Submitter : **Mr. Kevin Randall** **Date: 03/15/2007**

Organization : **Martin General Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachmcnt

CMS-2258-P-125-Attach-1.PDF

#125

Martin General HOSPITAL

310 South McCaskey Road
PO Box 1128
Williamston, N.C. 27892

Tel 252.809.6179
Fax 252.809.6263
www.martingeneral.com

March 13, 2007

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

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

Dear Ms. Norwalk:

Martin General Hospital appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule. We oppose this rule and will highlight the harm its proposed policy changes would cause to our hospital and the patients we serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how state funds 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 statue, 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 hospital 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 cost 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.

Martin General Hospital receives approximately $425,000 annually from the MRI program. This is necessary for us to fund certain programs; for example, our Women's Services which includes OB. Without this funding source we may have to close down this program of which 95% are Medicaid recipients.

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 If this devastating rule is not withdrawn, North Carolina hospitals will lose approximately $340 million immediately.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

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

Sincerely,

Kevin M. Randall, MACC, CPA
Chief Financial Officer

cc: Senator Elizabeth Dole
Senator Richard Buss

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

Organization : **Clinton County Mental Health and Addiction Service**

Category : **Local Government**

Issue Areas/Comments

GENERAL

GENERAL

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
Clinton County Director of Community Services

Submitter : Mr. B. Bradford Billings **Date:** 03/15/2007

Organization : Blessing Corporate Services, Inc.

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2258-P-127-Attach-1.PDF

#127

BLESSING
Corporate Services, Inc.

Subsidiaries
Blessing Hospital
Blessing Affiliates, Inc.
BlessingCare Corporation
The Blessing Foundation
Denman Services, Inc.

B. Bradford Billings
President / Chief Executive Officer

March 15, 2007

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

Dear Ms. Norwalk:

RE: Pending CMS Action to Limit Medicaid Payments

As the President/CEO of a three hospital health system in rural west central Illinois, I am writing you to register my concern and opposition to proposed Rule CMS-2258-P Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (Vo. 72, No. 11), January 18, 2006.

While we are not directly impacted, as we are not a public hospital, it basically means less Medicaid dollars available to the State of Illinois to serve these patients. Currently, we treat in and out-patient Medicaid clients at reimbursement rates well below our cost for providing the services. Enacting this rule would only exacerbate an already heavy burden on others who have to subsidize the Medicaid patients' care.

Our Governor is attempting to broaden access to healthcare for state residents through an ambitious new set of program initiatives. I believe his action to do so is responsible but funding has to accompany new demands on providers. It is calculated that this proposed rule will have a $623 million negative impact on Illinois Medicaid payments. The government (state and federal) cannot continue to create further utilization demands without accompanying financial resources much less a reduction in those resources.

I would ask your respectful review of this proposal in the context of the harm it will do to the 57 million Americans who rely on Medicaid.

Sincerely,

B. Bradford Billings
President/CEO

BBB/sem

cc: Maureen A. Kahn, President/CEO – Blessing Hospital (Quincy, IL)
Connie L. Schroeder, President/CEO – Illini Community Hospital (Pittsfield, IL)

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

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-128-Attach-1.DOC

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

#128

March 15, 2007

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

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

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals. The AHA opposes this proposed rule and would like to highlight the harm it would cause to our nation's 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 programs. The rule further restricts how states reimburse safety-net hospitals. In addition, CMS fails to provide data justifying the need or basis for these restrictions. This unauthorized and unwarranted shift in policy will have a detrimental impact on providers of Medicaid services, particularly safety-net hospitals, and on patient access to care.

CMS estimates the rule will cut $3.9 billion in federal funds over five years. This amounts to a budget cut for safety-net hospitals and state Medicaid programs that bypasses the congressional approval process and comes on the heels of vocal congressional opposition to the Administration's plans to regulate in this area. Last year, 300 representatives and 55 senators signed letters to Health and Human Services (HHS) Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. Recently, Congress restated its position with 226 representatives and 43

senators having signed letters to the House and Senate leadership urging them to stop this proposed rule from moving forward.

Policy changes of this magnitude must be made in a way that will ensure the health care needs of Medicaid recipients are met. Historically, whenever there has been a substantial change to Medicaid funding policy – such as prohibiting provider-related taxes and donations, modifying disproportionate share (DSH) hospital allotments, or modifying application of Medicaid upper payment limits (UPLs) – those changes have been made, or at the very least, supported by Congress. If CMS intends to make further sweeping changes to Medicaid, they should first be made by legislation, not regulation. Indeed, the Administration recognized this in its fiscal year 2006 budget submissions to Congress, where it proposed that Congress pass legislation to implement the very policy changes contained in this rule.

The AHA also is concerned that in several places in the preamble discussion, CMS describes its proposed changes as "clarifications" of existing policy, suggesting that these policies have always applied, when in fact, CMS is articulating them for the first time. By describing many changes as clarifications, CMS appears to be trying to do an "end run" around the notice-and-comment process. Any attempt to implement these proposals in a retrospective nature would violate the *Administrative Procedures Act*.

Attached to this letter is a detailed discussion of our concerns relating to:

- The cost-based reimbursement limitation and the individual provider-based UPL to be applied to government-operated providers;
- The proposed narrowing of the definition of "unit of government;"
- The proposed restrictions on intergovernmental transfers and certified public expenditures and the characterization of CMS' proposed changes as "clarifications" rather than changes in policy; and
- The absence of data or other factual support for CMS' estimate of savings under the proposed rule.

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

If you have any questions, please feel free to contact me or Molly Collins Offner, senior associate director for policy, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

The American Hospital Association's Detailed Comments on CMS-2258-P

Table of Contents

Cost Limit for Public Hospitals

The rule proposes to limit reimbursement for government-operated hospitals to the cost of providing Medicaid services to Medicaid recipients. In addition, the rule restricts states' ability to make supplemental payments to providers with financial need by setting the Medicaid UPL for government-operated hospitals at the individual facility's cost. This proposal is effectively a cut in funding for those public hospitals[1] and safety-net providers that – as CMS has recognized – are in stressed financial circumstances and are most in need of enhanced payments. These cuts will undermine the ability of states and hospitals to ensure quality of care and access to services for Medicaid beneficiaries, as well as to continue their substantial investments in health care initiatives to promote HHS' policy goals, including adoption of electronic health records, reducing disparities in care provided to minority populations, and enhancing access to primary and preventative care.

As explained below, the AHA believes that it is arbitrary and capricious to impose a cost-based limitation on hospital reimbursement and to deny states the flexibility to reward hospitals – both public and private – whose costs for services are less than the rates states might pay, for example, under a prospective payment system. Further, imposing a hospital-based UPL is contrary to the requirement of the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000* (BIPA) that CMS establish an aggregate UPL, and it will create an unwarranted burden on providers and states.

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. The AHA is very concerned that in CMS' zeal to reduce federal Medicaid spending, important costs, such as graduate medical education, physician on-call services or clinic services, would not be recognized and therefore would no longer be reimbursed. The AHA is further concerned that the Administration plans to eliminate all federal funding for Medicaid graduate medical education as outlined in the president's fiscal year 2008 proposed budget. Congress should have the opportunity to review any change to the Medicaid program's support for graduate medical education, and we urge CMS not to move forward with any proposed rule that would implement the president's budget proposal.

Cost Limit

In the preamble to the proposed rule, CMS says that it does not find Medicaid payments in excess of cost to government-operated health care providers to be consistent "with the statutory principles of economy and efficiency as required by section 1902(a)(30)(A)" of the *Social Security Act* (the "Act"). If CMS' goal is to assure that Medicaid payments are consistent with economy and efficiency, then there is no basis for imposing a cost-based reimbursement system to only government-operated hospitals. The AHA, however, opposes limiting any individual hospital's reimbursement to 100 percent of costs.

In the Regulatory Impact Analysis of its January 2001 final rule modifying the Medicaid UPL, CMS concluded:

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[1] Although the AHA confines its comments to hospitals, it recognizes the broader implications of the proposed rule for non-hospital providers of Medicaid services.

> While a facility-specific limitation may be the most effective method to ensure state service payments are consistent with economy and efficiency, when balanced against the additional administrative requirements on states and HCFA, coupled with congressional intent for states to have flexibility in rate setting, *we are not sure that the increased amount of cost efficiency, if any, justifies this approach as a viable option.*

66 Fed. Reg. 3148, 3174 (Jan. 12, 2001) (emphasis added).

In the preamble to its January 18, 2002 final rule removing the 150 percent UPL for hospital services furnished by non-state, government-owned or -operated hospitals, CMS stated that the revised UPL of 100 percent for non-state government providers "will assure that payments will be consistent with 'efficiency, economy and quality of care' as required by section 1902(a)(30)(A) of the *Social Security Act*." 67 Fed. Reg. 2602, 2608 (Jan. 18, 2002).

CMS does not provide any explanation in the proposed rule why the 100 percent aggregate UPL is now insufficient to meet the efficiency and economy requirements of section 1902(a)(30)(A) and must be replaced with a UPL based on each individual provider's costs and a cost-based reimbursement limit. As CMS is aware, Congress moved away from cost-based reimbursement under Medicaid when it adopted the so-called "Boren Amendment" in 1980. 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.

CMS says that it has examined state Medicaid financing arrangements and found that "many" states are making supplemental payments to government-operated providers in excess of cost, and that this excess payment is used to subsidize health care operations unrelated to Medicaid, or is returned to the state as a source of revenue. The agency provides no data or factual support for how many states are making such "excess payments" nor any specific information regarding how providers in these states are using these excess payments. Moreover, as CMS has repeatedly recognized, the aggregate UPL system affords states the flexibility to tailor reimbursement policy to meet local needs by making supplemental payments to particular hospitals in financial stress.

In a brief filed in federal court litigation over the 2002 UPL rule[2] (the "UPL Brief"), CMS described the "concept" behind the UPL as being able "to set aggregate payment amounts for specifically-defined categories of health care providers and specifically-defined groups of providers, but leave the states considerable flexibility to allocate payment rates within those categories and groupings." UPL Brief, page 9. In the preamble to the 2002 final rule, CMS stated that, under the 100 percent UPL, "states also retain some flexibility to make enhanced payments to selected public hospitals under the aggregate limit." 67 Fed. Reg. at 2603. CMS

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[2] Defendant's Memorandum in Support of His Motion for Summary Judgment and in Opposition to Plaintiffs' Motion for a Permanent Injunction, *Ashley County Medical Center v. Thompson*, 205 F. Supp. 2d 1026 (E.D. Ark.) (No. 4:02CV00127).

reiterated this position on pages 3-4 of the UPL Brief, stating that "[t]he new rules leave states considerable flexibility to direct higher Medicaid payments to particular hospitals that may be in stressed financial circumstances."

