125

Don Snell
President &
Chief Executive Officer

MCG
Health System

March 12, 2007

Ms. 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:

I write you as the President and Chief Executive Officer of MCG Health, Inc., the academic medical center that supports the Medical College of Georgia, here in Augusta, Georgia. MCG Health, Inc. is a 632 bed, two (2) hospital, public teaching hospital / safety net hospital (Level I Trauma Center, Level III NICU, only private Psychiatric service in the region) , that serves the patients and families of Georgia, South Carolina, and much of the Southeast. We appreciate this opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule CMS 2258-P. We vehemently oppose this rule and urge the Centers for Medicare and Medicaid Services (CMS) to withdraw it from consideration. 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 nations poor and uninsured have access to a full range of primary, specialty, acute and long term care. The cuts would eliminate 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. For an institution like MCG Health, Inc, the result of this regulation would be a severely compromised safety net system, unable to meet current demand for services and incapable of keeping pace with fast-paced changes in technology, teaching, research, and the best practices that result in the highest quality of patient and family centered care.

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 providers and beneficiaries alike. And in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

In it's Regulatory Impact Analysis, CMS asserts that the Proposed Rule will not have a significant impact on providers, but then estimates that the rule will cut $3.9 billion in federal spending over the next five (5) years. This amounts to a severe budget cut for safety-net hospitals and state Medicaid programs that bypasses the congressional approval process and comes on the heels of very vocal congressional opposition to the Administration's plans to regulate in this area. The yearly funding reduction for Georgia hospitals exceeds $253 million. For MCG Health, Inc., alone, the reimbursement reductions beginning September 2007 could exceed $15 million per year. Over 5 years, the cut exceeds $80 million. The magnitude of this reduction would severely compromise our ability to deliver upon our three (3) part mission of patient care, teaching, and research. We would be forced to reduce services to the poor (Medicaid) and uninsured. We would by necessity be forced to eliminate or reduce community services such as our Level I Trauma service, Level III NICU, and community psychiatric services. Workforce reductions (layoffs) to reduce the devastating financial impact on the organization would exceed 300 employees or almost 1/10th of our workforce. These reductions are anything but insignificant. Last year 300 members of the House of Representatives and 55 Senators signed letters to Health and Human Services Secretary Michael 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 again having signed letters urging their leaders to stop the proposed rule from moving forward.

Again as a public safety net teaching hospital that has depended upon these supplemental payments to deliver our mission, we urge CMS to permanently withdraw this rule and would like to outline our most serious 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 estimate of savings.

1. Limiting Payments to Governmental Providers:

The Proposed Rule proposes to limit reimbursement for governmental hospitals to the cost of providing services to Medicaid patients, and restricts states from making supplemental payments to these safety net hospitals through the 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 it's 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. 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. With a "payor mix" of 30% Medicaid, and 10% self-pay, MCG Health, Inc. would experience reimbursement reductions (estimated at $15 million / year) that would force it to re-evaluate and reduce the services it could provide to this population, and unfortunately we are the region's largest provider of services to the Medicaid population and uninsured (2nd in the state only to the Grady Health System). 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 (as Medicare does not pay excessive rates) and allows the states appropriate flexibility to target support to communities and providers where it is most needed.

CMS 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. 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 payment. We believe the cost limit as proposed, 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 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 rule announced on October 5, 2000.

Finally, in proposing a cost-based reimbursement system for government hospitals, CMS fails to define allowable costs. As a large academic medical center that trains over 330 interns / residents / fellows each year we are very concerned that, in CMS' zeal to reduce federal Medicaid spending, important costs such as Graduate Medical Education (GME) and physician on-call services or clinic services would not be recognized, and therefore would no longer be reimbursed. This is a total administrative disconnect from recent federal health policy discussions calling for an increase in physician manpower by 30% or more over the next five (5) years. CMS should not modify the current upper payment limit.

2. New Definition of "Unit of Government":

The Proposed Rule puts forward a new and very restrictive definition of "unit of government" such as a public hospital. Public hospitals that meet this new definition must demonstrate that 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. This new restrictive definition would no longer permit many public hospitals that operate under public benefit corporations or many state universities from helping finance their share of Medicaid funding. Currently it is estimated in Georgia, that only two (2) hospitals (MCG Health, Inc. and Warm Springs Rehabilitation Hospital) would qualify under the new restricted definition, where previously there were 40 to 50 and even we aren't sure we would qualify. The potential dollar reduction of this strict definition has been estimated to be $253 million out of a federal state cap / limit of $417 million. This is significant and would cripple the safety net structure in place in Georgia.

We don't believe that CMS has 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 it's 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 the 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 deliver a core governmental function (ensuring access to health care) through the most efficient and effective means. Countless governments including the University System of Georgia Board of Regents here in Georgia, 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.

In summary, there is no basis in Federal statute that supports this proposed change in definition. CMS should continue to defer to state designations of governmental entities.

