Submitter : Diane St. Denis **Date:** 03/16/2007

Organization : Diane St. Denis

Category : Individual

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

This regulation will reduce the reimbursements to County Hospitals and Clinics. Considering that these systems are often the only option for health care for your constituents, the loss of funding will further reduce the options. There is already a huge uncompensated care issue. Our county is facing a huge deficit and will undoubtedly have to lay off many of our public health nurses. With fewer nurses to provide services to those at home, many will feel obligated to go to the emergency dept for care, overloading an already overloaded system. Also, the cost for care at home vs hospital is much less, so there will be increased costs for treating the same medical issues. This is just plain wrong, and is a poor fiscal decision. Let's look at the big picture, not just in the here and now. Keeping people out of the hospital saves money, but for those who come to the hospital, pay for those services so those that don't have any other access to healthcare, don't drain the system dry with their costs. Until there is a way to ensure that everyone has access to COMPENSATED health care, this issue will continue. This is the last safety net for so many people, and creating layoffs and cuts in services due to uncompensated care will only complicate matters.
Thank you.

Submitter : Mr. Loren Dyer **Date:** 03/16/2007

Organization : Tampa General

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attached

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 Gruman **Date:** 03/16/2007

Organization : Office of HealthCare Financing

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-154-Attach-1.RTF

#154

Wyoming Department of Health

Commit to your health.
visit healthywyoming.org

Brent D. Sherard, M.D., M.P.H., Director and State Health OfficerGovernor Dave Freudenthal

March 16, 2007

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

Subject: Electronic Submission of Comments on Proposed Rules – CMS-2258-P
Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership

The State of Wyoming, Department of Health appreciates the opportunity to comment on the proposed rules related to the Medicaid Program as set forth in the January 18, 2007 Federal Register. The State would like to enter the following comments for CMS' consideration related to the Proposed Rules in CMS-2258-P.

> Page 2242 of the proposed rule states "When States do not use CPEs to pay providers operated by units of government, the new provisions would require the State Medicaid agency to review annual cost reports to verify that actual payments to each governmentally operated provider did not exceed the provider's costs". Does this provision apply to Medicaid payments that are not developed using IGTs or CPEs? If so, (1) is the new hospital-specific test performed separately for outpatient and inpatient hospital services, or in the aggregate, and (2) does this test apply solely to non-state governmental hospitals and not to private hospitals?

The State looks forward to viewing CMS' response. Please do not hesitate to contact me if you have any further questions.

Sincerely,

Greg Gruman
Medicaid Director

equalitycare

Office of Health Care Financing, EqualityCare • 6101 Yellowstone Road, Suite 210
Cheyenne WY 82002 • WEB Page: http://wdh.state.wy.us/medicaid
FAX (307) 777-6964 • **(307) 777-7531**

Submitter : Mr. Loren Dyer **Date:** 03/16/2007

Organization : Tampa General Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-2258-P-155-Attach-1.DOC

#155

March 16, 2007

Melissa Musotto
CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development-A
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Proposed Tool Comments
File Code CMS-2258-P

Dear Ms. Musotto:

These comments by Tampa General Hospital ("TGH") are directed solely at the Tool to Evaluate the Governmental Status of Providers[1] (the "Tool"), which was released by the Centers for Medicare and Medicaid Services ("CMS") in conjunction with the proposed rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership," CMS-2258-P (the "Proposed Rule"). TGH believes that the Proposed Rule as well as the Tool exceed the agency's legal authority, defies the bipartisan opposition of a majority of the Members of Congress and would dismantle the Florida's intricate Medicaid-based safety net system, which will seriously compromise access for Medicaid and uninsured patients. As noted in our comments on the Proposed Rule, the effect on Florida's safety net is devastating - an estimated $932 million reduction in Medicaid payments annually.

While CMS' intent for drafting the Tool is admirable, we believe that it does not actually assist providers in determining their governmental status under the regulation, because once the Tool is completed, there is no indication of the outcome. Accordingly, we offer the following comments expressly related to the Tool:

1. CMS should revise its "Tool to Evaluate Governmental Status of Providers."

[1] Proposed Rule at 2242. A copy of this form is available at: http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=2&sortOrder=descending&itemID=CMS1192476&intNumPerPage=10.

A provider is not required to be included on the unit of government's consolidated financial report to be considered a "health care provider operated by a unit of government". However, it is not clear based on the Tool whether the comment above is actually true and accurate. Based on the reading of the Proposed Rule, a provider might believe that they are still a unit of government, but the same conclusion cannot be drawn by completing the form. Likewise, the unit of government is not required to be liable for a provider's operations, expenses, liabilities, and deficits in order for the provider to be considered a "health care provider operated by a unit of government under the language of the Proposed Rule. However, again, it is unclear when reviewing responses to the Tool, what the outcome is. The disconnect between the Proposed Rule and the Tool will make it very difficult for states, governmental entities, and providers to determine whether they qualify as a "unit of government" under the regulation.

2. CMS should place a deadline on determinations made using the "Tool".

Under the Proposed Rule, States would be required to provide the completed "Tool" on each applicable provider within three months of the effective date of the final rule. However, there is no stated deadline for CMS' response to the information provided

Recommendation: CMS should impose a three month deadline for decisions and determinations made using the Tool.

3. CMS should provide a procedure for challenging decisions made using the "Tool".

This concludes the comments submitted by Tampa General Hospital regarding the "Tool".

Best Regards,

Sincerely yours,

Submitter : **Mr. Richard Eitel** **Date: 03/16/2007**

Organization : **Memorial Health System**

Category : **Hospital**

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

Regulatory Impact Analysis

Regulatory Impact Analysis

See attachment

CMS-2258-P-156-Attach-1.PDF

#156

Memorial Health System

We Hear. We Heal. We Care.

Sent Via Email and Federal Express

March 16, 2007

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

The purpose of this letter is to comment on the proposed rule, 42 CFR Part 433, 447 and 457 entitled, *Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal–State Financial Partnership.* 72 FR 2236-01, (2007) (to be codified at 42 CFR Parts 433, 447, and 457, proposed Jan. 18, 2007). This comment is submitted on behalf of Memorial Health System (MHS), a wholly-owned enterprise by the City of Colorado Springs (City). Colorado Springs City Code 13.1.103 (2006). MHS submits this comment requesting that CMS further clarify its definition of a "unit of government" under the proposed rule.

According to the proposed rule, a health care provider meets the definition of a "unit of government" if it can demonstrate that: (1) it is "city-operated"; (2) it is included "as a component unit on the government's consolidated annual financial report"; and (3) the city "appropriates funding derived from taxes it collected to finance the health care provider's generally operating budget". 72 FR 2240, (2007)(to be codified at 42 CFR §433.50, proposed Jan. 18, 2007)

MHS does meet the definition of unit of government as specified in numbers one and two above as evidenced by the following facts. MHS was purchased by the City in 1943. In 1949, the citizens of the City approved ordinances that read in pertinent part, "The [hospital] Board shall advise the City Manager and Council of the amount deemed necessary to be raised by tax levy for the hospital for the ensuing year". Colorado Springs City Code 13.1.101, (2006). "The City of Colorado Springs shall continue the operation and maintenance of Memorial Hospital, now owned by said City, and the City Council shall, commencing with the annual tax and appropriation ordinance for the year 1950, annually levy a tax and appropriate the proceeds there from solely for the use of said Hospital. Said tax shall be sufficient to pay the estimated deficit in all expenses incurred in conducting, maintaining and improving the hospital in the next

ensuing fiscal year, including the payment of bonds and interest thereon, repairs, upkeep, betterments, equipment, supplies, depreciation, insurance, employee's salaries and all other expenses incident to the operation and maintenance." City of Colorado Springs Code 13.1.108, (2006). Furthermore, MHS is reflected on the City's consolidated annual financial report.

The aforementioned facts lead MHS to conclude that it essentially meets the definition of a "unit of government" as set forth in the proposed rule. There is one fact however that brings this conclusion into question. MHS has been financially self-sufficient since 1974 and therefore has not had to rely on City tax revenues for its operations, even though the City is required by ordinance to levy a tax and appropriate the revenues to MHS. It is therefore questionable as to whether MHS meets criterion number three mentioned above.

This criterion is also set forth in question number three in CMS' Form 10176 entitled, *Governmental Status of a Health Care Provider*. This question number reads, "Does the unit of government that operates the health care provider appropriate generally applicable tax revenue to the health care provider", to which MHS would have to answer "no".

It appears that for the most part, MHS does meet the definition of a unit of government because it is owned and operated by the City, is a component unit in the City's annual financial report and the City is required by ordinance to levy a tax to fund its operations. The mere fact that MHS has not required the City to do so brings into question whether MHS meets the definition of a unit of government.

MHS is hereby requesting that CMS clarify the definition of a unit of government with respect to whether a health care provider that is owned and operated by a local government that is required by ordinance to levy a tax to support its operations, must actually access these revenues on an annual basis in order to meet the definition of a unit of government.

Respectfully Submitted,

Richard K. Eitel, Chief Executive Officer

Submitter : Mr. R. Edward Howell **Date:** 03/16/2007

Organization : University of Virginia Medical Center

Category : 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-157-Attach-1.DOC

#157

HEALTH SYSTEM

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

March 16, 2007

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

Re: CMS-2558-P

Dear Ms. Norwalk:

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

Unit of Government

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

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

P.O. Box 800809 • Charlottesville, VA 22908-0809
434-243-9308 • Fax: 434-243-9328

Inequitable Reimbursement

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

Harm to Medicaid Recipients

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

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

Sincerely,

R. Edward Howell
Vice President and Chief Executive Officer

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

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

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

Patrick W. Finnerty
Director, Department of Medical Assistance Services

Submitter : **Mr. Jeffrey Brannon** **Date: 03/16/2007**

Organization : **Medical Center Enterprise**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

As our community's sole provider of healthcare services, we cannot sustain cuts in reimbursement from any payment source, especially Medicaid, which is a federally mandated program. The hospital's ability to provide needed services will be severely damaged by any proposed reduction in reimbursement, therefore, I urge you to reconsider the proposed rules for Medicaid.