CMS also has expressly recognized the potential financial implications of limiting reimbursement to an individual provider's costs, and the importance of the aggregate UPL system for preserving access to Medicaid services, particularly with regard to safety-net hospitals. In the UPL Brief on page 39, CMS pointed out that "the upper payment limit is an aggregate limit for all institutions in the category of non-state public hospitals, not an individual limit for each hospital." Responding to the allegation that several public hospitals in Arkansas would be jeopardized by the 100 percent UPL, CMS reasoned that

> the state could increase payments for those particular hospitals and decrease payment levels at other county and local hospitals (perhaps in more affluent parts of the state) where the low-income patient load was less heavy. . . There is no reason to merely suppose that state governments will be indifferent to the special needs of particular urban or rural hospitals in deciding how aggregate Medicaid payments will be allocated among non-state public hospitals. An equal and across-the-board reduction in Medicaid payments for county and local hospitals – the assumption on which all of plaintiffs' fiscal speculations are apparently premised – is neither mandated nor even contemplated by the 100 percent rule.

Id. at 39-40 (emphasis in original).

CMS is now mandating just such an "across-the-board reduction," disregarding without explanation its prior statements regarding the importance of the flexibility allowed states under the UPL system to make enhanced payments to hospitals in special need. This policy change will penalize states and providers that have never utilized abusive or inappropriate funding mechanisms by denying those states the ability to pay public hospitals more than 100 percent of costs. Moreover, CMS has not provided clear direction in the proposed rule as to which costs CMS will permit states to reimburse.

CMS' proposal will directly harm the ability of states to meet their statutory obligation to ensure access to care for Medicaid beneficiaries. Under section 1902(a)(30)(A) of the Act, states must assure that Medicaid payments "are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." By prohibiting states from reimbursing a provider for more than costs, and restricting states from making enhanced payments to providers in financial need, CMS is imposing a funding restriction that will ultimately be passed on from the states to government providers. To the extent that these cuts in funding will lead to a curtailment in beneficiary care and services, it is the states – and not CMS – that will be subject to challenge or complaint by beneficiary advocates and to witnessing their citizens' care compromised.

DIFFERENTIAL TREATMENT OF PUBLIC AND PRIVATE HOSPITALS

Under CMS' proposal, the cost-based limit on reimbursement and the individual provider-based UPL, will apply only to government-operated providers. States will continue to be able to make Medicaid payments to private hospitals that exceed costs, and private hospitals will continue to be reimbursed under an aggregated UPL. If, as CMS suggests, its policy is consistent with the requirements of economy and efficiency under section 1902(a)(30)(A) of the Act, there is no rational basis for distinguishing between public and private hospitals. Requiring differential treatment of public and private Medicaid hospitals also is inconsistent with the equal protection clause of the Constitution, as well as CMS' own repeated statements regarding the importance of payment equality for all categories of Medicaid hospitals.

As discussed above, CMS' rationale for proposing a cost limitation on reimbursement for government-operated providers is the requirement of economy and efficiency in section 1902(a)(30)(A) of the Act. CMS does not provide any explanation of why subjecting public, but not private, hospitals to a cost limitation is economic and efficient. To the contrary, CMS has repeatedly emphasized the importance of payment equality among categories of Medicaid providers. Restoring such "payment equity" was one of the Secretary's stated rationales for implementing the 100 percent UPL in the 2002 final rule. CMS agreed with the statement of commenters to the 2002 final rule that "one group of providers should not have a financial benefit over another group of providers who provide the same type of services." 67 Fed. Reg. at 2604. CMS went on to explain that its intent in the rule was "to treat all facilities equally, and apply the same aggregate UPL to each group of facilities, regardless of who owns or operates the facilities." Id. This notion of payment equity across groups of Medicaid providers is repeated throughout the preamble to the 2002 final rule,[3] and the "equity rationale" was highlighted in CMS' 2002 UPL Brief as "standing alone . . . sufficient to sustain the 100 percent rule against a claim that it is arbitrary and capricious, in violation of the Administrative Procedures Act." CMS provides no explanation for how it is now consistent with economy and efficiency to reverse its stance on the importance of payment equity by imposing a discriminatory and unfair reimbursement limit on government-operated providers. There is no rational basis for a policy that prevents public Medicaid providers from availing themselves of the same benefits afforded private Medicaid providers, and it is contrary to the equal protection afforded under the Constitution. Moreover, the AHA opposes limiting any individual hospital's Medicaid reimbursement to 100 percent of costs.

REQUIREMENTS OF THE MEDICARE, MEDICAID AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000

Section 705(a) of BIPA required CMS to issue a final regulation modifying the UPL test applied to state Medicaid spending "by applying an *aggregate* upper payment limit to

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[3] *See, e.g.*, 67 Fed. Reg. at 2604 ("this rule is critical for maintaining the fiscal integrity of the Medicaid program and ensuring that all facilities are treated equally under Federal Medicaid UPL regulations"); *id.* at 2605 ("We believe the reduction of the UPL from 150 percent to 100 percent will be sufficient to maintain the fiscal integrity of the Medicaid program and ensure that all facilities are treated equally under the Federal Medicaid UPL regulations").

payments made to government facilities that are not state-owned or -operated facilities." (Emphasis added.) Section 701(a)(3) of BIPA, which addressed modifications to DSH payments, used the same language in describing the final regulation required under section 705(a), as "relating to the application of an *aggregate* upper payment limit test for state Medicaid spending . . . [for services] provided by government facilities that are not state-owned or -operated facilities." (Emphasis added.) Congress explicitly contemplated that CMS' final regulation regarding UPLs would apply an aggregate limit. CMS' proposed rule, which removes the aggregate UPL and imposes a limit based on the individual provider's costs, is precluded by the clear statement in BIPA that UPLs be based on an aggregate limit for each provider class.

PROPOSED DEFINITION OF "UNIT OF GOVERNMENT"

CMS proposes to define the term "unit of government" by reference to a provision of the Medicaid statute that defines the distinct and more narrow term "unit of *local* government." Both of these terms are used in the subsection of the statute regarding provider donations and taxes, but by picking and choosing which provisions it will apply, CMS has ignored both the statutory framework and purposes of these distinct terms. Moreover, even if the statutory definition of "unit of local government" were applicable to CMS' proposal, it cannot reasonably be read to have the narrow meaning that CMS sets forth in the proposed rule.

CMS proposes to add new language to its rules governing state financial participation in Medicaid. Specifically, CMS proposes to define a unit of government to "conform" with the definition of "unit of local government" in the provider tax and donations provisions of the Medicaid statute (1903(w)(7)(G)). Under the proposed rule, only those entities that meet CMS' new definition of "unit of government" will be permitted to fund the state's share of Medicaid expenditures. CMS inappropriately limits its definition of "unit of local government" to entities with "generally applicable taxing authority." There is no basis for this restriction in the Medicaid statute. CMS' proposed definition ignores the principles of federalism that afford states discretion in structuring their political subdivisions and will impose substantial harm on public hospitals. We urge CMS not to finalize this proposal.

In the rule, CMS proposes to use Congress' definition for a unit of *local* government as the basis for its proposed definition of the broader term "unit of government." Section 1903(w)(7)(G) of the Act defines the term "unit of local government." This term is used in subsection 1903(w)(1)(A) of the Act, which reduces the federal contribution to Medicaid by revenues received by states or units of local government from certain provider donations or health care-related taxes. The proposed rule has no connection to this subsection. Rather, CMS is using the definition of unit of local government to define a different, broader term – "unit of government" – which is the term used in the subsection 1903(w)(6)(A) of the Act restricting CMS' authority to regulate intergovernmental transfers (IGTs).

CMS' reliance on the definition of unit of local government is misplaced. "Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the

disparate inclusion or exclusion."[4] Congress used the narrower term "unit of *local* government" to define those government entities subject to the prohibition on provider donations and taxes (1903(w)(1)(A)), but recognized that other government entities may permissibly make IGTs, and thus purposely used the broader and different term "unit of government" in the IGT section of the statute (1903(w)(6)(A)).

Not only is CMS basing its proposal on the wrong statutory definition, it has narrowed the definition in a way that is incompatible with the terms of the statute. Section 1903(w)(7) (G) defines a unit of local government to mean, "a city, county, special purpose district, or other governmental unit in the state." The proposed rule, by comparison, limits the definition of a unit of government to those entities that have "generally applicable taxing authority." It further states that 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:
> - The health care provider has generally applicable taxing authority; or
> - The health care provider is able to access funding as an integral part of a 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.

CMS states in its preamble discussion that the proposed provisions are modified "to be consistent" with the statute. The AHA respectfully disagrees with this characterization. The definition of "unit of government" in section 1903(w)(7)(G) does not include the words "generally applicable taxing authority" nor any of the other restrictive language that CMS proposes. Instead, Congress defined the term in a way that affords deference to the states' right to structure their own governmental subdivisions, in accordance with the constitutional principles of federalism. Rather than "conforming" the regulation to this statutory definition, CMS narrows it in a manner that is not authorized by the plain text of the statute and intrudes upon the traditional authority of the states.

The deference that Congress provided to states under its definition of unit of local government is reinforced by section 1903(d)(1) of the Act, which requires the Secretary to estimate the amount of the federal Medicaid payment based on the state's reported estimate of Medicaid expenditures for the quarter and the amount "appropriated or made available by the state and its political subdivisions for such expenditures in such quarter." There is no limitation in section 1903(d)(1) on which political subdivisions may make funding available for Medicaid expenditures, and certainly no requirement that such subdivisions have "generally applicable taxing authority."

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[4] *Russello v. United States*, 464 U.S. 16, 23 (1983) (quoting *United States v. Wong Kim Bo*, 472 F. 2d 720, 722 (5th Cir. 1972). "[C]ourts must presume that a legislature says in a statute what it means and means in a statute what it says there." *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992).