3. 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.

The requirement in the Proposed Rule, that intergovernmental transfers (IGTs) be derived only from tax revenues ignores the much broader nature of public funding. States, local governments, and governmental providers derive their funding from a variety of sources not just taxes, and such funds are no less public due to their source. Limiting IGTs to tax revenue 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.

4. 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 (5) years. But CMS fails to provide any relevant data or facts to support this conclusion. CMS claims to have examined Medicaid financing arrangements across the country and has identified state financing practices that do not comport with the Medicaid statute. CMS, however, provides no information on which states or how many states are employing questionable financing practices. The public without access to such data, has not been given the opportunity to meaningfully review CMS' proposed changes, calling into question CMS' adherence to administrative procedure.

MCG Health, Inc. 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. Georgia hospitals are already, out of necessity, having to discuss the imposition of provider taxes to make up for the potential shortfall in funding. 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 multimillion dollar funding cuts. As was stated in the beginning of these comments, MCG Health, Inc. has estimated a funding reduction of almost $15 million for the first year. The State of Georgia has estimated a loss of almost $253 million during the first year of enactment. These reductions are more than significant. They are the difference for most hospitals between financial viability and insolvency.

These reductions are ill-advised at a time when the demands on the health care safety net are greater than ever. CMS should reevaluate its estimates of the impact of the Proposed Rule and the need for regulatory relief under the Regulatory Flexibility Act.

To summarize, MCG Health, Inc. vehemently opposes the Proposed Rule, and strongly urges that CMS permanently withdraw it. If these policy changes are implemented, the nation's health care safety net will unravel, and health care services for millions of our nation's most vulnerable citizens will be jeopardized.

Thank you again for the opportunity to comment on the Proposed Rule.

Sincerely,

Donald F. Snell
President and Chief Executive Officer

DS:tp

Cc: The Honorable John Barrow
The Honorable Saxby Chambliss
The Honorable Johnny Isakson
Donald M. Leebern, Jr.

126

Archbold Medical Center

910 South Broad Street
Thomasville, Georgia 31792
(229) 228-2739

Leslie V. Norwalk, 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 Archbold Medical Center, the safety net healthcare provider for a wide area of southwest Georgia, I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The rule, as proposed puts at risk some $8.8 million in critical Medicaid payments for Archbold, funding that has been essential to our ability to provide healthcare services to all who need them.

Archbold Medical Center is a not-for-profit healthcare system comprised of five hospitals, four nursing homes, two home health agencies and a network of clinics and facilities that reaches across a wide area of southwest Georgia and north Florida. Our system hospitals are operated pursuant to long-term lease agreements with their respective hospital authorities. Archbold operates the only designated trauma center in southwest Georgia (the next closest is some 150 miles away), as well as a number of rural health clinics, and we serve a high percentage of Medicaid patients and a large number of uninsured citizens.

As a key safety net provider in our region of Georgia 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. This letter details the negative aspects of the rule and its negative impact on our health system and the patients who depend on us for their care.

As proposed, this rule would impose on states a new definition of a "unit of government" that would require 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"). We oppose this

restrictive new definition and urge the CMS to allow states to determine which entities are units of government pursuant to state law.

For years, Georgia Medicaid has recognized our role as a safety net provider and has provided crucial financial support through Georgia's Indigent Care Trust Fund (ICTF) and through supplemental "upper payment limit" ("UPL") payments, totaling $3.7 million in FY 2006. Georgia hospitals and health systems have long provided the non-federal share of these support payments through IGTs, and it is our understanding that CMS approved the 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.

As a result of this proposed change, Georgia hospitals and health systems would no longer be able to support 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 during FY 2006 we provided $19.3 million in care to the uninsured, providing access to those who often have nowhere else to turn.

The impact to our facilities 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."

We are equally opposed to the proposed rule's new cost limit on Medicaid payments to governmental providers. This limit puts hospitals in a box – either they are considered to be a private entity and, as such, are unable to provide IGTs to fund our supplemental payments, or they are considered to be governmental but 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 $8.1 million 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.

Georgia recently established Georgia Healthy Families, a program to enroll Medicaid recipients into private care management organizations ("CMOs"). As CMO enrollment grows, it directly impacts 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 FY 2007 UPL payments, we expect to lose approximately $1.7 million 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 negative impact on our patients will be severe. We urge you to withdraw the regulation immediately.