Sincerely,

Jeffrey M. Brannon, RN
Chief Executive Officer
Medical Center Enterprise
400 N. Edwards Street
Enterprise, AL 36330

Submitter : Mr. Van Smith **Date:** 03/16/2007

Organization : The Outer Banks Hospital

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-159-Attach-1.PDF

#159

THE
OUTER BANKS
HOSPITAL

March 16, 2007

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

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

Dear Ms. Norwalk:

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

The Outer Banks Hospital (TOBH) is a 19 bed, Critical Access Hospital (CAH), located in Nags Head, North Carolina on the famous Outer Banks. This unique coastal region of Dare County has a population of 34,000 (swelling to 275,000 in summer). TOBH is part of University Health Systems of Eastern Carolina.

It is estimated that prior to obtaining CAH status in March 2006, the proposed rule would decrease TOBH's reimbursement by about $750 thousand. Potential loss following CAH conversion is estimated at about $220 thousand. As a small CAH, every dollar of reimbursement is critical to the ongoing viability of our hospital. Given our location, we are the only hospital provider in a large geographic area, which makes us a vital part of protecting our community's health and welfare. Proposed legislation that reduces our reimbursement, weakens the hospital and jeopardizes our ability to fulfill our mission of serving the community.

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

4800 South Croatan Highway Nags Head, NC 27959 252.449.4500 Fax 252.449.4555 1.877.359.2172

applicable taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Nowhere in the Medicaid statute, however, is there any requirement that a "unit of government" have "generally applicable taxing authority." This new restrictive definition would disqualify many long-standing truly public hospitals from certifying their public expenditures. There is no basis in federal statute that supports this proposed change in definition.

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

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

Sincerely,

D. Van Smith, Jr.
President

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

Submitter : Mr. Michael Horsley **Date:** 03/16/2007

Organization : Alabama Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-160-Attach-1.PDF

#160

J. Michael Horsley
PRESIDENT

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:

This letter is written on behalf of the members of the Alabama Hospital Association (AlaHA) to express our opposition to the above-referenced regulation and to share our specific concerns. If the rule is implemented as proposed with the strictest interpretation, the Alabama Medicaid Agency could lose as much as $1 billion in funds, or one fourth of the Agency's total budget. And since the vast majority of Alabama's Medicaid program is federally mandated, losing such a significant amount of the funding could literally shut down the Medicaid program. Such a move could mean the loss of health care coverage for almost one million Alabamians.

First, the proposed rule is a significant change from long-standing Medicaid policy. The proposed rule imposes new restrictions on how states fund their Medicaid program, and further restricts how states may reimburse hospitals. These proposed changes would cause major disruptions to our state Medicaid program and hurt providers and beneficiaries alike. In addition, 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 for the U.S. Again, Alabama could lose over $700 million in federal funds next year. This amounts to a severe budget cut for our Medicaid program that bypasses the congressional approval process. It also 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

500 North East Blvd. • Montgomery, AL 36117 • phone: (334) 272-8781 • fax: (334) 270-9527 • web: www.alaha.org

opposition, with 226 House members and 43 Senators signing letters urging the proposed rule be stopped.

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

1. Limiting Payments to Government Providers

The rule proposes to limit reimbursement for government hospitals to the cost of providing services to Medicaid patients, and restricts states from making supplemental payments to these safety net hospitals through Medicaid Upper Payment Limit (UPL) programs. Nearly 27 years ago, Congress moved away from cost-based reimbursement for the Medicaid program, arguing that the reasonable cost-based reimbursement formula contained no incentives for efficient performance. Rather, in proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. Examples of CMS' zeal to reduce federal Medicaid spending include important costs, such as graduate medical education and physician on-call services or clinic services that would not be recognized and therefore would no longer be reimbursed. CMS also fails to explain why it is changing its position regarding the flexibility afforded to states under the UPL program. CMS, in 2002 court documents, described the UPL concept as setting aggregate payment amounts for specifically defined categories of health care providers and specifically defined groups of providers, but left to the states considerable flexibility to allocate payment rates within those categories. Those documents further note the flexibility to allow states to direct higher Medicaid payment to hospitals facing stressed financial circumstances. CMS reinforced this concept of state flexibility in its 2002 UPL final rule. CMS is disregarding (without explanation) its previous decisions that grant states flexibility under the UPL system to address the special needs of hospitals through supplemental payments.

2. New Definition of "Unit of Government"

For the first time since the creation of the Medicaid program, CMS is proposing to redefine "units of government within a state" as those entities that have "generally applicable taxing authority." Traditionally, states have been afforded the discretion of how these entities are defined. CMS's proposed definition usurps this authority and sharply conflicts with well-established Federal precedent for determining whether an entity is governmental in nature. The proposed definition is therefore seriously flawed and should not be adopted.

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

The proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). There is no authority in the statute for CMS to

restrict IGTs to funds directly generated from tax revenue. CMS has inexplicably attempted to use a provision in current law that *limits the Secretary's authority to regulate* IGTs as the source of authority that *all* IGTs must be made from state or local taxes. Not only is the proposed change inconsistent with historic CMS policy, but it is another instance in which CMS has misinterpreted a federal law. CPEs are restricted as well, so that only hospitals that meet the new definition of public hospital and are reimbursed on a cost basis would be eligible to use CPEs to help states fund their programs. These restrictions would result in fewer dollars being available to pay for needed care in Alabama.

4. Insufficient Data Supporting CMS's Estimate of Spending Cuts

CMS is required to examine relevant data to support the need to change current policy. The proposed rule estimates that the policy changes will result in $3.87 billion in spending cuts over the next five years. In Alabama alone, the proposed rule could cost the Medicaid Agency $ 1 billion or one-fourth of next year's budget. CMS has failed to provide any relevant data or facts to support its conclusion. CMS claims to have examined Medicaid financing arrangements across the country and has identified state financing practices that do not comport with the Medicaid statute. CMS, however, provides no information on which states or how many states are employing questionable financing practices. Alabama is in compliance with current financing requirements. The public, without access to such data, has not been given the opportunity to meaningfully review CMS' proposed changes, which call into question CMS' required adherence to administrative procedure requirements.

We oppose the rule and strongly urge that CMS permanently withdraw it. If the proposed rule is implemented, there will be drastic cuts in health care for the citizens of Alabama.

Sincerely,

J. Michael Horsley, president
Alabama Hospital Association

Submitter : Mr. Dwight Dill **Date:** 03/16/2007

Organization : Center for Human Development, Inc.

Category : Other Health Care Professional

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

CMS-2258-P-161-Attach-1.DOC

#161

CHD Center for Human Development, Inc.

1100 K Avenue La Grande, OR 97850 (541) 962-8800 Fax (541) 963-5272 TDD Dial 771

March 16, 2007

To Whom It May Concern:

My name is Dwight Dill and I represent the Center for Human Development, Inc., the Mental Health provider for Union County in the State of Oregon. I am writing to comment on the impact that proposed regulation CMS 2258-P will have on the Medicaid system in Oregon, with specific emphasis on the Medicaid Mental Health System.

Oregon County governments provide a substantial amount of Medicaid Mental Health Services under the State's 1115 demonstration waiver. Substantially all of the Medicaid Mental Health Services are provided by county government in 15 of the 36 Oregon Counties and 7 additional counties use a hybrid model of government and non-governmental providers. In all 22 cases, the counties are the critical safety net provider, treating the most seriously disabled Medicaid enrollees in their communities.

In most of the 22 counties served by government providers, the Medicaid Prepaid Inpatient Health Plans (PIHP) use risk-bearing payment mechanisms where counties are sub-capitated for all or a portion of the Medicaid enrollees. Under these financial arrangements the counties are responsible for meeting the mental 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 Oregon or a significant number of other states that have 1115 or 1915(b) waivers for their Medicaid Mental Health Systems.

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.***

Sincerely,

Dwight W. Dill
Mental Health Director

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

Organization : Alabama Hospital Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-162-Attach-1.DOC

#162

Gilliard Health Services, Inc.
and Affiliated Companies
P. O. Box 11809 3091 Carter Hill Road
Montgomery, Alabama 36111
Tel: 334 265-5009 Fax: 334 265-0305
gmckenzie@gilliardhealth.com

Evergreen Medical Center
Evergreen, Alabama

Jackson Medical Center
Jackson, Alabama

March 15, 2007

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

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

Dear Ms. Norwalk:

This letter is written on behalf of the members of the Alabama Hospital Association (AlaHA) to express our opposition to the above-referenced regulation and to share our specific concerns. If the rule is implemented as proposed, the Alabama Medicaid Agency could lose as much as $1 billion in funds ($300 million in state funds and $700 million in federal funds), or one fourth of the Agency's total budget. And since the vast majority of Alabama's Medicaid program is federally mandated, losing such a significant amount of the funding could literally shut down the Medicaid program. Such a move could mean the loss of health care coverage for almost one million Alabamians.

First, the proposed rule is a significant change from long-standing Medicaid policy. The proposed rule imposes new restrictions on how states fund their Medicaid program, and further restricts how states may reimburse hospitals. These proposed changes would cause major disruptions to our state Medicaid program and hurt providers and beneficiaries alike. In addition, 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 for the U.S. Again, Alabama could lose over $700 million in federal funds next year. This amounts to a severe budget cut for our Medicaid program that bypasses the congressional approval process. It also 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 signing letters urging the proposed rule be stopped.

We urge CMS to permanently withdraw this proposed rule. Following are our most significant concerns, which include: (1) the limitation on reimbursement of governmentally operated providers; (2) the narrowing of the definition of public

hospital; (3) the restrictions on intergovernmental transfers and certified public expenditures; and (4) the absence of data or other factual support for CMS's estimate of savings.