CMS' restrictive definition will have significant practical implications for public hospitals, particularly those that have restructured to achieve gains in efficiency. For example, the University of Colorado Hospital Authority was established as a quasi-governmental and corporate entity based on a finding by the Colorado General Assembly that the University of Colorado University Hospital Authority was "unable to become and remain economically viable due to constraints imposed by being subject to various kinds of government policy and regulation." Colo. Rev. Stat. § 23-21-501(1)(d). In a February 20 letter to Colorado Gov. Bill Ritter, University of Colorado Hospital President and CEO Bruce Schroffel stated that the University of Colorado Hospital could lose $30 million in funding a year because it would not meet CMS' restrictive new definition of "unit of government" and would be unable to generate certified public expenditures (CPEs). Similarly, in a March 14 letter to CMS Acting Administrator Leslie Norwalk, the California Hospital Association Disproportionate Share Task Force noted that the University of California's medical centers and Alameda County (CA) Medical Center may be at risk of losing essential funding because they would appear not to meet CMS' stringent proposed definition.

LIMITATIONS ON INTERGOVERNMENTAL TRANSFERS AND CERTIFIED PUBLIC EXPENDITURES

CMS' proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through IGTs and CPEs, including limiting the source of IGTs to funds generated from tax revenue. The AHA believes these proposed restrictions directly conflict with the purpose and plain language of the Medicaid statute. In 1991, Congress identified certain provider donations and provider-related taxes as an inappropriate means of funding the non-federal share of Medicaid payments and restricted the use of these financing mechanisms. In doing so, however, Congress included a specific provision in section 1903(w)(6)(A) of the Act to make clear that these restrictions would not affect the use of IGTs. CMS is now using this provision, which was intended to limit the Secretary's authority to regulate IGTs derived from state or local taxes, as the basis for a new requirement that *all* IGTs must be made from state or local taxes.

In the proposed rule's preamble, CMS states that it has systematically eliminated inappropriate financing arrangements, such as recycling mechanisms, through the state plan amendment process. If these abusive practices have been addressed, it is unclear why CMS is proposing an unauthorized restriction on the source of IGTs. This proposal is inconsistent with Medicaid law and historic CMS policy.

RESTRICTIONS ON IGTS

Under the proposed rule, only entities that meet CMS' restrictive new definition of "unit of government" are permitted to make IGTs. As discussed above, CMS says that it has based this definition on section 1903(w)(7)(G) of the Act, which defines a unit of *local* government, not a "unit of government." Additionally, in the preamble to the proposed rule, CMS claims that, "generally," for the state to receive the federal match where a government-operated heath care provider has transferred the non-federal share, the state must demonstrate "(1)

[t]hat the source of the transferred funds is state or local tax revenue (which must be supported by consistent treatment on the provider's financial records); and (2) that the provider retains the full Medicaid payment and is not required to repay, or in fact does not repay, all or any portion of the Medicaid payment to the state or local tax revenue account." This fundamental change in IGT policy appears to be discussed only in the preamble and is not addressed in the text of the proposed regulations. The use of the term "clarify" suggests that CMS views the fundamental changes it is proposing as merely clarifications of existing Medicaid funding policy. However, CMS is articulating for the first time a substantial shift in Medicaid policy. The proposed changes go far beyond mere clarifications and, as a result, any attempt to implement them on a retrospective basis would be contrary to the notice and comment requirements of the *Administrative Procedure Act.*

As noted above, CMS claims that the basis for these new limitations on the use of IGTs is the agency's intent "to conform" its regulatory language to section 1903(w)(6)(A) of the Act, which sets forth an exception from restrictions on provider-related donations and taxes. Rather than "conforming" the proposed rule to this statutory exception, CMS does the opposite. Congress included this statutory exception to permit states to continue using state or local taxes to make IGTs. It did not authorize CMS to require states to only use state or local taxes to make IGTs, nor did it preclude the use of other sources of funds, such as patient care revenues.

Section 1903(w)(6)(A) is not the only place where Congress made clear that the state share of Medicaid payments could come from local sources other than local tax revenue. Section 1902(a)(2) of the Act permits up to 60 percent of the state's share of financial participation to come from "local sources," without restriction. If Congress had wanted to limit state financial participation to funding from state or local tax revenue, it would have included that requirement explicitly.

CMS itself has acknowledged that it has limited authority to regulate IGTs. In the 2002 final rule, CMS stated that, "[u]nder section 1903(w)(6)(A) of the Social Security Act, the Congress limited [CMS'] authority to regulate states' certain uses of IGTs." 67 Fed. Reg. at 2606. CMS stated further, in response to a comment that public hospitals be required to have a net gain of at least two-thirds of additional federal funds collected under hospital-based UPL plans, "[i]t is not clear what the commenter believes would be the legal authority for CMS to limit a hospital's use of its own funds." Id. at 2605. Moreover, although CMS "gave consideration to formulating a policy with respect to" IGTs in the Regulatory Impact Analysis of its 2001 final rule, CMS said that it "did not pursue this alternative because we recognize that states, counties, and cities have developed their own unique arrangements for sharing in Medicaid costs. Furthermore, there are statutory limitations placed on the Secretary which limit the authority to place restrictions on IGTs." 66 Fed. Reg. at 3175. Now, contrary to these prior statements, CMS is inappropriately construing the same statutory terms to impose restrictions on states that Congress did not authorize or intend.

RESTRICTIONS ON CPES

The AHA is troubled by CMS' new standards for generating and documenting CPEs and is concerned about the administrative burden on both hospitals and states. CMS proposes new standards for the documentation of CPEs that are used to fund the non-federal share of

expenditures. The government entity will be required to submit to the state Medicaid agency a certification statement including an attestation regarding compliance with the Medicaid state plan and the Medicaid regulations. The certification must be submitted by the state to CMS as the basis for the state claim for federal funds within two years of the date of the expenditure. In addition, CMS states that a public provider may generate a CPE from its own costs only if the state plan contains an actual cost reimbursement methodology.

Under the proposed rule, in order for the states to develop interim payment rates for providers that are paid using a cost reimbursement methodology funded by CPEs, the state must undertake two separate reconciliations. Additionally, while generating little real benefit, the new documentation standards are likely to result in substantial administrative burden on hospitals and may even subject Medicaid providers to unwarranted allegations of *False Claims Act* violations. AHA members take seriously their obligations to report Medicaid expenditures properly, and CMS can ensure the accuracy of Medicaid claims without imposing this burdensome certification requirement.

INSUFFICIENT DATA TO SUPPORT CMS' ESTIMATE OF SPENDING CUTS

The proposed rule is subject to the arbitrary and capricious standard of review under the *Administrative Procedure Act*. Before a rule is finalized, an agency "must examine the relevant data and articulate a satisfactory explanation for its action including 'a rational connection between the facts found and the choice made.'"[5] CMS says that the proposed rule is estimated to result in $3.87 billion in savings over five years, but does not provide any relevant data or facts to support this conclusion. The basis for this estimate appears to be that CMS has "examined Medicaid state financing arrangements across the country" and, in doing so, has "identified numerous instances in which state financing practices do not comport with the Medicaid statute." CMS does not indicate what these financing practices might be or how many states are currently employing them. Moreover, CMS expressly says that it has systematically required states to eliminate problematic financing arrangements through the state plan amendment process. This raises further questions about the estimated savings and casts doubt on the rational upon which CMS has based these sweeping policy changes to how states finance their share of Medicaid and how states reimburse their public providers.

---

5 *Ashley County Medical Center v. Thompson*, 205 F. Supp. 2d 1026, 1048 (E.D. Ark. 2002)

Submitter : Mrs. LouEllen Strong **Date:** 03/15/2007

Organization : The Arc of Iroquois County

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attached

#129

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

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

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

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

Organization :

Category : **Psychiatric Hospital**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See attachment

CMS-2258-P-130-Attach-1.TXT

CMS-2258-P-130-Attach-2.DOC

#130

My name is Larry Ulrich, and I represent Four County Counseling Center, a community mental health organization in the State of Indiana. I am writing to comment on two specific ways the proposed regulation CMS 2258-P will impact the Medicaid Behavioral Health System in a number of states.

Cost Limit Provisions in States with At-Risk Provider Contracts

A large number of county governments provide substantial amounts of Medicaid Behavioral Health Services under 1915(b), 1915(c) or 1115 waivers across the country. In many cases the counties are the critical safety net provider, treating the most seriously disabled Medicaid enrollees in their communities.
In many of these systems, the Medicaid health plans use risk-bearing payment mechanisms where counties are sub-capitated or case rated for all or a portion of the Medicaid enrollees. Under these financial arrangements the counties are responsible for meeting the behavioral health needs of enrollees regardless of whether sufficient sub-capitation revenue is available in a given year.

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

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

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

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

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

Intergovernmental Transfers in States with Government-Organized Health Plans

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

In reviewing the proposed regulation, specifically pages 22 – 23, it appears that the intergovernmental agreements that set up the Medicaid Health Plans do not meet the definition of a "unit of government" because the plans were not given taxing authority and the counties

have not been given legal obligation for the plan's debts. Thus, it appears that the regulation would render the flow of local dollars, the purpose of which is to supply Medicaid match, unallowed match, simply because of the chain of custody of those dollars.

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

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

Organization : Clackamas County Department of Human Services

Category : Local Government

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

#131

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

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

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

Submitter : **Mr. Greg Gombar** **Date: 03/15/2007**

Organization : **Carolinas Medical Center**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-132-Attach-1.PDF

CMS-2258-P-132-Attach-2.PDF

CMS-2258-P-132-Attach-3.PDF

#132

Carolinas 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:

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

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

Although there are many troublesome aspects of the proposed regulation, the provision that will have the most detrimental effect in North Carolina is the proposed definition of "unit of government." Our understanding is that all of these 43 public

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

Yet, under CMS's proposed new definition requiring all units of government to have generally applicable taxing authority or to be an integral part of an entity that has generally applicable taxing authority, virtually none of these truly public hospitals will be able to certify their expenditures. In fact, CMC, which is a division of the Charlotte Mecklenburg Hospital Authority, which was organized in 1943 under the North Carolina Hospital Authorities Act, and is a public body would not be a public hospital under CMS's very narrow definition. Imposing a definition that is so radically different and has the effect of wiping out entire valuable programs that are otherwise fully consistent with all of the Medicaid statutes is unreasonable and objectionable. CMC respectfully requests that CMS reconsider its position on the definition of unit of government and defer to applicable State law.