Sincerely,

J. William Sellers, Jr.
Senior Vice President & CFO

CC: Congressman Bishop
Senator Chambliss
Senator Isakson

127

New Mexico Human Services Department

2007 MAR 20 AM 10: 00

Medical Assistance Division
PO Box 2348
Santa Fe, NM 87504-2348
Phone: (505) 827-3106

Bill Richardson, Governor
Pamela S. Hyde, J.D., Secretary

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:

Thank you for the opportunity to comment on the proposed regulation concerning the cost limits for providers operated by units of government and provisions to insure the integrity of Federal-State financial partnerships. The New Mexico Medicaid program agrees that there should be a strong commitment to fiscal integrity of the Medicaid program and has made many changes to the program to insure this is achieved. The program changes that have been made as well as our existing program structure have been done within the limits of statutory requirements and with federal approval. The changes in this proposed rule could cause significant impact on New Mexico's health care delivery system including hospitals, tribal facilities, trauma care, school based and other public providers. Furthermore, all the changes in reporting and reconciliation as required in the proposed rule would apply further strain and burden to the management of the Medicaid program.

It is difficult to determine exactly the amount of impact that the proposed rule will have on New Mexico's Medicaid program due to the lack of specificity and clarity in the proposed rules. We urge the Centers for Medicare and Medicaid Services (CMS) not to move forward on these proposed rules without a process that looks at the specific impact to states.

Thank you for your consideration of the following comments.

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

Defining unit of government
§ 433.50(a)(1)(i), attempts to define "unit of government" as a unit with taxing authority. There are several long-standing programs, approved by CMS, which have contributed to the non-federal share of Medicaid expenditures that do not meet this definition. These programs have

gone to great lengths to meet federal audit requirements and are key in assisting with funding for the program. We urge you not to implement this section or to reconsider the restrictive language that defines a unit of government.

Differentiating between public and private entities
We have an approved state plan to reimburse school programs. 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. Our state already goes to great lengths to meet the CMS current requirements in this area. This provision is unnecessary.

Treatment of Tribal entities
In section 433.50(i), the proposed regulation indicates that a governmental unit will include Indian tribes. This section of the regulations is not clear. This section seems to directly conflict with the unique government-to-government relationship the United States has with Tribal governments. CMS has issued clarification that states may use certain funds toward matching federal dollars. This proposed regulation seems to reverse those decisions (i.e., the State Medicaid Director Letter #05-004 issued on October 18, 2005, June 9, 2006, CMS letter #06-014. 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
We oppose the restrictions the proposed rule imposes on current state flexibility to develop appropriate and reasonable Medicaid reimbursement systems. The proposed rules at § 447.206 would limit the reimbursement to providers that are operated by a unit of government to no more than the cost of providing covered Medicaid services to eligible Medicaid recipients. We request CMS to consider several issues prior to finalizing the rule:

1) The proposed rule is taking a narrow view on reimbursement to providers operated by units of government. These providers are critical to the viability of the entire health care delivery system in our state. They provide access to care in rural areas, serving a large volume of Medicaid, and providing the vast majority of services to the uninsured. Reimbursement for Medicaid services to these facilities would be limited to a strict definition of cost, yet it is likely that our DSH allotment will be insufficient to reimburse government providers 100 percent of their cost of care for the uninsured. The proposed rule would have the direct outcome of forcing our state to fund uninsured services with state only funding.

2) Our state has paid institutional providers on a prospective basis for many years under an approved state plan. Our prospective nursing facility and inpatient hospital reimbursement systems treat facilities that would be considered units of government

identical to those that are non-profit organizations or privately owned. These prospective payment systems have proven to be effective, and create appropriate incentives for providers to control their costs. To now force states to revert back to an outdated retrospective settlement for government operated facilities creates an inequity between our government facilities and non-government operations. In fact, the proposal would require us to treat our government operations at a distinct disadvantage as compared to the non-government operations.

We disagree with CMS' assertions in the proposed rule that states operate inappropriate financing structures. The Medicaid reimbursement formulas we have in place have been approved by CMS and in accordance with federal guidelines. We have been subjected to constant federal audit reviews. These continuous audits will identify any problems with the operation of the program that could occur at some future point. We strongly oppose any further duplicative and overly burdensome administrative procedures proposed by CMS.

Additional payments to providers
The proposed regulation is not clear on the how graduate medical education (GME) payments to providers should be handled and we request clarification on this section prior to implementation of the proposed rule. Our GME payments have been approval by CMS. GME is helpful in meeting the needs of our state and we request that CMS not move forward with the implementation of this section until states are able to determine the impact.

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." CMS needs 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, New Mexico has an approved state plan for upper payment limit which is based on an aggregate cost limit for facilities and we request that CMS not implement a rule that would limit the flexibility to maintain these types of reimbursement policies.

We also ask that CMS provide clarification on the proposed rule's applicability to managed care organizations (MCOs) prior to any implementation of the final rule. The proposed rule does not address how the cost limit would apply to managed care programs and the negotiated capitated rates. The rule does not clarify how the cost limit applies to government providers participating in an MCO network.