1. Limiting Payments to Government Providers

The rule proposes to limit reimbursement for government hospitals to the cost of providing services to Medicaid patients, and restricts states from making supplemental payments to these safety net hospitals through Medicaid Upper Payment Limit (UPL) programs. Nearly 27 years ago, Congress moved away from cost-based reimbursement for the Medicaid program, arguing that the reasonable cost-based reimbursement formula contained no incentives for efficient performance. Rather, in proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. Examples of CMS' zeal to reduce federal Medicaid spending include important costs, such as graduate medical education and physician on-call services or clinic services that would not be recognized and therefore would no longer be reimbursed. CMS also fails to explain why it is changing its position regarding the flexibility afforded to states under the UPL program. CMS, in 2002 court documents, described the UPL concept as setting aggregate payment amounts for specifically defined categories of health care providers and specifically defined groups of providers, but left to the states considerable flexibility to allocate payment rates within those categories. Those documents further note the flexibility to allow states to direct higher Medicaid payment to hospitals facing stressed financial circumstances. CMS reinforced this concept of state flexibility in its 2002 UPL final rule. CMS is disregarding (without explanation) its previous decisions that grant states flexibility under the UPL system to address the special needs of hospitals through supplemental payments.

2. New Definition of "Unit of Government"

The proposed rule puts forward a new and very restrictive definition of "unit of government," such as a public hospital. Public hospitals that meet this new definition must demonstrate they are an integral part of a unit of government that has taxing authority, at least according to a proposed survey recently published by CMS. Hospitals that do not meet this new definition would not be allowed to certify expenditures to our Medicaid program. The definition of "unit of government" does not require there to be "generally applicable taxing authority." It appears this new, restrictive definition would no longer permit many public hospitals from helping Alabama finance their share of Medicaid funding. There is no basis in federal statute that supports this proposed change in "unit of government" definition.

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

The proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). There is no authority in the statute for CMS to restrict IGTs to funds directly generated from tax revenue. CMS has inexplicably attempted to use a provision in current law that *limits the Secretary's authority to regulate* IGTs as the source of authority that *all* IGTs must be made from state or local taxes. Not only is the proposed change inconsistent with historic CMS policy, but it is another instance in which CMS has misinterpreted a federal law. CPEs are restricted as well, so that only hospitals that meet the new definition of public hospital and are reimbursed on a cost basis would be eligible to use CPEs to help states fund their programs. These restrictions would result in fewer dollars being available to pay for needed care in Alabama.

4. Insufficient Data Supporting CMS's Estimate of Spending Cuts

CMS is required to examine relevant data to support the need to change current policy. The proposed rule estimates that the policy changes will result in $3.87 billion in spending cuts over the next five years. In Alabama alone, the proposed rule could cost the Alabama Medicaid Agency over $700 million in federal funds in the next year. But CMS has failed to provide any relevant data or facts to support their conclusion. CMS claims to have examined Medicaid financing arrangements across the country and has identified state financing practices that do not comport with the Medicaid statute. CMS, however, provides no information on which states or how many states are employing questionable financing practices. Alabama is in compliance with current financing requirements. The public, without access to such data, has not been given the opportunity to meaningfully review CMS' proposed changes, which call into question CMS' required adherence to administrative procedure requirements.

We oppose the rule and strongly urge that CMS permanently withdraw it. If the proposed rule is implemented, there will be drastic cuts in healthcare for the citizens of Alabama.

Sincerely,

Gil McKenzie

Submitter : Mrs. Karen Dutton **Date:** 03/16/2007

Organization : Wyoming Medical Center

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

My comment would be to support the Emergency Nurses Association proposal. In Wyoming, we separated by long distances to the nearest healthcare facility and to make people who live in this state travel those distances; in many cases 50-100 or more miles, to obtain healthcare will be a detriment to their health status. Many of our hospitals have already closed and more will follow because of inadequate funding.

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

Organization : **Parkland Health & Hospital System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-164-Attach-1.DOC

#164

Parkland Health & Hospital System

March 16, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Parkland Memorial Hospital

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

Dear Ms. Norwalk:

Community Oriented Primary Care

On behalf of Parkland Health & Hospital System (Parkland), I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes $83 million in critical Medicaid support payments for funding that has been essential to our ability to serve as a major safety net health care system in our community.

Parkland Community Health Plan Inc.

Parkland serves over 1 million patients annually through our tertiary care hospital and our community oriented primary care system. We are one of two Level 1 trauma centers in the region and deliver approximately 16,000 babies annually. We are the regional burn center and only one of four in the state of Texas. We are an academic medical center and serve as the primary teaching hospital for the University of Texas Southwestern Medical Center. Approximately 50 percent of the doctors practicing in this county trained at Parkland

Parkland Foundation

As the major safety net provider in our community, we strongly oppose the Proposed Rule, and respectfully request you to withdraw it immediately. Moreover, we endorse the comments on the Proposed Rule by the National Association of Public Hospitals and Health Systems, submitted to the Centers for Medicare and Medicaid Services (CMS) on March 8, 2007. Below we provide more detailed comments on specific aspects of the rule, along with a description of how we believe each of these provisions would impact our hospital, our patients and our community.

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

Under current regulations, states are permitted to provide Medicaid reimbursement to hospitals and other providers up to the amount that would be payable using Medicare

payment principles. The Proposed Rule would reduce that limit to Medicaid costs for governmental providers only, resulting in significant cuts for our institution. We oppose the cost limit for public providers.

We currently receive supplemental Medicaid payments of approximately $107 million annually, based on the upper payment limit. These payments are critical to our ability to serve as a health care safety net in our community, as described above. If these supplemental payments are subject to the cut envisioned in the Proposed Rule, we will be forced to drastically scale back the scope of these activities, as they are not fully reimbursed and we do not have unlimited access to other sources of funding to replace the Medicaid cuts.

Limiting Medicaid payments to cost for safety net providers such as Parkland is, in our view, extremely short-sighted public policy. CMS asserts that the cost limit is necessary because public providers "use the excess of Medicaid revenue over cost to subsidize health care operations that are unrelated to Medicaid, or they may return a portion of the supplemental payments to the State as a source of revenue." (72 Fed. Reg. 2241). CMS has overreached in imposing this limit on us when we do not engage in these practices.

Second, to the extent that the Parkland uses Medicaid reimbursement to support the financial viability of the critical services described above, we submit that such activities *are* integrally related to Medicaid, and we are mystified at CMS' assertion to the contrary. A viable and financially stable Level I trauma center is absolutely essential to our community's health care system and in particular to Medicaid recipients. Similarly, our Medicaid program has a keen interest in ensuring that there is a strong emergency response capability in our region so that Medicaid beneficiaries can be assured of the care they need when they need it (even if stand-by capacities are not directly billable to Medicaid in and of themselves). Medicaid, just like Medicare, should be permitted to support a strong and vibrant medical education system so that there are sufficient doctors to provide care to Medicaid patients in the future. And our efforts to invest in accessible community-based clinics with hours that are compatible with the busy schedules of working families, doctors providing a "medical home," and staff that provides culturally and linguistically competent care are absolutely consistent with the goals of the Medicaid program.

We do not understand why CMS believes that these kinds of activities are not related to Medicaid. Nor do we understand why, when they are so clearly in the best interest of Medicaid recipients, CMS deems them not worthy of Medicaid's support. Governmental providers have a special role in our health care system, one that is entirely compatible with the goals of the Medicaid program. CMS should not single out governmental providers for such a particularly harsh and rigid reimbursement limit. We urge you to retain the current regulatory upper payment limits.

Intergovernmental Transfers (IGTs) (72 Fed. Reg. 2238)

The preamble to the Proposed Rule asserts that health care providers making intergovernmental transfers of funds to the Medicaid agency "must be able to demonstrate . . . [t]hat the source of the transferred funds is State or local tax revenue" in order for the funds to receive federal match. This

requirement that IGTs be derived from tax revenues is not repeated in the text of the regulation itself. We urge CMS to rescind this preamble statement.

Parkland has worked hard to reduce its reliance on taxpayer funding for its operations and instead has sought to achieve fiscal autonomy. Our reliance on taxpayer revenue is minimal in proportion to the size of our budget and the amount of uncompensated care we provide. In limiting IGTs to taxpayer funding only, the Proposed Rule would establish a significant financial incentive to do the exact opposite of what we have been doing, and would reward us with federal matching dollars for each dollar of taxpayer subsidy we obtain.

Funds held by a public entity are public funds, regardless of where those funds were derived, including patient care revenues. All sources of public funds held by a public entity should be a permissible source of funding for the non-federal share of Medicaid expenditures. The preamble statement should be withdrawn.

Effective Date (§§447.206(g); 447.272(d)(1); 447.321(d)(1))
CMS proposes to implement the Proposed Rule as of September 1, 2007 – an astonishingly ambitious schedule given the sweeping nature of the changes proposed. Assuming that a final regulation is not issued until this summer, states will have very little time to adopt the changes necessary to come into compliance. In our state, for example, the legislature is only in session 140 days every other year. After adjourning on May 28, the Texas Legislature will not convene again It would not be able to properly consider the changes in our program that may be required under the regulation in time to meet the deadline. Nor would our Medicaid agency have time to develop and obtain approval for any state plan amendments that may be required or to adopt changes to state rules and provider manuals. Establishing appropriate cost-reporting mechanisms as envisioned in the Proposed Rule will, in and of itself, require months of work.

Moreover, given the longstanding payment policies and financing arrangements that would be disrupted by the Proposed Rule, CMS should provide a generous transition period for states and providers to adjust to these enormous changes. We would recommend a minimum transition period of at least ten years.

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

If you have any questions, please feel free to contact Steven Bristow, Director of Legislative Advocacy at 214-590-6182.

Sincerely,

Ron Anderson M.D.