If CMS elects to go forward with the proposed regulation and with the proposed new definition of unit of government, it is absolutely critical that the effective date be extended significantly to allow for a reasonable organized response by the State of NC and the participating hospitals. CMC believes that the consequences of allowing anything less than two full years before the rule takes effect will be catastrophic. Having September 1, 2007, as an effective date basically cuts the knees off of the NC program and does not allow adequate time to obtain other funding. North Carolina's indigent patients, the hospitals that provide care for these patients, the State Legislature and the State Agency responsible for the Medicaid program need time to adequately prepare, because the new regulations totally eliminate what has always been considered to be a legal and legitimate means for providing the Non-federal share of certain enhanced Medicaid payments and DSH payments to the State's safety net hospitals. Ironically, CMS has approved on multiple occasions the NC SPA definition of a public hospital, going back to 1996 and as recently as the current SPA, and now they choose to do a 180 degree reversal and disallow as public virtually all hospitals they had approved as public for the last 10 years. At least two years is necessary for the affected stakeholders to try to mitigate the detrimental impact of the changes.

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

Respectfully submitted,

Greg A. Gombar
Executive Vice President
Administrative Services-CFO

GAG:sd

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

Submitter : Ms. Colleen Scanlon **Date:** 03/15/2007

Organization : Catholic Health Initiatives

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comment letter from Catholic Health Initiatives.

CMS-2258-P-133-Attach-1.DOC

#133

CATHOLIC HEALTH INITIATIVES®

A spirit of innovation, a legacy of care.

1999 Broadway
Suite 2600
Denver, CO
80202

Phone 303.298.9100
Fax 303.298.9690

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:

Catholic Health Initiatives appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. CHI is a faith-based, mission-driven health system that includes 71 hospitals, 42 long-term care, assisted-living and residential units, and two community health service organizations in 19 states. **We oppose this rule.**

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

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

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

Sincerely,

Colleen Scanlon, RN, JD
Senior Vice President Advocacy

Submitter : Mr. Dennis Phillips **Date:** 03/15/2007

Organization : Carolinas Rehabilitation

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-134-Attach-1.PDF

#134

Carolinas Rehabilitation

March 15, 2007

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

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

Dear Ms. Norwalk:

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

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

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

Although there are many troublesome aspects of the proposed regulation, the provision that will have the most detrimental effect to the Carolinas Rehabilitation hospital is the proposed definition of "unit of government." and Non-Public hospitals. Over 40 of North Carolina public hospitals have been participating in Medicaid programs as public hospitals for over a decade with the full knowledge and approval of CMS. Yet, under the proposed new definition requiring all units of government to have generally applicable taxing authority or to be an integral part of an entity that has generally applicable taxing authority, virtually none of these truly public hospitals will be able to certify their expenditures. Imposing a definition that is so radically different and has the effect wiping out entire valuable programs that are otherwise fully consistent with all of the Medicaid statutes is unreasonable and objectionable. Carolinas Rehabilitation hospital respectfully requests that CMS reconsider its position on the definition of unit of government and defer to applicable State law. This narrow definition basically eliminates all public hospitals in the country as so few have taxing authority since most public hospital boards are to elected by the electorate.

If CMS elects to go forward with the proposed regulation and with the proposed new definition of unit of government, it is absolutely critical that the effective date be extended significantly beyond the September 1, 2007 date to allow for a reasonable organized response by the State and participating hospitals. North Carolina's indigent patients, the hospitals that provide care for these patients, the State Legislature and the State Agency responsible for the Medicaid program need time to adequately prepare, because the new regulations totally eliminate what has always been considered to be a legal and legitimate means for providing the Non-federal share of certain enhanced Medicaid payments and DSH payments to the State's safety net hospitals. **A minimum of least two years is necessary for the affected stakeholders to try to mitigate the detrimental impact of the changes.** It is our understanding that CMS has set precedent for 3+ years transitions in the past for significant changes such as the UPL change for Pennsylvania Nursing homes several years ago. Why then, should this rule have a less than one year period for hospitals and states to adjust? This is not only unfair, but it is unrealistic for us to make much significant adjustments in the provision of care due to the dramatic reductions in payment that will occur.

Carolinas Rehabilitation hospital urges CMS to withdraw its proposed regulation, or in the alternative revise it substantially by among other things adopting applicable state law to define the public hospitals (or units of government). If the regulation is not withdrawn or adequately revised, Carolinas Rehabilitation hospital urges CMS to adopt a more reasonable implementation schedule that allows for at least two full years but preferably 3-5 years before the changes take effect. Thank you for your consideration.

Respectfully Submitted,

Dennis Phillips, President
Carolinas Medical Centers-Charlotte

DP:sd

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

Submitter : Mr. Paul Franz **Date:** 03/15/2007

Organization : Carolinas Medical Center - University

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-135-Attach-1.PDF

#135

Carolinas Medical Center University

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:

Carolinas Medical Center-University strongly opposes the radical change in the above rule especially the proposed definition of a public hospital. Requiring all units of government to have general taxing authority when for over 10 years CMS approved the NC definition of a public hospital is unfair and a complete change in CMS policy. North Carolina hospitals should not be expected to be able to adjust to this change by September 1, 2007, the effective date of the rule.

Carolinas Medical Center-University requests CMS to withdraw this proposal regulation or provide a definition more consistent with what the agency has approved for North Carolina for the last 10 years. If this is not done, Carolinas Medical Center-University asks for a more reasonable effective date than September 1, 2007. North Carolina will need at least 18 to 24 months from June 30 to find alternatives to fund the North Carolina Medicaid program.

Respectfully submitted,

Paul S. Franz
Executive Vice President
Operations

PF:sd

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

Submitter : Mrs. Phyllis Wingate-Jones **Date:** 03/15/2007

Organization : Carolinas Medical Center-Mercy

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-136-Attach-1.PDF

#136

Carolinas Medical Center
Mercy

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:

Carolinas Medical Center-Mercy opposes the change in the above rule and especially the proposed definition of a public hospital. Requiring all units of government to have general taxing authority is inconsistent with the CMS approved NC definition of a public hospital that has been in place for several years. North Carolina hospitals should not be expected to be able to adjust to this change by September 1, 2007, the effective date of the rule.

Carolinas Medical Center-Mercy requests CMS to withdraw this proposal regulation or provide a definition more consistent with what the agency has approved for North Carolina for the last 10 years. If this is not done, Carolinas Medical Center-Mercy asks for a more reasonable effective date than September 1, 2007. North Carolina will need at least 2 years to find alternatives to fund the North Carolina Medicaid program.

Respectfully submitted,

Phyllis Wingate-Jones
Senior Vice President

Operations

PWJ:sd

Cc: Senator Elizabeth Dole
Senator Richard Burr
Congresswoman Sue Myrick

Submitter : Ms. Roger Schwartz **Date:** 03/15/2007

Organization : National Association of Community Health Centers

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-137-Attach-1.PDF

#137

National Association of Community Health Centers, Inc.

March 15, 2007

[*If by electronic means]*
http://www.cms.hhs.gov/eRulemaking

[*If by overnight or express mail*]
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2258-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, M.D. 21244-1850

[*If by hand or courier]*
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2258-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership [File Code CMS-2258-P]

To Whom It May Concern:

The National Association of Community Health Centers, Inc. ("NACHC") is pleased to respond to the above-cited solicitation from the Department of Health and Human Services ("DHHS") Centers for Medicare & Medicaid Services ("CMS") for comments on the proposed rules related to the non-Federal share of Medicaid payments published at 72 Fed. Reg. 2236 (Jan. 18, 2007).

NACHC is the national membership organization for federally supported and federally recognized health centers (hereinafter interchangeably r eferred to as " health centers" or "FQHCs") throughout the country, and is an Internal Revenue Code Section 501(c)(3) organization.

MAIN OFFICE
7200 Wisconsin Ave, Suite 210
Bethesda, MD 20814
301-347-0400
301-347-0459 fax

FEDERAL AND STATE AFFAIRS OFFICE
1400 Eye Street NW, Suite 330
Washington, DC 20005
202-296-3800
202-296-3526 fax

I. Background

There are, at present, more than 1000 FQHCs nationwide. Most of these FQHCs receive Federal grants under Section 330 of the Public Health Service Act (42 U.S.C. §254b) from the Bureau of Primary Health Care ("BPHC"), within the Health Resources and Services Administration ("HRSA") of DHHS. Under this authority, health centers fall into four general categories: (1) those centers serving medically underserved areas (invariably poor communities), (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farm worker populations within similar community or geographic areas, and (4) those serving residents of public housing. Except for a limited number of public health centers (*i.e.*, health centers operated by local governmental units such as health departments), each health center is a charitable, nonprofit, tax-exempt IRC Section 501(c)(3) corporation formed under the laws of the particular state in which it operates. Although there are some slight differences in the grant requirements for each of these four program types, for all intents and purposes, the ways in which these health centers operate are identical.

To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center's board of directors must be composed of at least fifty-one percent (51%) users of the health center, and the health center must offer services to all persons in its catchment area, regardless of their ability to pay or insurance status.

BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients from eligible communities[1] who are not indigent and able to pay or who have insurance, whether public or private, are expected to pay for the services rendered. Approximately 35.7% of the patients served by health centers are Medicaid recipients, approximately 7.5% are Medicare beneficiaries, and approximately 40.1% are uninsured.

II. Comments on the Proposed Rule

A. General Comments

NACHC recognizes that CMS is obliged to protect the integrity of the Medicaid program and to address perceived abuses. However, we urge CMS to withdraw this proposed rule for two reasons. First, as explained in further detail below, the proposed rule impermissibly conflicts with the underlying federal statute, in which Congress forbade the federal government from restricting how States use their funds and

[1] The term "community" in this context refers to either a geographic area or the specific population toward which the program is aimed.

legitimized the practice of claiming funds transferred from governmental entities, including health care providers, as part of their non-federal share of expenditures.

Second, NACHC believes that CMS has underestimated substantially the adverse impact this proposed rule will have on the ability of safety net providers--such as health centers--to provide critical health care services to thousands and thousands of uninsured poor in this country. This impact will be felt by health centers in a number of ways: some health centers are parts of units of government that may not have taxing authority, others are public entity health centers (without taxing authority) that have contractual arrangements with such units of government or with their state Medicaid agency, others receive funding from their state uncompensated care fund, and all will feel the effect of cutbacks in Medicaid services and eligibles as states attempt to recover from the financial impact of these rules. Indeed, on a broader level, we believe the proposed rule has the potential to undercut publicly supported metropolitan and rural healthcare systems that play a key role in responding to the crises this country currently faces in the increasing numbers of low-income individuals who are uninsured and/or who lack access to health care services.