§ 457.628 Other applicable Federal regulations

New Mexico's State Children's Health Insurance Programs (SCHIP) is a Medicaid expansion program. 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' SCHIP. CMS needs to provide more clarification of this section. Specifically, it is unclear if CMS is creating a new definition for what will be considered an "SCHIP provider." In New Mexico there is no difference between those providers who provide services to the SCHIP population and those who provide services to

other 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. 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 request that CMS revise the effective date of the proposed rule. There are many aspects of the proposed regulation that are very confusing and many items that need to be clarified. We suggest that CMS work with states to clarify the rules and determine the impact on states. This will take additional time to accomplish.

If the proposed rules are implemented we will need time to change information systems, notify providers, change payment methodologies, change state plans amendments, notify stakeholders and work with legislators on the impact of these regulations. We would need at least a year from the date of issuance of the final rule in order to make the appropriate changes in our state budget which would require legislative approval. Therefore, we request that states be provided with a reasonable amount of time to implement these changes.

Thank you for this opportunity to comment. Please feel free to contact me at 505-827-3106 for further information.

Sincerely,

Carolyn M. Ingram
Director

128

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH SERVICES
LOCAL GOVERNMENT UNIT and ADMINISTRATIVE OFFICES
5467 UPPER MOUNTAIN ROAD, SUITE 200
LOCKPORT, NEW YORK 14094-1895

Antoinette Lech, M.A., M.B.A.
Director
(716) 439-7410
(716) 439-7418 Fax

March 12, 2007

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

Re: Code # CMS-2258-PMedicaid 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 Niagara County New York, Department of Mental Health I am commenting on the above-referenced proposed rule published in the Federal Register of January 18, 2007 on pages 2236 and 2248.

The Niagara County Department of Mental Health serves under New York State Mental Hygiene law as the Local Governmental Unit (LGU) for Mental Health and Mental Retardation/Developmental Disabilities and as the Local Designated Agency (LDA) for Alcohol and Drug Abuse Services. The Department is also a provider of Adult Outpatient Services for Mental Health that would be directly affected by this rule change.

The Role of the LGU and LDA has been and continues to be, planning and implementing the Mental Hygiene services for the population in need within its catchment area. Within this charge the development of services has included the assessment of need for service, access to services, financial feasibility of the provider, Character and Competence of the provider and the likelihood that services would be provided within regulatory guidelines. Niagara County's current service configuration was created on these principals.

Niagara County and its recipients have specific concerns related to this proposed rules change. Those concerns include:

1. Disregard for the process to build the services system over many years, involving providers, recipients, community members and various State and Local government personnel.
2. The potential to limit choice on the part of recipients by putting long standing government direct services operators out of business.
3. The disruption of continuity of care for approximately 2,000 recipients in our county who have formed a clinical alliance and would need to start over with new providers.
4. The loss of the range of Mental Health services available to both Adult and Children with Serious Mental Health issues.

5. New limitations on allowable services under rehabilitation option would be particularly harmful to individuals with mental retardation and receiving health related specialty services which allow them meaningful participation in a more mainstreamed manner.
6. While Niagara County is not officially listed a rural County one of our clinics is the largest provider accessible to the eastern rural population. The potential loss of this service due to the rule change and no other avenue to replace the lost revenue would cause this population to travel an additional 20 miles for services. In a county with limited public transportation this could in fact be a denial of access.

I 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.

Sincerely yours,

Antoinette Lech
Antoinette Lech, M.A., M.B.A.
Chief Executive Officer
Community Service Board
County of Niagara

MW/je

CC: U.S. Senator Charles Schumer
U.S. Senator Hillary Rodham Clinton
U.S. Congresswoman Louise Slaughter
U.S. Congressman Thomas Reynolds

BEFORE THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

In the Matter of	)	
	)	
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

COMMENTS OF THE STATE OF TENNESSEE

The State of Tennessee 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 Tennessee and throughout the nation. Tennessee has joined in Joint Comments, submitted this day, on behalf of a group of states in opposition to the proposed rules, and believes that those Comments set forth compelling reasons for CMS to abandon the proposal, which is without redeeming merit.

The purpose of these Comments of Tennessee is to show how the proposed rules would severely impact the Tennessee Medicaid program, undermining the joint efforts of the State and CMS over the past several years to restore the landmark TennCare program to financial soundness, and threatening serious decline in the basic health care and services that the TennCare program today provides to a substantial portion of the population of the State.

Financing the TennCare Program

TennCare is the first of the statewide managed care demonstration projects to have been authorized under section 1115 of the Social Security Act. The program began on January 1, 1994, and this is its 14th year of operation.

The TennCare experiment was founded on the premise that there were sufficient assets in the public health care programs to serve the needy population if only the assets were managed in a more efficient manner. Over the years TennCare has more than proved the validity of the premise; it has maintained and even expanded services to the needy while maintaining program expenditures below what they would have been under the former fee-for-service system. Despite some bumpy periods and a need for mid-course corrections, TennCare has been a success of federal as well as state policy.