Ron J. Anderson, MD
President & CEO

Submitter : **Kevin Rowley** **Date: 03/16/2007**

Organization : **Southeastern Regional Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attached letter from J. Luckey Welsh, Jr., President and CEO of Southeastern Regional Medical Center in Lumberton, NC

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: 03/16/2007**

Organization : **La Rabida Children's Hospital**

Category : **Hospital**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

please see attachment for comments on proposed rule

CMS-2258-P-166-Attach-1.DOC

#166

March 16, 2007

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

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

Dear Sir/Madam:

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

The regulation as proposed would cut Medicaid funding by $3.8 billion, which would significantly limit the funding available for state Medicaid programs. If this regulation were to go into effect as planned in September 2007, our state could face a significant Medicaid funding shortfall that could result in cuts to the program. For Illinois, the impact of the proposed rules would represent a serious financial impact to hospitals and nursing homes providing healthcare for thousands of low-income, elderly, and disabled people throughout the state. Illinois' Governor has stated that this action would mean "a serious financial blow of $623 million" to certain public hospitals in Illinois and to the State. The total negative impact to Illinois' Medicaid program could be even greater. Therefore, the new restrictions in the proposed rule would not only impact public providers, but also all beneficiaries, especially children, and all health care providers participating in the program.

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

Impact on Children Covered by Medicaid

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

La Rabida is one of only a few hospitals in the country devoted to the care of children with complex, chronic illnesses and disabilities and the only such facility in the Chicago area. The hospital is a nationally recognized leader in caring for these children and for the victims of child abuse and sexual abuse. Nearly all of the children we serve are African Americans or other ethnic minorities from low-income families. La Rabida serves as a vital safety net for Chicago's poorest and most vulnerable children.

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

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

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

La Rabida is particularly reliant upon Medicaid because of the population we serve and could be severely harmed by substantial cuts to the Medicaid program. La Rabida is the most Medicaid-dependent hospital in the state of Illinois, with over 80% of revenue coming from Medicaid.

Additional Changes Unnecessary

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

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

Conclusion

As you can see from our comments, we are extremely concerned about this proposed regulation

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

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Nicole Paulk at 773-256-5902 or npaulk@larabida.org. Thank you for your consideration.

Sincerely,

Nicole S. Paulk
Associate Vice President, Planning and External Affairs
La Rabida Children's Hospital

Submitter : **Ms. Mary Ann Bergeron** **Date: 03/16/2007**

Organization : **Virginia Assn of Community Services Boards**

Category : **Other Association**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

Definition of Units of Government

GENERAL

GENERAL

See Attachment

CMS-2258-P-167-Attach-1.DOC

Virginia Association Of
Community Services Boards, Inc.
Making a Difference Together

Premier Mental Health, Mental Retardation, and Substance Use Disorder Services in Virginia's Communities

#167

10128-B West Broad Street • Glen Allen, VA 23060 • (804) 330-3141 • Fax (804) 330-3611 • Email: vacsb@vacsb.org

March 19, 2007

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

Re: CMS-2558-P

Dear Ms. Norwalk:

The Virginia Association of Community Services Boards (VACSB) is commenting on the proposed rule published January 18, 2007 on the "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership." The VACSB is composed of the public authorities, Community Services Boards (CSBs), charged by Virginia Code with assuring community-based services for individuals with mental illness, mental retardation, and substance use disorders, children and youth with serious emotional disturbance, and infants and toddlers with developmental disabilities and developmental delays.

As is the case with most public agencies, Virginia's Community Services Boards serve those children and adults with the most severe disabilities and assist them in overcoming the many limiting conditions associated with their disabilities and living in their communities. Given the very stringent criteria accorded by Virginia to people who are in the Aged, Blind, and Disabled category and their severe disabilities, the cost of care and supports for such individuals is high and typically not covered by the Medicaid rate. The VACSB opposes the proposed rule and strongly urges CMS to withdraw it.

It would appear that the rule is attempting to make judgments about 50 states, each of which has different FFP, eligibility for Medicaid, different state plan options, waivers, rates, and practices.

The VACSB agrees fully with the Virginia Department of Medical Assistance Services (DMAS) and does not believe that the proposed rule is necessary in any way to ensure the integrity of the federal-state financial partnership. The rule unreasonably interferes with the state determination of public entities and unfairly discriminates against those public entities considered public agencies in Virginia, regardless of the criteria used by CMS, of which most, if not all, would not apply to Community Services Boards. While some CSBs may be considered more closely attached to their local governments than most, all are governed by the same state policies, regulations, and DMAS provider agreements. Why should certain CSBs be at risk of being treated differently than others?

Why would cost reporting be necessary for publicly-operated health care providers who do not participate in the non-federal share of FFP and who retain all of the payments made by the State Medicaid agency to them? The proposed rule unreasonably limits reimbursement to public providers and imposes unnecessary, unneeded

and burdensome cost reporting requirements on public providers. The rule is too broad with great probability for unintended consequences.

The final point VACSB would make is that the Virginia rates for Medicaid services have not been indexed for inflation over the past fourteen years. It should not be necessary for CSBs to prove costs.

The VACSB appreciates the opportunity to comment on the proposed rule. Our members would encourage CMS to withdraw the proposed rule. We believe that it will harm the Virginia Medicaid program and Virginia service recipients.

Yours truly,

Mary Ann Bergeron, Executive Director

Submitter : Mr. Scott Street **Date:** 03/16/2007

Organization : Duncan Regional Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comment letter.

CMS-2258-P-168-Attach-1.DOC

#168

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 Duncan Regional Hospital, we appreciate 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. Duncan Regional Hospital opposes this proposed rule and would like to highlight the harm it would cause to hospitals and the patients we serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid 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, our state—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 580-251-8555 or by email at

scott.street@duncanregional.com.

Sincerely,
Duncan Regional Hospital

Scott Street
President & CEO
P.O. Box 2000
Duncan, OK 73534

Submitter : **Mr. Michael McManus** **Date: 03/16/2007**

Organization : **Touchette Regional Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-2258-P-169-Attach-1.DOC

#169

Touchette
Regional Hospital

5900 Bond Avenue, Centreville, IL 62207
P: 618.332.3060 F: 618.332.5256
www.touchette.org

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:

Touchette Regional Hospital appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospitals and the patients they serve.

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

CMS estimates that the rule will cut $3.9 billion in federal spending over five years. This amounts to a budget cut for us as a safety-net hospital 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.

The impact of the proposed rules would represent a serious financial impact to us as we provide healthcare for low-income, elderly, and disabled people in our service area. Our Governor has stated that this action would mean "a serious financial blow of $623 million" to certain public hospitals in Illinois and to the State. The total negative impact to Illinois' Medicaid program could be even greater.

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

Limiting Payments to Government Providers

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

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

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

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

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

STH Touchette
Regional Hospital

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

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

Sincerely,

Michael McManus
Chief Operating Officer

Submitter : **Mrs. Belle Shepherd** **Date: 03/16/2007**

Organization : **Josephine County Public Health**

Category : **Local Government**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

see the attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see the attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

see the attachment

CMS-2258-P-170-Attach-1.TXT

#170

Josephine County, Oregon

Board of Commissioners: Dwight Ellis, Jim Raffenburg, Dave Toler

TTD# 1-800-735-2900 **Belle Shepherd, MPH, Administrator**
Josephine County Public Health

715 NW Dimmick
Grants Pass, OR 97526
(541) 474-5325
Fax (541) 474-5353
E-mail : publichealth@co.josephine.or.us

March 15, 2007

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

Re: Medicaid Program; Cost Limit for Providers operated by Units of Government and Provisions to ensure the integrity of Federal-State Financial Partnership

Dear Secretary Leavitt:

Please accept this letter as a comment in response to the above proposed rule change from Josephine County Public Health Department in Grants Pass, Oregon. It seems clear that the intent of the proposed rule change is valid, in that it seeks to provide a clean source of funds for Medicaid and SCHIP match dollars; however the actual impact could be much broader. Specifically, upon review of the change it seems apparent that there would be an adverse impact on our ability to provide Medicaid services to the residents of our community, especially medically at-risk infants and children.

Currently, our county uses funds for matching purposes that come from fees, contributions, non-profit grants and other resources. If we are unable to use these funds our ability to secure Medicaid funds will be severely limited. The rule proposal recommends use of tax dollars or County general funds for matching. These dollars are continually being decreased for our department, so do not represent a stable or substantial enough match amount for our programs. The Medicaid funds that we currently receive are critical to the sustainability of services to vulnerable populations.

Given the high poverty levels in Josephine County (63% of our WIC clients), and the amount of funding that comes from Medicaid, approximately 11%, Josephine County Public Health would be severely limited in it's ability to provide services to those most in need if this proposed rule change takes effect. Our community members have come to rely upon our ability to provide these services for those most at need in the County.

Additionally, the proposal requires considerable increases in reporting, which could outweigh the benefits of providing the service particularly in rural areas, or a majority of Josephine County. Other concerns regarding payment prior to reimbursement could debilitate the State coffers and should be taken into consideration prior to any change of this magnitude.

I would encourage you to consider these concerns as you move forward with this rule making process. When rules are revised and revenue streams are impacted, we are unduly impacting those who can afford it the least – the children of our county.

Sincerely,

Belle S. Shepherd, MPH
Administrator

Submitter : Mr. Dale Spencer **Date:** 03/16/2007

Organization : Anson Community Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-171-Attach-1.DOC

#171

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, 2007

Dear Ms. Norwalk:

Anson Community Hospital is a small primary care facility that operates 30 acute and 95 long-term care beds. The Hospital offers a range of medical, surgical, emergency, and pediatric services on both an inpatient and outpatient basis. The Administration and Trustees of Anson Community Hospital oppose the promulgation of the regulations that were published on January 18, 2007.

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

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

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

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

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

Anson Community 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, Anson Community Hospital 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,

Fred G. Thompson, Ph.D., FACHE
Chief Executive Officer

Dale Spencer, C.H.F.P.
Chief Financial Officer

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

Organization : SC Department of Health and Human Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-172-Attach-1.DOC

#172

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

March 16, 2007

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

Dear Ms. Norwalk:

The South Carolina Department of Health and Human Services is submitting the following comments on the proposed rule regarding Cost Limits for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Partnership published in the Federal Register on January 18, 2007.

South Carolina supports the concept of limiting Federal reimbursement to reasonable and necessary costs of delivering Medicaid services. The stated intent of the proposed rule to limit reimbursement for health care providers that are operated by units of government to an amount that does not exceed the provider' s cost would appear to be consistent with that philosophy, and we believe that South Carolina's reimbursement methodologies would already be in compliance with many of the provisions of the proposed rule. However, in our opinion, some provisions of the proposed rule create an unreasonable administrative burden on the Medicaid agency and providers, some provisions are unclear, and other provisions may have the unintended effect of increasing rather than decreasing Federal reimbursement for some health care providers that are operated by units of government. Those specific concerns are outlined below.