B. Defining a Unit of Government (§ 433.50)

The proposed rule would limit the State's share in claiming Federal Financial Participation ("FFP") to funds from "units of government", which the proposed rule has defined as "a State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority." 72 Fed. Reg. at 2246. This definition contradicts the statutory scheme established by Congress for units of government. As noted in the preamble to the proposed rule, Congress created an exemption for units of government at Section 1903(w)(6)(A) of the Social Security Act ("Act") when it significantly reduced States' use of provider related taxes and donations to fund the non-Federal share of Medicaid payments. 72 Fed. Reg. at 2237. That provision states:

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

42 U.S.C. § 1396b(w)(6)(A)(emphasis added).

In contravention to this statutory language, the proposed rule would restrict States' use of funds by narrowing the category of funds which may satisfy the non-Federal share of Medicaid payments. The federal statute defines "unit of government" as

"a city, county, special purpose district, or other governmental unit in the State". 42 U.S.C. § 1396b(w)(7)(G). The proposed rule, in contrast, requires units of government to have taxing authority. Because not all units of government have taxing authority—some merely are subject to governmental administration or control—the proposed rule disqualifies a class of funds that Congress had permitted States to use as the State share. In so doing, the proposed rule departs from the clear language of Congress, is arbitrary and capricious, and is unlikely to withstand a *Chevron* analysis.[2]

Moreover, CMS misstates its statutory authority. In its preamble to the proposed regulation, CMS states that "the Medicaid statute provides that units of government within a State may transfer State and/or local tax revenue to the Medicaid agency for use as the non-Federal share of Medicaid payments." 72 Fed. Reg. 2238. Instead, the statute provides that such funds be "***derived*** from State or local taxes". U.S.C. § 1396b(w)(6)(A) (emphasis added). Under a standard dictionary definition, "derive" means "obtain or issue from a source".[3] Consequently, federal law allows units of government to transfer any funds that can be traced to tax revenues. This means that units of government do not need to have their own taxing authority; they can transfer funds from other government units which have taxing authority.

Similarly, under the proposed rule, government health care providers would be considered as units of government only when they have generally applicable taxing authority or are "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." *Id.* This definition also conflicts with Congressional language to allow States to use funds from government health care providers—regardless of whether those providers have taxing authority—to satisfy the State share.

When it sanctioned these practices in 1999, Congress must have recognized that not all government health care providers had taxing authority. Indeed, many government healthcare entities were then, and are now, separately incorporated entities or operated under contract to a unit of government. What makes these providers different from other providers—and explains why Congress exempted them from the general prohibition of provider donations—is that these providers are under the administrative control or operation of a unit of government and exist solely to serve an inherently public purpose.

For example, in Illinois, certain health centers operate under a "public entity" model, in which they are operated within state or local government. There is no typical model and each utilizes a different governance structure. These health centers have contractual arrangements with the state Medicaid agency to certify expenditures above reimbursement for purposes of securing federal matching contributions which are given back to the health center. These health centers do not have taxing authority and therefore would not meet the new definition of "unit of government". Consequently, under the

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[2] *Chevron USA, Inc. v. Natural Resources Defense Council,* 467 U.S. 837, 837 (1984).
[3] American Heritage Dictionary, 2nd College Ed. (1983).

proposed rule, the health centers could lose hundreds of thousands of dollars in federal resources that further the public entity's mission of providing health care to indigent populations.

Because proposed 42 C.F.R. § 433.50 is inconsistent with applicable federal law and would cause substantial harm to patients who access health care through safety net providers, including health centers, we strongly urge CMS to withdraw this proposed regulation.

Retention of Payments (§ 447.207)

The proposed rule would require that all providers retain the full amount of Medicaid payments provided to them for services. Aside from the constitutional implications under the takings clause of the U.S. Constitution[4] that would result if private health care providers could not freely transfer their payments from Medicaid (*i.e.*, use those payments to pay the provider's own expenses), this overly broad regulation clearly conflicts with the statutory exception in Section 1903(w)(6)(A) of the Act for government health care providers:

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

42 U.S.C. § 1396b(w)(6)(A)(emphasis added).

The proposed rule would be unlikely to survive judicial scrutiny because it renders the italicized language meaningless. There is no reason for Congress to have inserted the phrase "regardless of whether the unit of government is also a health care provider" unless it had intended to continue to allow government health care providers to refund Medicaid payments—which are derived from State taxes—to the State. While it is true that these refunds have allowed some States to pay for costs that were outside the Medicaid program, this financing mechanism was expressly permitted by Congress under Section 1903(w)(6)(A) of the Act for these government health care providers.

Furthermore, these funds from government health care providers have been essential to States for financing health care to indigent populations. CMS asserts that Congress has not "expressly addressed" whether the Medicaid program should help finance the cost of providing services to non-Medicaid populations. 72 Fed. Reg at 2238. However, the financing mechanism described above specifically allows government

[4] U.S. Constitution, Amendment V.

health care providers to do just that. Consequently, prohibiting government health care providers from returning funds would reduce federal funds that have provided access to vital health care services for uninsured populations.

Because proposed 42 C.F.R. § 447.207 is inconsistent with applicable federal law and would cause substantial harm to patients who access health care through safety net providers, including health centers, we believe it should be withdrawn..

III. Conclusion

For the reasons discussed above, NACHC believes that the proposed rule is contrary to Federal law. We also believe that it is unnecessary because, as stated in the preamble to the proposed rule, CMS currently carries out oversight through its review and approval of state plan amendments relating to state payments, in which the great majority (90%) of these proposals are approved. *See* 72 Fed. Reg. at 2237.

Finally, health centers have a particularly important stake in CMS giving thoughtful reconsideration to this proposed rule. As noted at the outset of this letter, health centers, by virtue of their mission and the terms of their Section 330 grant, serve all those in their medically underserved area regardless of their patients' ability to pay. The uninsured comprise an increasing percentage of health center patients. In fact, between 1990 and 2005, the uninsured served by health centers has increased by 128% and the Section 330 grants received by health centers now covers only about 52% of centers' costs for serving the uninsured.

Adoption of these proposed rules will result in other providers having to cut back on the number of uninsured they can treat, with the predictable result that these individuals will go to health centers, which, in turn, will soon be overwhelmed with uninsured patients. In short, even health centers that are not currently receiving uncompensated care funds from units of government will feel the impact of these rules—with their financial viability, and consequently, their ability to serve any of their patients (including Medicaid) will be put at risk.

We appreciate the opportunity to comment on the proposed regulations, and we would welcome the opportunity to further discuss these concerns. If you have questions, please contact Roger Schwartz, Legislative Counsel, at 202-296-0158 or rschwartz@nachc.org.

Sincerely,

Roger Schwartz, JD
Legislative Counsel and Director of State Affairs

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

Organization : MHA An Assoc of MT Health Care Providers

Category : Health Care Professional or Association

Issue Areas/Comments

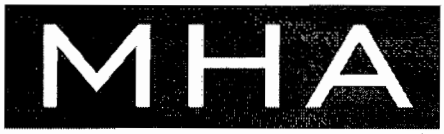
GENERAL

GENERAL

See Attachment

CMS-2258-P-138-Attach-1.DOC

#138



AN ASSOCIATION OF
MONTANA HEALTH
CARE PROVIDERS

March 15, 2007

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

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

Dear Ms. Norwalk:

On behalf of our 83 member hospitals, health systems and other health care organizations, including our 45 nursing facility members, MHA, An Association of Montana Health Care Providers (MHS) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals and nursing facilities. The MHA opposes this proposed rule and would like to highlight the harm it would cause to Montana nursing facilities and the patients they serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how Montana Medicaid funds its programs and how it pays for nursing facility services. The proposal comes at a time when most States are facing a difficult time funding their programs adequately, and will likely further erode Medicaid funding for nursing facilities.

Montana has a modest intergovernmental transfer program to help fund nursing facility services. That program was only recently modified to meet changing federal policy and expectations. The changes implemented by Montana means that the current program approved by CMS just one year ago will continue to meet proposed federal regulations. However, the new IGT regulations, coupled with the new cost limits on public facilities will likely place some small government facilities at greater financial risk, and will further erode the IGT program.

MHA does not object to CMS putting a stop to the most egregious and notorious practices whereby States recycled federal Medicaid funds. We would support regulatory changes intended to accomplish that policy. But the proposed regulations go much further

than protecting the integrity of the Medicaid program. They work to erode, reduce and harm the Medicaid program.

CMS states that health care providers that forego generally applicable tax revenue that has been contractually obligated for the provision of health care services to the indigent or for any other non-Medicaid activity, which is then used by the State as the non-Federal share of Medicaid payments, are making provider-related donations. Any Medicaid payment linked to a provider-related donation renders that provider-related donation non-bona fide.

Montana has a significant number of small, rural nursing facilities that receive local tax revenue aimed at preserving access to services. The funds are not typically contractually obligated between local government and the facility. In most cases, the local government is relying on either a voted or permissive levy to support nursing facility operations. In fact, those funds are typically needed to make up the payment shortfalls from Medicaid.

We believe that the regulation allows a local government to direct its tax funds to the State in order to boost Medicaid payments and help cover the facility's treatment costs. We ask that the final regulation include a discussion that confirms that a State may use local revenues in this fashion.

The American Hospital Association (AHA) expressed their concerns that in several places in the preamble discussion, CMS describes its proposed changes as "clarifications" of existing policy, suggesting that these policies have always applied, when in fact, CMS is articulating them for the first time. By describing many changes as clarifications, CMS appears to be trying to do an "end run" around the notice-and-comment process. Any attempt to implement these proposals in a retrospective nature would violate the *Administrative Procedures Act.*

The items referred to by AHA include:

- The cost-based reimbursement limitation and the individual provider-based UPL to be applied to government-operated providers;
- The proposed narrowing of the definition of "unit of government;"
- The proposed restrictions on intergovernmental transfers and certified public expenditures and the characterization of CMS' proposed changes as "clarifications" rather than changes in policy; and
- The absence of data or other factual support for CMS' estimate of savings under the proposed rule.