A key component of that success has been the ability to tap a full array of public resources that support the TennCare system. In particular, this includes the resources of public hospitals throughout the State--large hospitals like the Regional Medical Center in Memphis and Metropolitan Nashville General Hospital and the University of Tennessee Health Systems, but also over two dozen smaller, mostly rural hospitals that have been established by counties or special governmental districts to assure the availability and accessibility of hospitals in those more remote areas where the private hospital systems have been able to meet the need.

The manner in which these public resources have been tapped is through Certification of Public Expenditures (CPEs). The public hospitals have identified their expenditures for serving all those who would meet TennCare eligibility standards, as well as indigents, and from the outset of the TennCare program these expenditures have been included among those reported by TennCare and for which it has received federal financial participation.

The proposed regulations threaten this highly successful method of capturing matchable expenditures by limiting the right to certify to those hospitals that are themselves governmental units with taxing authority or are part of an entity with such authority and which has the legal obligation to fund the hospital's expenses, liabilities and deficits. While some of the certifying hospitals might satisfy this highly restrictive standard, many would not. Yet these hospitals are undoubtedly public entities. They have been created by government bodies under the authority of state law. See Tenn. Code Ann.§§7-57-101 - 7-57-404 (authorizing the creation of hospital authorities) and Tenn. Code Ann. §§7-57-501 - 7-57-603 (granting additional powers to hospital authorities and hospital districts created by a private act of the general assembly). These governmentally-created hospitals service a public purpose. They are governed by government officials or persons appointed by government officials; they are not beholden to private shareholders but rather to the public they serve. As shown in the Joint Comments, these are entities that have traditionally been treated as public from the earliest days of Medicaid. Nothing in the law would warrant a change in that treatment, and the suggested change represents terrible policy that can only thwart the efforts of states to maintain their Medicaid programs in a manner consistent with the overall objective of the program of enabling states to furnish medical assistance "so far as practicable" to program eligibles.

While many of these public hospitals receive sizeable subsidies from "units of government" with taxing authority, it is not enough that the proposed rules would permit the governmental entities themselves to certify the expenditures of any subsidies derived from tax revenue. That is because the hospital expenditures are supported not only by these subsidies but also by operating revenue and revenue from other operations. These sources have traditionally been viewed as public funds, and CMS and its predecessor agency have knowingly authorized

the State to count these expenditures toward the state share of TennCare costs. There is no reason in law, and the State sees no valid reason in policy, for not allowing this to continue.

Without the federal matching of TennCare's certified expenditures the program would be crippled. Currently, the level of certified expenditures by hospitals is approximately $415 million, which produces $267 million in FFP for the TennCare program. Loss of those federal funds would doom the State's multi-year effort, now fully in place, of sizing TennCare to meet the resources available for the program, and could instead force the State to choose between dropping a substantial number of people from the rolls or cutting other essential services and programs for Tennesseans.

Public Nursing Homes

There are close to 30 public nursing homes in Tennessee, established in almost every case by the county government in which the home is located, that participate in the Tennessee Medicaid program (long term care is presently provided outside of the TennCare program). These homes, like all nursing homes in the State, are reimbursed pursuant to an approved methodology that utilizes certification of expenditures as the basis for FFP in the facilities' costs as reported on their Cost Reports (which are based on Medicare cost principles) plus supplemental payments that do not exceed the difference between certified expenditures and the Medicare Upper Payment Limit established in regulations for non-state public facilities. The supplemental payment cover, among other things, costs attributable to the nursing home operations that are not reflected in Medicare cost principles and are not picked up by the Joint Annual Report.

This approved payment methodology would be potentially impacted in three different ways by the proposed regulations: (1) the prohibition on payments in excess of cost, if

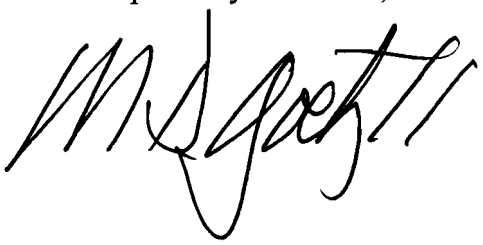
applicable (it would apply if the facilities are deemed "units of government"), would potentially preclude the supplemental payments, since CMS, which reserves the right to determine what constitutes cost, has so far always based its cost determinations on Medicare reimbursement principles; (2) the prohibition on certification of expenditures that cannot be shown to have been derived from tax dollars would potentially apply; and (3) the limitation of certification to "units of government" would prevent at least some of the public facilities from using this reimbursement method, since not all of them are "in" the government of the county that established them.

As shown in the Joint Comments, there is no legal justification for these prohibitions. And even if there were, they would be bad policy and ought not to be adopted. Under current policy nursing homes may be reimbursed up to the level that Medicare would reimburse for the same type of service. That is a sensible limit, particularly in light of changes in the Medicare system over the past decade that have made it more sensitive to patient acuity and thus to the level of care provided. The Medicare approach rewards efficient operation, permitting good operators to earn a reasonable profit on their business and thereby assure the continued availability of the service to the Medicare program. The same approach is now followed in the Medicaid program by many states, including Tennessee. But the proposed rules would thwart that sound policy, in the case of nursing homes that meet the "unit of government" definition, by limiting reimbursement to cost as defined by a federal agency. The federal agency that also administers the Medicare program should not be adopting rules that preclude states from paying to Medicaid providers what those providers would be paid for serving Medicare patients.

