Congress urged the Administration not to move forward with this change administratively. Nevertheless, the Proposed Rule was issued on January 18, 2007; subsequently, in the 110th Congress' 226 members of the House and 43 Senators have similarly objected to both to the proposed Rule's severe impact on the nation's public hospitals and the disregard for the views of the legislative branch. Given the overwhelming bipartisan opposition, CMS should withdraw this proposal immediately and seek authorization from Congress for any major Medicaid changes it wishes to implement.

NYCHHC urges CMS to withdraw this ill-conceived proposed rule. At a time when the administration is professing a commitment to addressing the crises of uninsured, it seems contradictory to propose a rule that would severely cripple the nation's public hospitals. These hospitals are the backbone of the safety net that provides comprehensive health care for tens of millions of uninsured Americans.

Sincerely,

Alan D. Aviles

cc: Michael O. Leavitt

EARLY MEMORIAL NURSING HOME
11740 Columbia Street – Blakely, Georgia 39823
Phone (229) 723-4241

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
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:

As administrator of Early Memorial Hospital, I am writing to oppose the proposed Medicaid regulation published on January 18, 2007, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes significant Medicaid support payments for our hospital, funding that is key to our continued financial viability.

Early Memorial Hospital is owned by the Early Memorial Hospital Authority and is operated pursuant to a long-term lease management agreement with John D. Archbold Memorial Hospital. We also operate a nursing home and several rural health centers that provide key healthcare services to our community, and, last year, we provided more than $700,000 in healthcare services to the uninsured, providing access to those who often have nowhere else to turn.

Overall, we estimate the Proposed Rule would result in a net loss of $1.5 million to Early Memorial Hospital and our related healthcare entities.

Because of the drastic negative impact to our facilities and the patients who depend on us for their care, we strongly oppose the Proposed Rule and ask that CMS withdraw this proposed rule change.

Sincerely,

Robin Rau
Administrator

CC: Senator Chambliss
Senator Isakson
Congressman Bishop

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Utah Medical Education Council
230 S. 500 E. Ste. 550
Salt Lake City, UT 84102
Phone: (801) 526-4550
Fax: (801) 526-4551
www.utahmec.org

March 9, 2007

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

The Utah Medical Education Council (UMEC) is an organization with representation from all of the graduate medical education program sponsors and teaching hospitals for the State of Utah. The UMEC is gravely concerned about the impact Proposed Rule: CMS-2258-P will have on Utah hospitals involved in Graduate Medical Education (GME). Our comments center around three areas of concern:

1. Limiting government providers to cost
2. Removal/Reduction of UPL and DSH payments to government providers
3. Additional reporting requirements for government providers

The UMEC appreciates CMS' goal of ensuring accountability and protecting the fiscal integrity of the Medicaid program. That said, the UMEC has deep reservations regarding the proposals listed above, namely, limiting government providers' reimbursement to cost, removal/reduction of the UPL and DSH payments to government providers, as well as the additional reporting requirements this proposal would impose on government providers. We view these proposals as inherently unfair to government providers, particularly state-university owned/operated academic health centers which typically treat a larger percentage of Medicaid patients than do privately owned/operated hospitals.

In addition to treating a large percentage of Medicaid patients, these facilities generally sponsor a high percentage of GME and other training programs. Our fear is that should this proposed rule take effect as currently constituted, these facilities will be forced to reduce funding for training in order to make up for lost revenues. This at a time when there is increasing evidence that the nation is

facing a shortage of physicians over the next 10-15 years. We feel it is short-sighted at best to place these inequitable burdens on those facilities that treat a large percentage of Medicaid patients and also train the bulk of the nation's physician and healthcare workforce.

We respectfully request that CMS remove from consideration the aforementioned proposals as it pursues its goal of ensuring accountability and enhancing the fiscal integrity of the Medicaid Program.

Sincerely,

David Squire
Executive Director,

WNC
HEALTH
NETWORK
Providers Working Together

March 15, 2007

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

Re: (CMS-2258-P) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

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

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

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

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

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

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

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

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

Sincerely,

Gary Bowers
Executive Director

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

Oregon
Theodore R. Kulongoski, Governor

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March 15, 2007

DHS Oregon Department of Human Services

Office of Strategic Regulations and Regulatory Affairs
Division of Regulations Development
Attn: Melissa Musotto, CMS-2258-P
Identifier: CMS-10176
Room C4-26-05, 7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Musotto:

The Oregon Department of Human Services (DHS) respectfully submits this comment letter in response to the above-proposed collection of information requirements. While DHS recognizes the importance of a strong state-federal partnership, the breadth of the mandated information collection and the severity of their terms cause DHS to oppose the proposed paperwork requirements. If the related proposed rule were approved, the associated forms would seriously burden DHS and our partners.

The State will incur additional administrative workload impacts to track and validate the source of the funds from governmental providers. Under the proposal, non hospital and non nursing facility providers will be required to annually compete a form regarding, at a minimum, the identification of the relevant category of expenditures under the State plan; explanation about whether the contributing unit of government is within the provider-related taxes and donations limitations; and demonstration that the actual expenditures were incurred in the provision of Medicaid services. Hospitals and nursing facilities will have to complete the Medicare 2552-96 to identify allowable Medicaid costs. CMS has provided estimates for the completion of these forms, but DHS feels that these are understated. The Department is not currently staffed to review or audit cost reports or forms of this magnitude.

As a public provider itself, DHS will have to be able to document its costs for purposes of complying with the cost limits on Medicaid reimbursement and its own upper payment level (UPL).

In addition, if the proposed rule is approved, there is a requirement to obtain initial information from providers to determine if they are units of government. States will be requested to respond to this collection of information on an as need basis. The burden with this requirement is the staff time necessary to review, verify and submit to CMS within the mandated timeframe of three months after the effective date of the final rule.

In conclusion, the proposed forms would leave DHS with additional unfunded workloads and an unintended consequence could be that state and local governments have to reduce delivery of services. Therefore, we urge you to consider revising the proposal or not proceed by regulation. Thank you for your ongoing support and for your attention to this important issue.

Sincerely,

Bruce Goldberg, M.D.
Director

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