Rather than repeat these detailed concerns, MHA wishes only to endorse the AHA information, and extend AHA's comments to apply to nursing facilities.

We urge CMS to permanently withdraw its proposed rule.

If you have any questions, please feel free to contact me at (406) 442-1911, or by email at bob@mtha.org.

Sincerely,

Robert W. Olsen
Vice President

Submitter : Mr. Jan Kaplan **Date:** 03/15/2007

Organization : Lincoln County (OR) Health & Human Services Dep't

Category : Local Government

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

please see attached comments

GENERAL

GENERAL

please see attached comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

please see attached comments

Regulatory Impact Analysis

Regulatory Impact Analysis

please see attached comments

#139

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

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

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

Submitter : Mr. M. Dave Goetz, Jr. **Date:** 03/16/2007

Organization : State of TN - Dept. of Finance & Administration

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-2258-P-140-Attach-1.DOC

CMS-2258-P-140-Attach-2.PDF

#140

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,

Submitter : Mrs. Sherry Cox **Date:** 03/16/2007

Organization : Ashe Memorial Hospital, Inc

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-141-Attach-1.DOC

CMS-2258-P-141-Attach-2.DOC

would result in the elimination of almost 3,000 hospital jobs. That reduced spending and those lost jobs would be felt in local economies and the resulting economic loss to the State of North Carolina has been estimated at over $600 million and almost 11,000 jobs.

Specifically for our hospital, the loss of this program would mean a $344,000 reduction in reimbursement. This type of reduction in payment coupled with our already staggering $2,857,000 operating loss in 2006 could imperial the continued operations of this facility. This type of reduction would force this facility to consider discontinuing many services provided to the community such as Obstetrics and Cardio-Pulmonary rehab. The loss of these two services in our community would force 300-500 patients per year to travel in excess of 60 miles per trip to receive the care they need.

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,

Sherry Cox,
Chief Human Resources Officer
Ashe Memorial Hospital

cc: Senator Elizabeth Dole
Senator Richard Burr
Representative Virginia Foxx

Submitter : Mr. Mike Fogarty **Date:** 03/16/2007

Organization : Oklahoma Health Care Authority

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-142-Attach-1.DOC

#142

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

March 16, 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 Limitations for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership

The Oklahoma Health Care Authority (OHCA) respectfully submits this comment letter on the regulations proposed regarding cost limitations for providers operated by units of government and provisions to ensure the financing integrity of the Medicaid program. OHCA is commenting on the proposed rule published in the January 18, 2007 Federal Register (Volume 72, Number 11) for the Centers for Medicare and Medicaid Services (CMS). OHCA is the designated single state agency that administers the Medicaid program in Oklahoma.

OHCA appreciates the intent of the proposed rules to curtail what the federal government considers to be abuses of the source of the Medicaid non-federal share and potential "recycling" of federal funds. We do not condone the misuse of federal Medicaid funds and support efforts to ensure the appropriate use of such funds for the purpose of providing needed health care services to eligible members of the program. However, the proposed rules appear to go beyond legitimate efforts to curb misuse by placing undue burden on the administering state and federal agencies as well as the traditional safety net providers, including State and local governments. Congress and CMS previously imposed limits to restrict excessive payments to public providers and we question why the additional restrictions are necessary. These additional reforms undermine our state's effort to establish fair, equitable and efficient payment methodologies to provider groups and could result in reduced payments to providers serving the neediest patients. Reduced provider payments may impact access to care for Medicaid beneficiaries, particularly specialty care.

General Points and Summary

- **Attempts to define "public agency" by federal rule thus eliminating the State authority either by State Constitution or State Statute to make such a definition**

- **Ignores existing standards of acceptable accounting practices and creates an overly bureaucratic yet to be determined cost reporting system for State and Local Governments**
- **Establishes a bifurcated reimbursement system which unfairly treats public and government service providers as slaves to provider specific cost limitations while allowing private non-government providers to be exempt from such limitations and potentially exceed cost**
- **Allows States which were out of compliance with the last revisions to the Upper Payment Limit Regulations to continue to transition into compliance while forcing States which were in compliance to conform to the new and onerous regulations**

Comments on Provisions of the Proposed Rule

Defining a Unit of Government (§433.50)

This provision removes the state's discretion in defining a "public agency" and replaces it with regulations that allows CMS to more narrowly define a "unit of government" that is eligible to participate in the non-federal share of Medicaid. Medicaid statutes (1903 (w)(7)(G)) define a unit of government as a state, city, county, special purpose district, or other governmental unit in the State. The proposed rule adds to the definition by restricting to those entities *that have generally applicable taxing authority or are able to access funding as an integral part of a governmental unit with generally applicable taxing authority.* In part, this seems to change the long-standing practice of many non-state government owned hospitals being allowed to participate in the non-federal share of Medicaid. Often, these hospitals maintain a public status but are not specifically *operated* by a government, for the sake of efficiency. This proposed change could eliminate traditional funding provided by local hospitals and others. CMS seems to be exercising power to define governance without recognizing the many State-local relationships that may exist via State Constitution or statutory authority. CMS does not explain its legal authority to further restrict this definition and we ask that the definition of a unit of government continue to reside with the State.

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

This provision clarifies that the state share of Medicaid expenditures may only be contributed by units of government by removing the terms "public" and "public agency" from §433.51 and replacing with the new term "units of government" as defined in §433.50. The proposed regulatory language further states that the non-federal share of Medicaid expenditures may be appropriated directly to the State or local Medicaid agency or may be transferred from other units of government to the State or local agency. The source of state share becomes confusing, however, when taken in the context of the comments included in the preamble and given the current questions and documentation being required by CMS for State plan amendments.

First, the preamble defines an IGT as a transfer of funding from a local governmental entity to the State. We find this to be an accurate definition; however CMS' current practice has been to include funds transferred from one agency of the State to the Medicaid agency in discussions of an IGT. Since the "unit of government" is the State, these transfers are *intra*governmental transfers and are recorded as such in accounting records. We ask CMS to clarify that transfers within a unit of government are not considered intergovernmental transfers.

CMS also states in the preamble that, where a governmentally operated health care provider has transferred the non-federal share, the State must demonstrate that the source of the transferred funds is *State or local tax revenue.* At the same time, the regulations are revised to say that eligible funds may be appropriated directly to the State or local Medicaid agency or are transferred from other units of government to the State or local agency. The explanation provided by CMS that the State must demonstrate that the source of funds is *State or local tax revenue* is more restrictive than the actual regulation and does not recognize the right of a government to define the combination of methods that will be used to finance its services to the public. There are many revenues available to government agencies which they are authorized to assess and collect that are not direct appropriations of State or local taxes. These revenues include penalties and certain fines and fees assessed for the purpose of funding the agency's general operations. In a school or institution such funds may come from a retained percentage of vending machine sales. In a State agency, there may be an "unreserved fund balance" at year end that would be available for spending with the approval of the legislature. In Oklahoma, the collection of authorized revenues by a State agency for the purpose of funding its operations are, by law, "appropriated and budgeted" upon deposit of the monies into the appropriate fund. In the strictest sense, however, these funds are not always from tax revenue but should be considered State monies that are eligible to pay for the non-federal share of Medicaid expenditures.

This regulatory change also imposes minimum standards for documentation required to support a certified public expenditure. In the future, such costs must be reported in a form approved by the Secretary. While we have no issue with the requirement to submit auditable documentation, we are concerned whether CMS has considered that complicated approved methodologies exist today whereby an agency captures both administrative costs and program costs through cost allocation that are used to claim administrative costs by CPE and to set rates for programs such as TCM. We ask that CMS be aware that while requirements for reporting administrative costs and for reporting service costs are very different, they are also sometimes integrated in time studies. In such instances, we prefer the documentation requirements accommodate both administrative claiming and/or collection of the cost to provide a service, thereby avoiding a duplicative reporting process. Also, to what extent will CMS define how administrative claiming is documented? We request these requirements not go beyond the activities defined in OMB A-87 or GAAP to avoid potential changes to the State or agency accounting system. At the same time, we expect the allowable costs to be fully inclusive of costs as defined by OMB A-87.

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

The proposed rules for cost limits for governmentally operated providers are in direct conflict with many of the advances the State of Oklahoma has made in recent years related to provider reimbursements. For example, Oklahoma developed a DRG reimbursement system for hospitals consistent with the Medicare payment methodology so that all hospitals are reimbursed by the same methodology. No hospital providers are participating in the non-federal share or CPE. Because Oklahoma is currently paying at or near cost, there may be government operated hospitals from which this rule will require the agency to recoup significant funds annually using the DRG system. To avoid future overpayment scenarios and to be fair in general, the proposed rules will force Oklahoma to abandon the DRG system for government operated hospitals and return to the antiquated and inefficient cost-based system. By its own admission, CMS recognizes in the proposed rules that States may need to change reimbursement methods for government operated facilities. Establishing an alternative methodology that reconciles annually to cost

is a more labor intensive process for the agency and could create cash flow problems for the facilities. The government operated facilities represent some of the most vulnerable, rural hospitals in the State. Even CMS admits that they "*...expect this rule to have a significant economic impact on a substantial number of small entities, specifically health care providers that are operated by units of government, including governmentally operated small rural hospitals...*"

The proposed rules will create an administrative burden on the State which will be inefficient, time consuming and redundant. Under the proposed rules all government operated providers, even those not currently required to, will be forced to submit cost reports and will be treated differently from private providers. By CMS rule, the proposed changes impose onerous reporting and accounting processes to government systems, including schools, which would likely not be beneficial to the end result of a Medicaid payment for the effort required. We urge CMS to eliminate the individual provider cost limitation and to consider a reasonable measurement to ensure a proper and efficient reimbursement limitation without the unnecessary administrative burden and without creating the double standard of payment between private and government operated providers. Oklahoma generally agrees that government and even non-government operated providers should be paid a proper and efficient rate to reasonably cover the cost of services provided. What we object to is the bifurcation of our reimbursement systems for institutional and non-institutional providers that we created with CMS' approval to comply with the overriding mandate that our payments are consistent with efficiency, economy and quality of care and are adequate to enlist a sufficient amount of providers.