Conclusion

The proposed rules should not be adopted.

Respectfully submitted,



Oregon
Theodore R. Kulongoski, Governor

Department of Human Services
Office of the Director
500 Summer St. NE, E-15
Salem, OR 97301-1097
503-945-5944
Fax: 503-378-2897
TTY: 503-947-5330

DHS
Oregon Department of Human Services

March 15, 2007

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

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

Dear Mr. Leavitt:

The Oregon Department of Human Services (DHS) respectfully submits this comment letter in response to the above proposed rule changes. DHS agrees with the intent of the proposed rules, which seek to provide clean sources of funds for Medicaid and State Children's Health Insurance Program (SCHIP) match. However, the breadth of the proposals and the severity of their terms would have an adverse impact on our ability to provide Medicaid services to the citizens of the state.

We do not understand the logic of changing the use of clean public funds to only allow State and local taxes for match. Nor do we understand the need to limit public entities to the defined units of government. Currently DHS uses Other Funds, which are comprised of Intergovernmental transfers (IGT's), local funds, recoveries, and other sources, to match these expenditures. These sources are not recycled Federal funds. The proposed policies represent significant changes that will result in cuts of clean Other Funds match. The proposals would also cause substantial financial burdens to health care providers that provide essential health care services to children, the elderly, the disabled and other needy populations in our state. This is questionable public

policy as it conflicts with one of the most important national domestic policy objectives, expanding health care coverage throughout the nation.

Presently DHS receives matching funds through the IGT process that total $86.5 million annually, which is 19% of the Medicaid Other Fund matching budget. DHS currently has agreements with entities that provide these matching funds, which may not meet the new, more stringent regulatory definition. Oregon Health Science University (OHSU), the only public teaching hospital in Oregon, provides $59 million of this match. Oregon law (ORS 353.117) allows OHSU to create tax-exempt entities that are then defined as a unit of government. However, if CMS determines otherwise through the review of OHSU's questionnaire the result would be drastic. If the proposal is approved, DHS will need to review IGTs, related program rules, county agreements and related administrative rules to come into compliance.

Some of the reasons for opposing the Centers for Medicare and Medicaid (CMS) proposals are listed below in the same order as presented in the notice of proposed rule making.

State and Local Tax Revenue

The proposal prohibits the use of various sources of revenue from public entities that, along with funds appropriated from tax collections, have always been considered legitimate sources for the expenditures. As stated previously, these public funds are not recycled Federal funds and as such should still be allowable as match.

Some have questioned whether or not the proposal impacts provider taxes and Managed Care Plan taxes. Our general understanding of the proposal is that the regulation does not speak to these taxes since they are authorized by other Federal regulations. Therefore, our assumption is that there would be no impact to these sources of match.

Defining a Unit of Government

Our analysis indicates this may be the most complicated issue in the proposal. Until CMS has reviewed the completed provider questionnaires in some detail, it may be difficult to correctly assess what kinds of entities may be impacted and what that impact may have on the State's ability to obtain matching funds from these entities.

Oregon law defines public entities that are less obvious than the direct State, city, county, special district or other government unit. The organizational structures of some entities are so complex in nature that it is difficult to determine if they meet the

new federal criteria. In Oregon, there are a variety of ways that intergovernmental bodies may be formed. Oregon Statute allows tribes, counties or other units of local government who join together to form governmental units for specific purposes. The Oregon Council of Governments is an example of one type of these intergovernmental entities. These entities are an important part of our service delivery system and we are concerned that they may not meet the new more restrictive definition of a governmental entity.

Cost Limit for Providers Operated by Units of Government

The proposed rule includes imposing a cost limit for public health care providers and changing the definition of "public" status. This fundamental change would diminish long-standing legitimate state funding methods that CMS has previously approved. By requiring the identification of allowable costs, it seems that we are reverting to a fee for service basis. This approach seems inconsistent with CMS direction of moving to managed care and capitated rate methodology.

DHS is not currently staffed to accommodate the additional workload the proposal would require. The anticipated cost for DHS to analyze and approve the cost reports from all entities that would be required to file exceeds the estimates of payments exceeding costs. DHS believes that our rates are based upon provider allocation of allowable costs. We should not have different rates for governmental and non-governmental providers. The cost of implementing verification required in these rules will outweigh potential savings.