1. Disproportionate Share / Upper Payment Limit

Sections 447.272 and 447.321 of the proposed rule regarding the Medicaid Upper Payment Limit (UPL) calculation for institutional and acute care providers that are operated by units of government would not appear to impact the current calculation of

Office of the Director
P.O. Box 8206 Columbia, South Carolina 29202-8206
(803) 898-2504 Fax (803) 255-8235

the Medicaid DSH UPL's under the South Carolina State Plan. However, SC Medicaid DSH payments are prospectively established using a prior year base period trended forward to the DSH payment period and represent the unreimbursed costs of the uninsured and Medicaid HMO enrollees. While Section 447.272 of the proposed rule includes an exception for DSH payments, it is not clear whether this exception would allow the current South Carolina DSH payment methodology or whether it would require the State to annually review the actual unreimbursed costs of the uninsured and Medicaid HMO enrollees of DSH hospitals operated by units of government to ensure that the Medicaid DSH payments did not exceed the actual costs of providing inpatient and outpatient hospital services during the DSH payment period.

If the latter interpretation of the proposed rule is correct, then we recommend that the rule be modified to allow for the consistent application of a prospective DSH payment methodology which has been employed for a number of years, which uses base year cost reports trended forward rather than an annual reconciliation of costs. We believe that such a methodology meets the intent of the CMS proposal to limit reimbursement to DSH hospitals operated by units of government to no more than costs as long as the base years are updated annually. We would recommend that language be included in either the preamble or the body of the final rule which clarifies exactly how the rule does or does not affect DSH payments.

2. Medicare Cost Report vs State Specific Cost Report

Section 447.206 of the proposed rule requires the use of the applicable Medicare cost report to document the costs incurred by hospitals and nursing homes operated by units of government. While South Carolina employs the Medicare 2552-96 hospital cost report for hospitals and intermediate care facilities for the mentally retarded (ICF/MRs) in its rate setting and/or cost settlement activities, the state has developed its own state specific Medicaid cost report for nursing home providers. We found that the Medicare cost report did not provide the detailed information needed for our rate-setting process, and the South Carolina nursing home cost report provides much more detailed information by cost center. It would not make sense to require a state such as South Carolina to choose between adopting a cost report that provides less information than the one currently in use or to require providers to submit two cost reports. Therefore, we recommend that this section be modified to allow a state that is already using its own cost report form for non-hospital services as of the effective date of the regulations, to continue using its own form, provided that the form meets or exceeds the amount of information included in the Medicare cost report.

3. Market Based vs Cost and Cost Reports

Section 447.206 of the proposed rule also requires that providers of non-institutional/non-acute care Medicaid services operated by units of government must submit annual cost reports to ensure that Medicaid reimbursement does not exceed the allowable Medicaid costs of the provider, whether or not they are funded by certified public expenditures. This provision is in direct conflict with the current direction/instruction supplied to South Carolina by the CMS Non-Institutional Payment Team (NIPT), and in some cases would have the unintended effect of increasing rather than decreasing Federal reimbursement for Medicaid services provided by state agencies in South Carolina.

Over the past few years, the South Carolina Medicaid Program has expended a tremendous amount of time and effort developing market based rates for non-institutional/non-acute care Medicaid services provided by state agencies. We have worked closely with the NIPT to move from cost-based reimbursement rates to market-based rate setting methodologies that were acceptable to CMS. NIPT has instructed the state that if Medicaid rates are established using Medicare or commercial rates as the basis, cost reports would no longer be required from these providers unless certified public expenditures (CPE) are used.

There are several reasons why this change of methodology (i.e. from cost based/settled rates to market based rates) is beneficial to the state as well as CMS. Our experience is that the long-standing rules which allow state agencies to be reimbursed up to cost has in practice come to be interpreted as an entitlement for these providers to be able to recover their full cost, rather than serving as a limitation on cost. Thus there is no incentive for a state agency to control the cost of Medicaid services if they know that they will receive a retroactive cost settlement for the difference between the prospective rate and their actual allowable cost, which in the vast majority of cases is higher. This not only increases Federal Medicaid expenditures, but also results in inequities in which state agencies are reimbursed a higher rate than private providers for the same service. By moving to market-based rates, state agencies have the same incentive as private providers to control their costs to stay within the market based rate.

Another reason for moving to market-based rates is that it provides an opportunity to streamline administration for both the Medicaid agency and state agency and other governmental service providers, such as school districts. In South Carolina, state agency Medicaid service providers have been accustomed to funding their services through certified public expenditures, and they file annual cost reports in order to claim cost settlements up to their actual allowable cost of providing Medicaid services. The

cost report also serves the dual purpose of documenting their certified public expenditures.

For those agencies and services that we have not converted to market-based rates, this process is still in place, and would be in compliance with the proposed rule. However, based on guidance from NIPT, we have used elimination of the cost reporting requirement as an incentive for state agencies to voluntarily move to market-based rates. NIPT has advised South Carolina that the payment of the Medicare or commercial market rate is consistent with what the market pays for these services and therefore, would not exceed the reasonable costs for providing these services. Whenever possible we use Medicare rate as the market rate, because they are universally recognized, and there is less administrative cost involved in tying Medicaid rates to the Medicare fee schedule than developing our own rates. Another result of the change in methodology is that since cost reports have been eliminated, the state agencies must move from certified public expenditures to transferring state appropriations through IGT's to the Medicaid agency for the state share.

We have used this approach successfully with the South Carolina Department of Education and the eighty-five local school districts for the past two years, and have completed and/or begun the conversion process on an individual service basis with some of the other state agencies. We believe that the use of market-based rates, and funding through IGT's from allowable sources (state or local appropriated funds), is a superior alternative to cost-based reimbursement and CPE's in achieving the intent of the propose rule to assure that reimbursements to providers operated by units of government do not exceed the reasonable cost of providing the services. This approach has the additional advantage of more streamlined administration, thus lowering administrative cost as well.

South Carolina has acted in good faith in consultation with NIPT to develop this methodology, and it would be difficult to continue to move in this direction if providers operated by units of government are required to submit cost reports regardless of whether their reimbursement is cost-based or marked-based. This would be particularly problematic in the case of the numerous school districts that have never been required to submit cost reports on all of the Medicaid services that they provide (including professional). The additional staffing required to teach them how to do cost reports and the additional staff required to review those cost reports would substantially increase the administrative cost of those services. Therefore, we urge CMS to consider modifying the proposed rule to remove the requirement for cost reports for non-institutional/non-acute care services provided by providers operated by units of government when a CMS-approved market based reimbursement methodology is used and the services are not funded through certified public expenditures.

In the event that the proposed rule becomes final as drafted, then CMS should allow state agencies to allocate the administrative overhead cost to each of the Medicaid services that it provides. We see no difference between the operations of most state agencies and a home office provider which is allowed to allocate its costs to each of the providers which it operates/owns. Additionally, unless CMS develops a national cost report format for non-institutional/non-acute care Medicaid services provided by providers operated by units of government, then CMS should automatically accept the cost report format currently in use by the states.

4. Out of State IGT

Finally we would recommend that CMS add language in Section 433.51 and Section 457.220 that IGT's from out of state border hospitals that meet the criteria of units of government are an allowable source of the state share in claiming FFP. It is illogical that states are required to reimburse these out of state providers operated by units of government for Medicaid and DSH payments the same as in-state hospitals, yet there is no mechanism for those units of government to participate in the funding of these services.

In summary, we are not opposed to the overall objectives of the proposed rule, but we are opposed to some of the specific provisions which create an unreasonable administrative burden and which will actually increase rather than reduce Federal expenditures. We believe the proposed rule can be improved to more effectively accomplish its objectives by adopting the changes that we have recommended. We also believe that CMS can achieve a large majority of its goals by simply revising the institutional and acute care Medicaid UPL calculations to no more than allowable Medicare cost for each of the three classes cited in 447.272.

We appreciate your consideration of our comments.

Sincerely,

Robert M. Kerr
Director

RMK/lm

Submitter : Mr. Shawn Ullrich **Date:** 03/16/2007

Organization : Emergency Nurses Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached.

#173

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 : Ms. Kim Roberts **Date:** 03/16/2007

Organization : Santa Clara Valley Health & Hospital System

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-174-Attach-1.PDF

#174

Dedicated to the Health
of the Whole Community

SANTA CLARA
VALLEY
HEALTH & HOSPITAL SYSTEM

Kim Roberts
Acting Executive Director
2325 Enborg Lane #360
San Jose, California 95128
Phone: (408) 885-6868
Fax: (408) 885-6886

March 15, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

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

Dear Ms. Norwalk:

On behalf of Santa Clara Valley Medical Center (VMC), we are writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes nearly $32 million in critical Medicaid support payments for VMC, funding that has been essential to our ability to serve as a major safety net health care system in our community.

Valley Medical Center is the largest provider of medical services to residents of Silicon Valley. VMC provides a wide range of primary through tertiary inpatient services to a very large and diverse population. In 2006, nearly 200,000 people (or 1 in 10 residents of Santa Clara County) received care at VMC. Looking back over the past four years, VMC's unduplicated patient count was 410,000, meaning that 1 in 5 residents of Santa Clara County receives care at VMC.

Valley Medical Center is the only disproportionate share hospital remaining in Santa Clara County. We provided 50% of care to Medicaid patients and over 90% of the care provided to the uninsured in calendar year 2005. In addition, VMC is the only burn center in the region and one of only two burn trauma centers in California north of Los Angeles. VMC provides spinal cord and traumatic brain injury rehabilitation, pediatric

intensive care, regional Level III neonatal intensive care, and is the county's only psychiatric emergency service. VMC's outpatient department and community clinic partners provide over 1 million outpatient clinic visits each year. VMC also works with Stanford University to offer a top-notch physician training program.