For non-hospital and non-nursing facility services, the proposed rules stipulate that payment to government operated providers are limited to cost, based on documentation in a form to be approved by the Secretary. We are concerned with implementation issues of this provision: 1) when will the form be available?; and 2) what happens in cases where rates have been established and approved by CMS but do not potentially meet the cost test provided by the form? We are especially concerned with the potential implications of this rule, again to the traditional safety net providers, considering that these providers have never been required to produce cost report information. These providers include school-based service providers, health department clinics, community mental health clinics, physician services provided by state employees, and graduate medical education payments to universities. Since cost data for non-institutional services has never been captured, it is difficult to gauge the impact of whether the current rates are higher or lower than any provider's individual cost. This provision encompasses many providers and will require a great effort on the part of the State and on the part of the providers to collect, report, analyze and reconcile these costs annually.

At the end of the day, this policy for both institutional and non-institutional providers seems to be a big win for the many consulting companies that specialize in Medicaid and health care data as States short on resources will be forced to pay their high administrative fees to comply with the new requirements. Again, the effort seems ill-advised to implement a policy that establishes a double standard between private and government operated provider types and at the same time encourages government operated providers to ignore the provision of efficiency. The long term impact that the illusive potential short term savings of a cost reimbursement based policy may achieve is to send us directly into the inflationary abyss of a system that has no incentives for efficiency and only financial rewards for spiraling costs.

Also, CMS has encouraged States to consider innovative payment strategies to pay providers a higher rate for adhering to certain quality indicators to achieve better patient outcomes. Oklahoma is currently considering a Pay for Performance, or P4P, model for nursing homes and certain physician services. How can we logically expect to move forward with sound reimbursement policies incorporating quality measures if they don't apply to all providers of a service? A government operated provider subject to cost limitation will not be incentivized to meet quality goals or performance standards if they are cost reimbursed anyway. We request that CMS clarify how the cost limitation for government operated providers can successfully be integrated with a P4P model.

The expected compliance date of the cost limit provision is September 1, 2007. First, CMS has yet to define the manner in which non-institutional providers will be required to report costs. Second, these providers do not necessarily have accounting and cost allocation systems established to report cost information. We cannot be expected to collect cost data from these entities timely to make rational decisions regarding rate-setting methodologies by September 1. The State will need time to make rule changes, amend State plans, change rates and develop new payment methodologies for government operated providers. Of course, this can only be done after CMS has evaluated each provider based on the new assessment tool and has determined which providers qualify as a government operated provider. In Oklahoma, we expect to remove government operated hospitals from the DRG methodology, which will also require several months of work with consultants to recalibrate all the DRG weights and peer groupings excluding these facilities. We would also expect that changes could be forthcoming to our state-employee physician rates once cost report data is established. Since this includes a primary care case management capitation, actuaries would need time to reestablish payment ranges based on cost. We would also need time to amend the 1115 waiver for certain payments provided by government operated providers that may be in excess of cost. For all these reasons, the State takes issue with the compliance date and asks that a longer transition period be provided.

It is also important to question how much of the estimated federal savings in the Regulatory Impact Analysis is expected due to the cost limitation provision. We believe the payment methodologies we currently have in place for both institutional facilities and non-hospital and non-nursing home government providers provide adequate and equitable payments within the framework of the proper and efficient administration of the State plan. In order to hold individual providers to cost, the State of Oklahoma has no interest in achieving savings based on an overpayment of an interim rate. Our intent would be to ensure that such savings are redistributed to the providers that were paid less than cost, thereby negating any federal savings that may be assumed from this proposed change.

Retention of Payments (§447.207)

This is a new regulatory provision requiring that providers receive and retain the full amount of the total computable payment provided to them for services rendered. CMS suggests that compliance may be demonstrated by showing that the funding source of an IGT is clearly separated from the Medicaid payment received by the health care provider. This is another example of CMS' definition of an IGT being inconsistent with their current practice. In evaluating State plan amendments, CMS has previously considered funds transferred from a State agency to the State Medicaid agency as an IGT. As previously stated, we believe this constitutes an *intra*governmental transfer within the same unit of government and therefore CMS has no authority to evaluate these transfers with the same level of scrutiny as an *inter*governmental transfer.

We further believe that CMS goes too far in requiring that a transfer within the same unit of government must take place prior to a Medicaid payment and that the non-federal share must originate from taxes from an account that is separate from the account that receives the Medicaid payment. Government accounting principles, established by GASB, encourage States to use the least number of funds that are necessary to comply with legal operating requirements. The State of Oklahoma follows the GASB standards of fund classification, which generally means agency operations are accounted for in a general revenue fund unless funds are legally restricted for a specific purpose. This means that an agency's appropriated funds are deposited into the general revenue fund, with no account designation, and are expended from the same fund. In some cases where a State agency is also a health care provider, the Medicaid payment could be deposited into the same fund as the appropriation. In order to comply with CMS' rigid practice, the State legislature will need to statutorily create more funds to clearly segregate these monies. We ask again that CMS clarify its intent that this segregation of funds does not apply to *intra*governmental transfers and that a State's compliance with GASB standards in accordance with generally accepted accounting principles and a State agency's compliance with all applicable laws, rules and regulations with respect to fund accounting and budgeting should provide sufficient accountability.

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

At the present time, State's Medicaid payments to hospitals may not exceed the upper payment limit defined by federal statute as a reasonable estimate of the amount that Medicare would have paid to furnish the same set of services provided under the Medicaid State Plan. There are three aggregated UPL tests for both inpatient and outpatient services: privately owned; state owned and non-state government owned. CMS does not provide a formula to determine the upper payment limit, but has allowed States flexibility in calculating amounts within the statutory definition.

Oklahoma has traditionally used the cost method to determine UPL, primarily because, until late 2005, the methodology Oklahoma used to pay hospitals did not easily compare to the Medicare DRG model, thereby making it difficult to compute "the amount that Medicare would have paid..." However, since Oklahoma converted to the DRG model, we have considered a different calculation of the UPL test. The proposed rule and regulatory changes would further restrict the UPL definition for all government owned facilities to the cost method, and apparently would not allow the DRG UPL model except for private hospitals. This further enhances the double standard of payment being created by not only allowing a private facility to be paid higher than cost but also allowing the UPL to be set at a higher level than the cost method. These changes appear to establish two distinct UPL standards for private and governmental providers. The limit for private providers appears to allow a state flexibility in calculating the amount Medicare would have paid for the same services, potentially creating a system whereby Medicaid payments for private facilities could be higher than payments to governmental providers for the same services, without the private facility having to incur the cost. We ask CMS to reconsider these regulatory changes for government operated providers so that, if each facility is to be held to an individual UPL test, the standard for determining the upper payment limit for both private and government operated providers is at least the same standard that exists today.

Also, States that are still out of compliance from the last round of changes to the upper payment limit regulations because of the transition period do not have to conform to the new UPL provisions by the September 1, 2007 deadline. These States, where abuses previously occurred, will be allowed to continue transitioning out of their abusive systems while States like Oklahoma that have not abused the

system will have to immediately comply with the new and cumbersome administrative process. We ask that CMS try to come up with a fair implementation process and standardized implementation date for all States that does not continue to reward those that are not currently in compliance.

Tool to Evaluate the Governmental Status of Providers

It is clear that the assessment tool must be completed for any provider who is financing the non-federal share. However, States are also required to complete the form within 3 months of the effective date of the final version of the proposed rule for existing arrangements that involve payment to a governmentally operated provider. To what extent is the Medicaid agency responsible for identifying a provider as government operated? For example, if a facility has not asserted itself as a government provider, must the agency establish procedures to identify them?

In conclusion, we again urge CMS to reconsider the adoption of these severely restrictive policies that will impose significant administrative burdens on the State and federal government and on government providers without consideration of whether the benefit will be relative to the effort involved. It is our belief that the federal government has overstated the savings expected to be achieved by these proposed changes. In reality, the current rules and regulations should be sufficient to impede further abuses described by CMS from happening. The spirit of these changes – limiting government operated providers to cost – can easily be accomplished by adoption of a rational policy that holds ***all*** providers within a service type to rates that are based on the same measure of efficiency and economy within the context of the proper and efficient administration of the State plan without the need for extreme, arduous reporting requirements. We feel this is already primarily accomplished in our State using the Medicare DRG and physician fee schedule as models where appropriate. We further believe that the UPL aggregate groups currently established in regulation succeed in limiting the States' ability to abuse payments to providers and there is no need to limit the UPL standard to any individual provider.

We would be pleased to provide any additional information that may be helpful to you regarding these matters. Thank you for considering our comments. If you have any questions, please do not hesitate to contact me at (405) 522-7417.

Sincerely,

Mike Fogarty

Submitter : Gil McKenzie **Date:** 03/16/2007

Organization : Alabama Hospital Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#143

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

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

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

Submitter : **Mr. David Cress** **Date: 03/16/2007**

Organization : **North Memorial**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-144-Attach-1.DOC

#144

North Memorial
Health Care

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:

On behalf of North Memorial Health Care, we appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospital and the patients we serve. The Minnesota Hospital Association has estimated the potential impact to Minnesota hospitals could be well over $100 million dollars.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule f urther r estricts h ow s tates r eimburse h ospitals. These c hanges w ould 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.

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

Sincerely,

David W. Cress
President & CEO

3300 Oakdale Avenue North Robbinsdale, Minnesota 55422

Submitter : Mr. Wayne F. Shovelin **Date:** 03/16/2007

Organization : Gaston Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-145-Attach-1.PDF

#145

CaroMont HEALTH

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:

Gaston Memorial Hospital in Gastonia, NC, appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule. We oppose this rule and will highlight the harm its proposed policy changes would cause to our hospital and the patients we serve.

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

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

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

Specifically for our hospital, the loss of this program would mean a loss of revenue that could lead to a loss of jobs, a reduction in services, and/or a reduction in capital investments. During federal fiscal year 2006, Gaston Memorial Hospital received $5.9 million in payments from the MRI program. This accounted for over a third of our operating income for our most recent fiscal year. As a not-for-profit, public hospital, our earnings are used to either enhance services or to purchase capital equipment for our patients. Without this funding, we will either have to reduce these services, reduce capital spending, or reduce expenses. For our hospital, the MRI funding equates to approximately 96 FTEs, which is almost 5% of our workforce. Total economic impact due to the elimination of this program is estimated to be over $12 million - a huge loss to Gaston County which is already struggling with the loss of textile jobs over the past several years.