This rule proposes to limit Medicaid reimbursement for State government operated and non-State government operated facilities to the individual provider's cost. Current upper payment limit (UPL) regulations provide an aggregate limit based on the UPL facility group. This proposal will be an additional burden on providers. Also, it is not clear what the effect of a hospital-specific UPL based on Medicaid costs will have. But, it is possible that the effect will be a significant reduction in the amounts that can be paid to providers. The finalized Medicare cost report can be three or more years old. This does not allow for any changes to costs over time. What we pay providers today may be over their costs three years ago, however it may not be in today's market. Current compensation methodology does not reflect inflation.

We fear that public entities may stop participating in the Medicaid programs due to the unfunded administrative burden of preparing cost reports and also calculating separate UPL. In a sample of 231 Medicaid governmental providers, 61 received less than $10,000 reimbursement and may not think it is cost effective to continue. Small rural

providers (in many cases the only source of medical care in the community) would be adversely impacted. The cost limitation would impose on these entities massive accounting and reporting requirements way beyond the proportion to the scope of their operations.

Retention of Payments

DHS is not opposed to this issue. However, providers paying the matching portion prior to receiving reimbursement from DHS will be a change to current practice. This issue may cause conflicts with Oregon's Prompt Payment Act, which requires interest to be paid to the provider of goods and/or services if requests for reimbursement are not paid within 45 days of receipt. If approved, this would be an accounting burden for tracking which entities had paid and therefore appropriate to proceed with the reimbursement process.

Additional Concern

Another concern is the workload required to comply with the requirement to update waivers and the State Plan. CMS is explicit that the proposed rules would apply to waiver situations as well as to State Plan payments. Waivers contain provisions to the effect that the waiver terms and conditions would require amendments to conform to law and/or regulation.

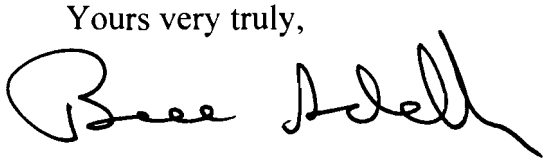
Questions

DHS has questions and asks for clarification and answers to the following:

- What will constitute a "unit of government?"
- Is the use of fees collected by public bodies and included within "public funds" legitimate sources to be used for state matching purposes?
- Does CMS intend to take a very literal interpretation of taxes to mean only taxes assessed and collected from taxpayers under government entity's general taxing authority?
- What does "the relevant category of expenditure under the State plan" mean?
- Does the above term pertain to the categories as reported on the CMS 64?
- Will CMS require holding the entities to cost based on no trending for today's cost?
- DHS contracts with Medicaid managed care organizations that then subcontract with counties. In this structure, would the counties have to comply with cost limits?

In conclusion, the proposed rule would leave DHS with gaping holes in our Medicaid budget that can be plugged only by diverting resources from other important state priorities, finding new sources of revenue or by cutting Medicaid and SCHIP services. Therefore, we urge you to reconsider the proposed rule changes and look forward to your response to our questions and concerns. Thank you for your ongoing support and your attention to this important issue.

Yours very truly,



Bruce Goldberg, M.D.
Director

BG:tlem

131

Alaska Native Health Board

3700 Woodland Drive, Suite 300
Anchorage, Alaska 99517

Phone: (907) 562-6006
FAX: (907) 563-2001

March 14, 2007

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

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

Dear Ms. Norwalk:

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

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

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

Statements made by the Acting Administrator, Deputy Administrator and other CMS officials during the most recent meeting of the Tribal Technical Advisory Committee made it clear that the it was CMS's intent that this proposed rule have no effect on the opportunity of Indian Tribes and Tribal organizations to participate in financing the non-Federal portion of medical assistance expenditures for the purpose of supporting certain Medicaid administrative services, as set forth in State Medicaid Director letters of

October 18, 2005, and as clarified by the letter of June 9, 2006. Unfortunately, we are convinced that, as written, the proposed rule would, in fact, negatively affect Tribal participation. We discuss our concerns and offer proposed solutions below.

Criteria for Indian Tribes to Participate

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

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

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

Criteria for Tribal Organizations to Participate

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

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

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

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

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

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

In the explanation of the proposed rule, the problem is exacerbated in the discussion of section 433.50. Many tribal organizations are not-for-profit entities. The explanation of the rule suggests that not-for-profit entities "cannot participate in the financing of the

---

used for match. But the SMD letter dated June 9, 2006, corrected this error. "[T]he Indian Health Service has determined that ISDEAA funds may be used for certified public expenditures under such an arrangement [MAM] to obtain federal Medicaid matching funding.")

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

non-Federal share of Medicaid payments, whether by IGT or CPE, because such arrangements would be considered provider-related donations."