As the major safety net provider in our community, we strongly oppose the Proposed Rule, and respectfully request you to withdraw it immediately. Moreover, we endorse the comments on the Proposed Rule by the National Association of Public Hospitals and Health Systems, submitted to the Centers for Medicare and Medicaid Services (CMS) on March 8, 2007. Below we provide more detailed comments on specific aspects of the rule, along with a description of how we believe each of these provisions would impact our hospital, our patients and our community.

- Defining a Unit of Government (§ 433.50)

The Proposed Rule would impose a new definition of a "unit of government" on states that would require an entity to have generally applicable taxing authority in order to be considered governmental. Entities that are not units of government (or providers operated by units of government) would be prohibited from contributing funding to the non-federal share of Medicaid expenditures through intergovernmental transfers ("IGTs") or certification of public expenditures ("CPEs"). VMC opposes this restrictive new definition and urges CMS to allow states to determine which entities are units of government pursuant to state law. As a governmental entity, VMC would be covered by this definition but other entities in California would not, which impacts VMC's fiscal health.

The Proposed Rule threatens to undermine the good that we have accomplished through California's Medicaid program. Medicaid has always recognized our funding as public, and, in accordance with the statutory scheme established by Congress in Title XIX of the Social Security Act, has allowed our funds to be used as the non-federal share of Medicaid expenditures. The matching of our funds is a *critical* element of our operation, and the $175-180 million in payments that we receive in connection with this match is essential to our ability to carry out the safety net role described above. Given that we, like many of our counterparts across the country, are contributing to Medicaid expenditures through mechanisms that are not in any way abusive, it is unclear why CMS feels the need to adopt a restrictive definition of a unit of government.

We urge you to defer to state law in the determination of "units of government."

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

Under current regulations, states are permitted to provide Medicaid reimbursement to hospitals and other providers up to the amount that would be payable using Medicare payment principles. The Proposed Rule would reduce that limit to Medicaid costs for

governmental providers only, resulting in significant cuts for our institution. We oppose the cost limit for public providers.

VMC currently receives supplemental Medicaid payments of approximately $35-40 million annually, based on the upper payment limit. These payments are critical to our ability to serve as a health care safety net in our community, as described above. If these supplemental payments are subject to the cut envisioned in the Proposed Rule, we will be forced to drastically scale back the scope of these activities, as they are not fully reimbursed and we do not have access to other sources of funding to replace the Medicaid cuts.

Limiting Medicaid payments to cost for safety net providers such as VMC is, in our view, extremely short-sighted public policy. CMS asserts that the cost limit is necessary because public providers "use the excess of Medicaid revenue over cost to subsidize health care operations that are unrelated to Medicaid, or they may return a portion of the supplemental payments to the State as a source of revenue." (72 Fed. Reg. 2241) First, VMC does not return Medicaid payments to California as a source of revenue. To the extent that the cost limit is intended to prevent such refunds, it is unnecessary in our case. CMS has overreached in imposing this limit on us when we do not engage in these practices.

Second, to the extent that VMC uses Medicaid reimbursement to support the financial viability of the critical services described above, we submit that such activities *are* integrally related to Medicaid, and we are mystified at CMS' assertion to the contrary. A viable and financially stable Level I trauma center is absolutely essential to our community's health care system and in particular to our Medicaid recipients. Similarly, our Medicaid program has a keen interest in ensuring that there is a strong emergency response capability in our region so that beneficiaries can be assured of the care they need when they need it (even if stand-by capacities are not directly billable to Medicaid in and of themselves). Medicaid, just like Medicare, should support a strong and vibrant medical education system so that there are sufficient doctors to provide care to Medicaid patients in the future. And our efforts to invest in accessible community-based clinics with hours that are compatible with the busy schedules of working families, doctors providing a "medical home," and staff that provides culturally and linguistically competent care are absolutely consistent with the goals of the Medicaid program.

Governmental providers have a special role in our health care system, one that is entirely compatible with the goals of the Medicaid program. CMS should not single out governmental providers for such a particularly harsh and rigid reimbursement limit. We urge you to retain the current regulatory upper payment limits.

- Intergovernmental Transfers (IGTs) (72 Fed. Reg. 2238)

The preamble to the Proposed Rule asserts that health care providers making intergovernmental transfers of funds to the Medicaid agency "must be able to demonstrate . . . [t]hat the source of the transferred funds is State or local tax revenue" in

order for the funds to receive federal match. This requirement that IGTs be derived from tax revenues is not repeated in the text of the regulation itself. We urge CMS to rescind this preamble statement.

VMC has worked hard to reduce its reliance on taxpayer funding for its operations and instead has sought to achieve fiscal autonomy. While our reliance on taxpayer revenue is increasing as cost and demand rise faster than increases in reimbursement, these funds are not the predominant source of support in proportion to the size of our budget and the amount of uncompensated care we provide. In limiting IGTs to taxpayer funding only, the Proposed Rule could establish a significant financial incentive to do the exact opposite of what we have been doing, and would reward providers with federal matching dollars for each dollar of taxpayer subsidy obtained.

Funds held by a public entity are public funds, regardless of where those funds were derived, including patient care revenues. All sources of public funds held by a public entity should be a permissible source of funding for the non-federal share of Medicaid expenditures. The preamble statement should be withdrawn.

- Applicability of the Proposed Rule to Professional Providers (§§ 433.50, 447.206)

California is awaiting approval from CMS for a state plan amendment that will allow our physicians to receive Medicaid reimbursement. Given the disproportionate burden that our physicians willingly undertake in serving low income Medicaid and uninsured patients, this funding is critical to our financial viability as well. The cost limit contained in the Proposed Rule does not specify whether it applies only to institutional providers or also to professional providers. If it applies to professional providers, it is unclear how to determine whether such providers are an "integral part" of a unit of government or are "operated by" a unit of government. A cost limit would be particularly inappropriate for professional services. We request that CMS clarify that the provisions of the Proposed Rule do not apply to professionals.

- Certified Public Expenditures (CPEs) (§§ 447.206(d)-(e))

As a public entity, we certify our expenditures to help finance the non-federal share of our Medicaid payments. We object to the discussion in the preamble of the regulation (that is not repeated in the text of the regulation) that units of government that are providers can only certify their expenditures if they are paid on a cost basis. There is no reason to impose this limitation on the use of CPEs. The preamble acknowledges that units of government that are *not* providers may certify their payments to providers even if the state plan payment methodology is not cost-based. The same should apply to the provider itself. We would, of course, not be able to certify any costs that are in excess of the payment that would result from the state plan methodology. But the costs that we incur in connection with services to Medicaid patients are no less real than the costs a non-provider unit of government would incur if they paid us for providing Medicaid services. Please confirm that the regulatory text stands on its own and rescind the

preamble discussion requiring providers to be paid on a cost basis in order to certify expenditures as the non-federal share.

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

The preamble to the Proposed Rule states that "all Medicaid payments ... made under ... Medicaid waiver and demonstration authorities are subject to all provisions of this regulation." (72 Fed. Reg. 2240). In Fiscal Year 2005/2006, our state negotiated an extremely complex Section 1115 demonstration program with CMS that we have been working hard to implement. The underpinning of this demonstration project is the establishment of the Safety Net Care Pool funding for which CMS has authorized through its authority under Section 1115(a)(2) of the Social Security Act to provide federal financial participation for expenditures that are not otherwise matchable. California has agreed, pursuant to the demonstration project, to limit Medicaid reimbursement to governmental hospitals to their costs, similar to the limit contained in the Proposed Rule. The savings derived from this voluntary agreement to keep payments lower than what would be allowed under the current upper payment limit regulation has been reinvested in the Safety Net Care Pool.

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

- Effective Date (§§447.206(g); 447.272(d)(1); 447.321(d)(1))

CMS proposes to implement the Proposed Rule as of September 1, 2007 – an ambitious schedule given the sweeping nature of the changes proposed. Assuming that a final regulation is not issued until this summer, states will have very little time to adopt the changes necessary to come into compliance. It would not be able to properly consider the changes in our program that may be required under the regulation in time to meet the deadline. Nor would our Medicaid agency have time to develop and obtain approval for any state plan amendments that may be required or to adopt changes to state rules and provider manuals.

Moreover, given the longstanding payment policies and financing arrangements that would be disrupted by the Proposed Rule, CMS should provide a generous transition

period for states and providers to adjust to these enormous changes. We would recommend a minimum transition period of at least ten years.

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

If you have any questions about this letter, please feel free to contact us at 408-885-6868.

Sincerely,

Kim Roberts
Chief Executive Officer
Santa Clara Valley Health & Hospital System

Robin Roche
Acting Director
Valley Medical Center

Submitter : Mr. Robin Roche **Date:** 03/16/2007

Organization : Valley Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-175-Attach-1.PDF

#175

Dedicated to the Health of the Whole Community

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Kim Roberts
Acting Executive Director
2325 Enborg Lane #360
San Jose, California 95128
Phone: (408) 885-6868
Fax: (408) 885-6886

March 15, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

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

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intensive care, regional Level III neonatal intensive care, and is the county's only psychiatric emergency service. VMC's outpatient department and community clinic partners provide over 1 million outpatient clinic visits each year. VMC also works with Stanford University to offer a top-notch physician training program.

As the major safety net provider in our community, we strongly oppose the Proposed Rule, and respectfully request you to withdraw it immediately. Moreover, we endorse the comments on the Proposed Rule by the National Association of Public Hospitals and Health Systems, submitted to the Centers for Medicare and Medicaid Services (CMS) on March 8, 2007. Below we provide more detailed comments on specific aspects of the rule, along with a description of how we believe each of these provisions would impact our hospital, our patients and our community.

- Defining a Unit of Government (§ 433.50)

The Proposed Rule would impose a new definition of a "unit of government" on states that would require an entity to have generally applicable taxing authority in order to be considered governmental. Entities that are not units of government (or providers operated by units of government) would be prohibited from contributing funding to the non-federal share of Medicaid expenditures through intergovernmental transfers ("IGTs") or certification of public expenditures ("CPEs"). VMC opposes this restrictive new definition and urges CMS to allow states to determine which entities are units of government pursuant to state law. As a governmental entity, VMC would be covered by this definition but other entities in California would not, which impacts VMC's fiscal health.