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,

Wayne R. Shovelin
President and CEO

cc: Senator Elizabeth Dole
Senator Richard Burr
The Honorable Sue Myrick

Submitter : Mr. Robert Clark **Date:** 03/16/2007

Organization : Bristol Bay Area Health Corporation

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2258-P-146-Attach-1.PDF

#146

Bristol Bay Area Health Corporation
6000 Kanakanak Road
P.O. Box 130
Dillingham, AK 99576
(907) 842-5201
800-478-5201
FAX (907) 842-9354

Bristol Bay Area Health Corporation is a tribal organization representing 34 villages in Southwest Alaska:

- Aleknagik
- Chignik Bay
- Chignik Lagoon
- Chignik Lake
- Clark's Point
- Dillingham
- Egegik
- Ekuk
- Ekwok
- Goodnews Bay
- Igiugig
- Iliamna
- Ivanof Bay
- Kanatak
- King Salmon
- Knugank
- Kokhanok
- Koliganek
- Levelock
- Manokotak
- Naknek
- New Stuyahok
- Newhalen
- Nondalton
- Pedro Bay
- Perryville
- Pilot Point
- Platinum
- Port Heiden
- Portage Creek
- South Naknek
- Togiak
- Twin Hills
- Ugashik

To promote health with competence, a caring attitude & cultural sensitivity

March 15, 2007

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

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

Dear Ms. Norwalk:

My name is Robert J. Clark. I am a Yup'ik (Eskimo) born 58 years ago in the old Kanakanak hospital (our current Administration wing) that we currently manage for the Indian Health Service, along with 29 village clinics. The Bristol Bay Area Health Corporation is a tribal organization for 34 tribes in Southwest Alaska. We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule published on January 18, 2007 at 72 Federal Register 2236. As currently written, we oppose the proposed rule and would like to offer suggested regulatory language that we believe will address tribal concerns consistent with existing CMS policy.

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

Criteria for Indian Tribes to Participate

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

determinations will almost certainly negatively affect the willingness of States to enter into cost sharing agreements with Indian Tribes since an error in the determination regarding this undefined term could have potentially negative effects for the State.

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

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

Criteria for Tribal Organizations to Participate

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

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

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

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

section 447.206.[2]

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

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

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

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

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

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

Based on the comments made by Leslie Norwalk during the TTAG meeting February 22, 2007, it is clear that the proposed rule regarding conditions for intergovernmental 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.

regard to approving the Washington State Medicaid Administrative Match Implementation Plan to exclude any "638 clinics that are reimbursed at the all-inclusive rate from participation in the tribal administrative claiming program." No such exclusion was ever contemplated by CMS when it sent the SMD letters referred to earlier. Such an exclusion would swallow the rule that allows Indian Tribes and Tribal organizations to participating in cost sharing.

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

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

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

BRISTOL BAY AREA HEALTH CORPORATION

Robert J. Clark
President/Chief Executive Officer

c: National Indian Health Board
Alaska Native Health Board
Senator Ted Stevens
Congressman Don Young
BBAHC Executive Committee
Darrel C. Richardson,Vice President/COO
Tom Berner, Chief Executive Officer
Carol Barbero, Esquire, Hobbs, Straus, Dean & Walker

Submitter : Ms. Patricia Andersen **Date:** 03/16/2007

Organization : Oklahoma Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter

CMS-2258-P-147-Attach-1.DOC

#147

4000 N Lincoln Blvd. Oklahoma City, OK 73105

March 16, 2007

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

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

Dear Ms. Norwalk:

On behalf of our over 140 member hospitals, health systems and other health care organizations, the Oklahoma Hospital Association (OHA) appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals. The OHA opposes this proposed rule and would like to highlight the harm it would cause to our state's 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 programs. The rule further restricts how states reimburse safety-net hospitals. In addition, CMS fails to provide data justifying the need or basis for these restrictions. This unauthorized and unwarranted shift in policy will have a detrimental impact on providers of Medicaid services, particularly safety-net hospitals, and on patient access to care.

CMS estimates the rule will cut $3.9 billion in federal funds over five years. We believe that a change of this magnitude must be authorized by Congress and that CMS does not have the legitimate authority to make such a massive change administratively. This proposed change in the Medicaid rules would result in a significant budget cut for safety-net hospitals and state Medicaid programs. The approach being used by CMS bypasses the Congressional approval process and has been proposed even after significant Congressional opposition to the Administration's plans to regulate in this area. In 2006, 300 representatives and 55 senators signed letters to Health and Human Services (HHS) Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. Recently, Congress restated its position with 226 Representatives and 43 Senators having signed letters to the House and Senate leadership urging them to stop this proposed rule from moving forward.

Policy changes of this magnitude must be made in a way that will ensure the health care needs of Medicaid recipients are met and that hospitals providing the care are not damaged. Historically, whenever there has been a substantial change to Medicaid funding policy – such as prohibiting provider-related taxes and donations, modifying disproportionate share (DSH) hospital allotments, or modifying application of Medicaid upper payment limits (UPLs)

– changes have been made by or at the very least supported by Congress. Congress—not CMS—should decide if such sweeping changes to Medicaid should be made and the changes should first be made by legislation, not by regulation. The Administration recognized this in its fiscal year 2006 budget submissions to Congress--it proposed that Congress pass legislation to implement the policy changes contained in this rule. We believe CMS is acting outside of its authority.

The OHA also is concerned that in several places in the preamble discussion, CMS describes its proposed changes as "clarifications" of existing policy, suggesting that these policies have always applied, when in fact; CMS is articulating them for the first time. By describing many changes as *clarifications*, CMS appears to be trying to circumvent the required notice and comment process. Any attempt to implement these proposals in a retrospective nature would violate the *Administrative Procedures Act*.

We have great concerns about the following components of the proposed rule and we refer you to the comment letter from the American Hospital Association for additional explanation and support:

1. The cost-based reimbursement limitation and the individual provider-based UPL to be applied to government-operated providers;
2. The proposed narrowing of the definition of "unit of government;"
3. The proposed restrictions on intergovernmental transfers and certified public expenditures and the characterization of CMS' proposed changes as "clarifications" rather than changes in policy; and
4. The absence of data or other factual support for CMS' estimate of savings under the proposed rule.

Today, Oklahoma has one of the lowest health statuses of any state in the United States; we have one of the highest proportions of uninsured in the country; we have already eliminated a very short lived IGT program; we are trying to implement a Medicaid waivered program to reduce the number of uninsured working poor; late in 2006, six Oklahoma hospitals entered bankruptcy; and only recently Oklahoma Medicaid implemented a DRG based prospective payment methodology for all Oklahoma hospitals. If these policy changes are implemented, we have great concerns that our state's health care safety net will be jeopardized and health care services for the over 600,000 Medicaid beneficiaries and the over 600,000 uninsured in Oklahoma may not be available.

We urge CMS to permanently withdraw its proposed rule.

If you have any questions, please feel free to contact me at 405-427-9537 or by email at pandersen@okoha.com.

Sincerely,
OKLAHOMA HOSPITAL ASSOCIATION

Patricia Andersen

Patricia Andersen, CPA
VP-Finance & Information Services
Oklahoma Hospital Association

Submitter : Patricia Andersen **Date:** 03/16/2007

Organization : Oklahoma Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comment letter from the Oklahoma Hospital Association>

CMS-2258-P-148-Attach-1.DOC

#148

Oklahoma Hospital Association

4000 N Lincoln Blvd. Oklahoma City, OK 73105

March 16, 2007

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

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

Dear Ms. Norwalk:

On behalf of our over 140 member hospitals, health systems and other health care organizations, the Oklahoma Hospital Association (OHA) appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals. The OHA opposes this proposed rule and would like to highlight the harm it would cause to our state's 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 programs. The rule further restricts how states reimburse safety-net hospitals. In addition, CMS fails to provide data justifying the need or basis for these restrictions. This unauthorized and unwarranted shift in policy will have a detrimental impact on providers of Medicaid services, particularly safety-net hospitals, and on patient access to care.

CMS estimates the rule will cut $3.9 billion in federal funds over five years. We believe that a change of this magnitude must be authorized by Congress and that CMS does not have the legitimate authority to make such a massive change administratively. This proposed change in the Medicaid rules would result in a significant budget cut for safety-net hospitals and state Medicaid programs. The approach being used by CMS bypasses the Congressional approval process and has been proposed even after significant Congressional opposition to the Administration's plans to regulate in this area. In 2006, 300 representatives and 55 senators signed letters to Health and Human Services (HHS) Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. Recently, Congress restated its position with 226 Representatives and 43 Senators having signed letters to the House and Senate leadership urging them to stop this proposed rule from moving forward.

Policy changes of this magnitude must be made in a way that will ensure the health care needs of Medicaid recipients are met and that hospitals providing the care are not damaged. Historically, whenever there has been a substantial change to Medicaid funding policy – such as prohibiting provider-related taxes and donations, modifying disproportionate share (DSH) hospital allotments, or modifying application of Medicaid upper payment limits (UPLs)

– changes have been made by or at the very least supported by Congress. Congress—not CMS—should decide if such sweeping changes to Medicaid should be made and the changes should first be made by legislation, not by regulation. The Administration recognized this in its fiscal year 2006 budget submissions to Congress--it proposed that Congress pass legislation to implement the policy changes contained in this rule. We believe CMS is acting outside of its authority.

The OHA also is concerned that in several places in the preamble discussion, CMS describes its proposed changes as "clarifications" of existing policy, suggesting that these policies have always applied, when in fact; CMS is articulating them for the first time. By describing many changes as *clarifications*, CMS appears to be trying to circumvent the required notice and comment process. Any attempt to implement these proposals in a retrospective nature would violate the *Administrative Procedures Act*.

We have great concerns about the following components of the proposed rule and we refer you to the comment letter from the American Hospital Association for additional explanation and support:

1. The cost-based reimbursement limitation and the individual provider-based UPL to be applied to government-operated providers;
2. The proposed narrowing of the definition of "unit of government;"
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VP-Finance & Information Services
Oklahoma Hospital Association

Submitter : **Patricia Andersen** **Date: 03/16/2007**

Organization : **Oklahoma Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

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Please see attached comment letter from the Oklahoma Hospital Association.

CMS-2258-P-149-Attach-1.DOC

#149

4000 N Lincoln Blvd. Oklahoma City, OK 73105

March 16, 2007

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Patricia Andersen

Patricia Andersen, CPA
VP-Finance & Information Services
Oklahoma Hospital Association

Submitter : Ms. Nancy Linehan **Date:** 03/16/2007

Organization : NYS Dept. of Health

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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