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

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

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

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

> (C) The health care provider is an Indian Tribe or a Tribal organization (as those terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (ISDEAA); 25 U.S.C. 450b) and meets the following criteria:
>
> (1) If the entity is a Tribal organization, it is—
>
> (aa) carrying out health programs of the IHS, including health services which are eligible for reimbursement by Medicaid, under a contract or compact entered into between the Tribal organization and the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, and
>
> (bb) either the recognized governing body of an Indian tribe, or an entity which is formed solely by, wholly owned or comprised of, and exclusively controlled by Indian tribes.
>
> (2) The cost sharing expenditures which are certified by the Indian Tribe or Tribal organization are made with Tribal

> sources of revenue, including funds received under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, provided such funds may not include reimbursements or payments from Medicaid, whether such reimbursements or payments are made on the basis of an all-inclusive rate, encounter rate, fee-for-service, or some other method.

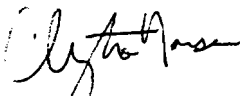
The caveat to paragraph (2) above regarding the source of payments was added to expressly address a new limitation that CMS proposed on February 23, 2007, with regard to approving the Washington State Medicaid Administrative Match Implementation Plan to exclude any "638 clinics that are reimbursed at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

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

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

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

Sincerely,



Clayton Hanson
Interim President/CEO

Cc: National Indian Health Board

132

Essex County

Community Services Board
Keela Rogers, Chairperson
Nicole P. Bryant, CSW
Director

P.O. Box 8 - Court Street
Elizabethtown, NY 12932
(518) 873-3670
Fax (518) 873-3777

Mental Health Services
Nicole P. Bryant, CSW
Director
Carmela Calvi, Ph.D.
Assistant Director

March 15, 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)

I am commenting on the above-referenced proposed rule published in the Federal Register of January 18, 2007 on pages 2236 and 2248.

Essex County 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 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 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 on this rule, and withdraw it from further consideration.

Very truly yours,

Nicole Bryant

Nicole Bryant, LMSW
Director

NB/djl

Cc: Honorable Charles Schumer, Member, U.S. Senate
Honorable Hilary Rodham Clinton, Member, U.S. Senate
Honorable Kirsten E. Gillibrand, Member, U.S. House of Representatives
Honorable John M. McHugh, Member, U.S. House of Representatives

Michigan Association of
COMMUNITY MENTAL HEALTH
Boards

March 13, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTENTION: CMS-2258-P
Post Office Box 8017
Baltimore, MD 21244-8017

We appreciate the opportunity to comment on the CMS notice of proposed rule making (CMS-2258-P); cost limits for providers operated by units of government and provisions to ensure the integrity of federal state financial partnerships.

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

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

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

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

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

Thank you for this opportunity to comment.

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

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

CORTLAND COUNTY
COMMUNITY SERVICES

CHARLES T. CAPANZANO, PH.D.
Director of Community Services

7 CLAYTON AVENUE
CORTLAND, NEW YORK 13045
PHONE (607) 758-6100
FAX (607) 758-6116

MICHAEL KILMER
Director of Administrative Services

March 15, 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,

Charles T. Capanzano, Ph.D.
Director of Community Services

Saved: Ltrs CTC 2007: CMS Proposed Rule

CLINTON COUNTY

MENTAL HEALTH & ADDICTION SERVICES

Administrative Office 18 Ampersand Drive Plattsburgh, NY 12901 Phone: 518-565-4000 Fax 518-566-0261

SHERRIE GILLETTE, MA, CASAC
Director of Community Services
Administrative Office
18 Ampersand Drive
Plattsburgh, NY 12901

Phone: 518-565-4000
Fax: 518-566-0261

LAURIE DURHAM
Administrative Services Officer
Administrative Office
18 Ampersand Drive
Plattsburgh, NY 12901

Phone: 518-565-4000
Fax: 518-566-0261

ILENE LESHINSKY, LCSW-R
Mental Health Clinic and Adult SPOA Coordinator
Mental Health Clinic
18 Ampersand Drive
Plattsburgh, NY 12901

Phone: 518-565-4060
Fax: 518-566-0168

SANDRA LUSHIA, CASAC
Addiction Services Coordinator
Addiction Services
16 Ampersand Drive
Plattsburgh, NY 12901

Phone: 518-565-4020
Fax: 518-562-2783

March 13, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-22580P
P.O. Box 8017
Baltimore, Maryland 2144-8017

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)

As a provider in New York State please accept my comments on the above referenced proposed rule published in the Federal Register of January 18, 2007 on pages 2236-2248.

In Clinton County, New York State we are concerned that the proposed rule would seriously undermine mental hygiene services. New limitations proposed in the regulatory definition of allowable costs for providers which are units of government would be particularly harmful. This would have a negative impact on the continuing viability of the range of services available to seriously mentally ill adults and children living in our county.

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.

Additionally, more rural counties appear to be disproportionately disadvantaged by the proposed rule. There are few if any alternative providers not subject to the costs limitation and we are more dependent on Medicaid transportation funding due to large travel distances and the lack of public transportation for those persons without any means of transportation.

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,

Sherrie Gillette

Sherrie Gillette
Clinton County Director of Community Services