The Proposed Rule threatens to undermine the good that we have accomplished through California's Medicaid program. Medicaid has always recognized our funding as public, and, in accordance with the statutory scheme established by Congress in Title XIX of the Social Security Act, has allowed our funds to be used as the non-federal share of Medicaid expenditures. The matching of our funds is a *critical* element of our operation, and the $175-180 million in payments that we receive in connection with this match is essential to our ability to carry out the safety net role described above. Given that we, like many of our counterparts across the country, are contributing to Medicaid expenditures through mechanisms that are not in any way abusive, it is unclear why CMS feels the need to adopt a restrictive definition of a unit of government.

We urge you to defer to state law in the determination of "units of government."

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

Under current regulations, states are permitted to provide Medicaid reimbursement to hospitals and other providers up to the amount that would be payable using Medicare payment principles. The Proposed Rule would reduce that limit to Medicaid costs for

governmental providers only, resulting in significant cuts for our institution. We oppose the cost limit for public providers.

VMC currently receives supplemental Medicaid payments of approximately $35-40 million annually, based on the upper payment limit. These payments are critical to our ability to serve as a health care safety net in our community, as described above. If these supplemental payments are subject to the cut envisioned in the Proposed Rule, we will be forced to drastically scale back the scope of these activities, as they are not fully reimbursed and we do not have access to other sources of funding to replace the Medicaid cuts.

Limiting Medicaid payments to cost for safety net providers such as VMC is, in our view, extremely short-sighted public policy. CMS asserts that the cost limit is necessary because public providers "use the excess of Medicaid revenue over cost to subsidize health care operations that are unrelated to Medicaid, or they may return a portion of the supplemental payments to the State as a source of revenue." (72 Fed. Reg. 2241) First, VMC does not return Medicaid payments to California as a source of revenue. To the extent that the cost limit is intended to prevent such refunds, it is unnecessary in our case. CMS has overreached in imposing this limit on us when we do not engage in these practices.

Second, to the extent that VMC uses Medicaid reimbursement to support the financial viability of the critical services described above, we submit that such activities *are* integrally related to Medicaid, and we are mystified at CMS' assertion to the contrary. A viable and financially stable Level I trauma center is absolutely essential to our community's health care system and in particular to our Medicaid recipients. Similarly, our Medicaid program has a keen interest in ensuring that there is a strong emergency response capability in our region so that beneficiaries can be assured of the care they need when they need it (even if stand-by capacities are not directly billable to Medicaid in and of themselves). Medicaid, just like Medicare, should support a strong and vibrant medical education system so that there are sufficient doctors to provide care to Medicaid patients in the future. And our efforts to invest in accessible community-based clinics with hours that are compatible with the busy schedules of working families, doctors providing a "medical home," and staff that provides culturally and linguistically competent care are absolutely consistent with the goals of the Medicaid program.

Governmental providers have a special role in our health care system, one that is entirely compatible with the goals of the Medicaid program. CMS should not single out governmental providers for such a particularly harsh and rigid reimbursement limit. We urge you to retain the current regulatory upper payment limits.

- Intergovernmental Transfers (IGTs) (72 Fed. Reg. 2238)

The preamble to the Proposed Rule asserts that health care providers making intergovernmental transfers of funds to the Medicaid agency "must be able to demonstrate . . . [t]hat the source of the transferred funds is State or local tax revenue" in

order for the funds to receive federal match. This requirement that IGTs be derived from tax revenues is not repeated in the text of the regulation itself. We urge CMS to rescind this preamble statement.

VMC has worked hard to reduce its reliance on taxpayer funding for its operations and instead has sought to achieve fiscal autonomy. While our reliance on taxpayer revenue is increasing as cost and demand rise faster than increases in reimbursement, these funds are not the predominant source of support in proportion to the size of our budget and the amount of uncompensated care we provide. In limiting IGTs to taxpayer funding only, the Proposed Rule could establish a significant financial incentive to do the exact opposite of what we have been doing, and would reward providers with federal matching dollars for each dollar of taxpayer subsidy obtained.

Funds held by a public entity are public funds, regardless of where those funds were derived, including patient care revenues. All sources of public funds held by a public entity should be a permissible source of funding for the non-federal share of Medicaid expenditures. The preamble statement should be withdrawn.

- Applicability of the Proposed Rule to Professional Providers (§§ 433.50, 447.206)

California is awaiting approval from CMS for a state plan amendment that will allow our physicians to receive Medicaid reimbursement. Given the disproportionate burden that our physicians willingly undertake in serving low income Medicaid and uninsured patients, this funding is critical to our financial viability as well. The cost limit contained in the Proposed Rule does not specify whether it applies only to institutional providers or also to professional providers. If it applies to professional providers, it is unclear how to determine whether such providers are an "integral part" of a unit of government or are "operated by" a unit of government. A cost limit would be particularly inappropriate for professional services. We request that CMS clarify that the provisions of the Proposed Rule do not apply to professionals.

- Certified Public Expenditures (CPEs) (§§ 447.206(d)-(e))

As a public entity, we certify our expenditures to help finance the non-federal share of our Medicaid payments. We object to the discussion in the preamble of the regulation (that is not repeated in the text of the regulation) that units of government that are providers can only certify their expenditures if they are paid on a cost basis. There is no reason to impose this limitation on the use of CPEs. The preamble acknowledges that units of government that are *not* providers may certify their payments to providers even if the state plan payment methodology is not cost-based. The same should apply to the provider itself. We would, of course, not be able to certify any costs that are in excess of the payment that would result from the state plan methodology. But the costs that we incur in connection with services to Medicaid patients are no less real than the costs a non-provider unit of government would incur if they paid us for providing Medicaid services. Please confirm that the regulatory text stands on its own and rescind the

preamble discussion requiring providers to be paid on a cost basis in order to certify expenditures as the non-federal share.

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

The preamble to the Proposed Rule states that "all Medicaid payments ... made under ... Medicaid waiver and demonstration authorities are subject to all provisions of this regulation." (72 Fed. Reg. 2240). In Fiscal Year 2005/2006, our state negotiated an extremely complex Section 1115 demonstration program with CMS that we have been working hard to implement. The underpinning of this demonstration project is the establishment of the Safety Net Care Pool funding for which CMS has authorized through its authority under Section 1115(a)(2) of the Social Security Act to provide federal financial participation for expenditures that are not otherwise matchable. California has agreed, pursuant to the demonstration project, to limit Medicaid reimbursement to governmental hospitals to their costs, similar to the limit contained in the Proposed Rule. The savings derived from this voluntary agreement to keep payments lower than what would be allowed under the current upper payment limit regulation has been reinvested in the Safety Net Care Pool.

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

- Effective Date (§§447.206(g); 447.272(d)(1); 447.321(d)(1))

CMS proposes to implement the Proposed Rule as of September 1, 2007 – an ambitious schedule given the sweeping nature of the changes proposed. Assuming that a final regulation is not issued until this summer, states will have very little time to adopt the changes necessary to come into compliance. It would not be able to properly consider the changes in our program that may be required under the regulation in time to meet the deadline. Nor would our Medicaid agency have time to develop and obtain approval for any state plan amendments that may be required or to adopt changes to state rules and provider manuals.

Moreover, given the longstanding payment policies and financing arrangements that would be disrupted by the Proposed Rule, CMS should provide a generous transition

period for states and providers to adjust to these enormous changes. We would recommend a minimum transition period of at least ten years.

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

If you have any questions about this letter, please feel free to contact us at 408-885-6868.

Sincerely,

Kim Roberts
Chief Executive Officer
Santa Clara Valley Health & Hospital System

Robin Roche
Acting Director
Valley Medical Center

Submitter : **Ms. Becky Martin** **Date: 03/16/2007**

Organization : **Jackson County Mental Health**

Category : **Other Health Care Professional**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

CMS-2258-P-176-Attach-1.DOC

#176

My name is Becky Martin and I am the Division Manger for Jackson County Mental Health, a mental health services provider in Southern Oregon. I am writing to comment on the possible consequences of proposed regulation CMS 2258-P for the Medicaid mental health system.

Jackson County Mental Health is part of a system of care provided under Oregon's 1115 demonstration waiver. We provide treatment services to severely and persistently mentally ill adults, mentally ill and severely emotionally disturbed children and adolescents and their families, and crisis intervention to the residents of Jackson County. While some of our services are subcontracted to community partners, we directly provide much of the service as a government (County) organization.

In order to manage all these types of care for our population, we carry substantial risk for psychiatric hospitalization. Obviously, that risk is not spread evenly over each year and we must develop risk reserves in order to be financially viable and responsible to our Medicaid eligible clients. Our risk reserves are managed at the County level and at the regional level through our Mental Health Organization, Jefferson Behavioral Health.

The Cost Limits for Units of Government provision in this rule would not allow Jackson County to provide the mental health services required by our Oregon Health Plan contract as the County currently does. I assume that the rule change is not intended to make County operations of managed care mental health services unsustainable although that would be the outcome.

I would request that the proposed regulation be modified to include provisions for risk reserves which are actuarially sound and necessary to sustain a risk-based contract to provide Oregon Health Plan services for mental health.

Submitter : **Ms. Kim Roberts** **Date: 03/16/2007**

Organization : **Santa Clara Valley Health & Hospital System**

Category : **Local Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attached

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. Stephen McKernan **Date:** 03/16/2007

Organization : University of New Mexico

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#178

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 McClure **Date:** 03/16/2007

Organization : Tennessee Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-179-Attach-1.DOC

#179

THA
TENNESSEE HOSPITAL ASSOCIATION

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:

The Tennessee Hospital Association (THA), on behalf of our over 200 member healthcare facilities, including hospitals, home care agencies, nursing homes, and health-related agencies and businesses, and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other health professionals, appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule. **We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospital(s) and the patients we (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 hospitals. These changes would cause major disruptions to our state Medicaid program and hurt providers and beneficiaries alike. And, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

CMS estimates that the rule will cut $3.9 billion in federal spending over five years. This estimate 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 by creating the proposed rule. More recently, following the issuance of the proposed rule, Congress again echoed that opposition, with 226 House members and 43 Senators having signed letters urging their leaders to stop the proposed rule from moving forward.

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

governmentally operated providers; (2) the narrowing of the definition of public hospital; (3) the restrictions certified public expenditures; and (4) the absence of data or other factual support for CMS's estimate of savings.

Defining a Unit of Government (433.50)

THA's major concerns about the Proposed Rule center around the new and restrictive definition of a "unit of government" and the restrictions on sources of non-federal share funding.

THA believes that CMS does not have the authority to redefine a "unit of government." The statutory definition contained in Section 1903(w)(7)(G) of the SSA does not limit the term to entities that have taxing authority. CMS is far exceeding its authority in placing such a significant restriction on the much broader definition adopted by Congress. Congress' definition afforded due deference to states' determination of which of its instrumentalities are governmental, as required by Constitutional principles of federalism. CMS' proposed definition is an unprecedented intrusion into the core of states' rights to organize themselves as they deem necessary. The definition also undermines the efforts of states and localities to deliver a core governmental function (ensuring access to health care) through the most efficient and effective means. Countless governments have organized or reorganized public hospitals into separate governmental entities in order to provide them with the autonomy and flexibility to deliver high quality, efficient health care services in an extremely competitive market, yet the Proposed Rule would not recognize such structures as governmental. CMS should defer to state designations of governmental entities.

CMS has exceeded its statutory authority in adopting a definition of a "unit of government" more restrictive than that established in Title XIX of the SSA. Section 1903(w)(7)(G) of the SSA defines a "unit of local government," in the context of contributing to the non-federal share of Medicaid expenditures, as "a city, county, special purpose district, or other governmental unit in the State." The Proposed Rule narrows the definition of "a unit of government" to include, in addition to a state, "a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) *that has generally applicable taxing authority.*" Congress never premised qualification as a unit of government on an entity's access to public tax dollars. Rather, Congress' formulation, which includes an "other governmental unit in the State," provides appropriate deference to the variety of governmental structures into which a state may organize itself. In narrowing this statutory definition, without instruction by Congress, CMS has eliminated the deference to states underlying the statutory formulation.

Section 1903(w)(7)(G) is not the only section of Title XIX which evidences a Congressional intent to allow states to determine which entities are political

subdivisions capable of participating in Medicaid financing. The absence of any requirement that units of government have taxing authority in order to contribute to the non-federal share of Medicaid expenditures is supported by the language elsewhere in the Medicaid statute. Section 1903(d)(1) requires states to submit quarterly reports for purposes of drawing down the federal share in which they must identify "the amount appropriated or made available by the State and its political subdivisions." The reference to the participation of political subdivisions in Medicaid funding nowhere includes a requirement that the subdivisions have taxing authority.

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

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

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

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

More than a century ago, state and local governments began establishing public hospitals to provide health care services to their residents, including their most needy residents. As the health care system matured, commercial insurance evolved and the Medicare and Medicaid programs were established, public hospitals filled a unique role in serving the poor and uninsured in their communities -- patients who were often shunned by other providers. The public hospitals were typically operated as a department of the state or local government, with control over hospital operations in the hands of an elected legislative body, funding appropriated to plug deficits, surpluses reverting into the general fund of the government, and subject to

sunshine laws, public agency procurement requirements, civil service systems and other local laws designed with the operations of traditional monopolistic governmental agencies such as libraries, police, fire and public schools in mind.

Over time, some states began authorizing local governments to establish public hospitals as separate governmental entities in recognition of the competitive market in which hospitals operate. Generic state laws authorizing local governments to create hospital authorities, public hospital districts and similar independent governmental structures began to proliferate.

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

Tennessee has created hospital districts engaged in a public-private partnership with the local government to operate the hospital to fulfill the governmental function of serving the health care needs of the local population. Many state university medical schools have spun off their clinical operations into a separate governmental entity for similar reasons.

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

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

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

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

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

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

The Proposed Rule would permit only units of government to participate in financing the non-federal share of Medicaid expenditures. The regulatory text then goes on to define a unit of government as "a State, a city, a county, a special purpose district or other governmental unit in the State (including Indian tribes) ***that has generally***

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

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

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

The use of the term "public" appears in several different contexts throughout the Medicaid statute, and many states employ their own definitions of public status within their Medicaid state plans. For example, federal financial participation is available at the rate of 75 percent of the costs of skilled professional medical personnel of the state agency or "any other public agency." A Medicaid managed care organization that is a "public entity" is exempt from certain otherwise applicable solvency standards. "Public institutions" that provide inpatient hospital services for free or at nominal charges are not subject to the charge limit otherwise applicable to inpatient services. Moreover, many states adopt special reimbursement provisions in their state plans for "public hospitals," "governmental hospitals" or other types of public providers. The use of terms such as "public," "unit of government" and "governmental" in other areas of state and federal Medicaid law does not incorporate the restrictions CMS is seeking to impose through the Proposed Rule. CMS should clarify that these restrictive definitions are for purposes outlined in the Proposed Rule only.

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

CMS should revise its "Tool to Evaluate Governmental Status of Providers."

CMS has released a worksheet that states can use to determine whether or not a health care provider satisfies the "unit of government" definition under the Proposed Rule. THA appreciates CMS's efforts to assist providers in determining their governmental status under the regulation, but requests that CMS revise the Tool in order to clarify precisely what results from the input of different responses into the form. We would be happy to work with you further to accomplish this clarification.

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

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

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

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

While the proposed regulatory language itself refers only to "*funds* from units of government" without specifying the source of those funds, the Preamble language clearly indicates CMS' intent to further restrict funding for state Medicaid programs by imposing the additional requirement that local funds be derived from tax revenues. The combination of adopting a restrictive definition of a unit of government and then further restricting the source of funds that can be transferred by entities that meet the strict unit of government test will leave state Medicaid programs, including important supplemental payment programs that support the health care safety net, with gaping funding holes. These shortfalls will need to be filled either by new broad-based uniform provider taxes (which would ultimately divert Medicaid reimbursement from patient care costs to covering the cost of new taxes), by new general revenue funding (shifting new costs onto state taxpayers) or by a reduction in Medicaid coverage or

reimbursement. All of these solutions will ultimately impact the care that Medicaid beneficiaries receive.

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

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

THA strongly believes that allowable costs should also include Medicaid's share of costs for the uninsured (beyond costs directly reimbursable through the limited available DSH funding). Absent universal coverage or full reimbursement of uninsured costs, hospitals must continue to rely on cross-subsidization from other payers, including commercial payers, Medicare and Medicaid, to pay for this care. CMS should allow state Medicaid programs to shoulder their fair share of such costs rather than placing the full burden on providers, Medicare and commercial payers. We therefore urge CMS to include uninsured costs among reimbursable Medicaid costs.

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

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

The time and resources invested in this process will ultimately have no impact whatsoever on the quality or effectiveness of care provided to patients; in fact, these

burdensome requirements divert scarce resources that would be much better spent on patient care. Moreover, the precision gained by reconciling payments to actual costs for the payment year as determined by a finalized cost report simply is not worth the massive diversion of such resources.

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

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

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

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

Certified Public Expenditures (§ 447.206(d)-(e))

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

In the Preamble to the Proposed Rule, CMS indicates that CPEs may only be used in connection with provider payments based on cost reimbursement methodologies. This restriction on the use of CPEs is unnecessary. Providers will incur costs

associated with providing care to Medicaid patients whether they are paid on a cost basis or not. Their costs are no less real or certifiable based on the payment methodology. For example, if a provider incurs $100 in cost in providing care to a Medicaid patient, but the payment methodology is a prospective one that results in a $90 payment, the provider could still certify that it incurred $100 in costs in connection with care for that patient.

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

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

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

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

Applicability to Section 1115 Waivers

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

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

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

Provider Donations

If the Proposed Rule is finalized in its current form, a number of providers that were previously considered public and that provided CPEs to help finance the non-federal share of Medicaid expenditures will no longer be able to do so. Some of these providers receive appropriations from a unit of government that does have taxing authority, but the provider cannot be considered to be an integral part of such governmental unit under the terms of the Proposed Rule. CMS should make clear that those appropriations will continue to be fully matchable under the new regulation and that it will not disallow such taxpayer funding as an indirect provider donation.

Effective Date

The September 1, 2007 effective date is not achievable.

The stated effective date of the new cost limit is September 1, 2007. An effective date for other portions of the regulation is not provided. Given that Tennessee will need to overhaul the provider payment system and plug large budgetary gaps

resulting from the required changes in non-federal share financing, the proposed effective date is not feasible. State plan amendments will need to be developed, vetted with the public, submitted to CMS and approved, a process which recently has routinely lasted 180 days or significantly longer. By the time a final rule is published, States will have long finalized budgets for fiscal years that include time periods after September 1, 2007 (SFY 2008 or, in some cases, SFY 2007 budgets). For many states, funding levels have already been set. The Tennessee state legislature is in session for a limited period of time, and the Medicaid budget for Tennessee must be approved prior to their going home in May or June. Elimination of federal funding of the magnitude proposed in this regulation cannot possibly be incorporated and absorbed at this late date. Moreover, to the extent that states have had advance warning of at least some of the policies contained in the final rule by virtue of this Proposed Rule and other agency activities, states are under no obligation to modify their programs based on the provisions of a proposed regulation without the force and effect of law, nor would it be wise to undertake such restructuring given that the regulation may undergo significant change.

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

Recommendation: CMS should revise the effective date of the Proposed Rule and establish generous transition periods so that states, health care provider, and other affected entities are provided adequate time to come into compliance.

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

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

Any attempt to impose these policies without going through notice and comment rulemaking would violate the Administrative Procedures Act (APA), which requires

legislative rules such as the policy changes articulated in the Proposed Rule to be adopted through a formal rulemaking process. Moreover, in addition to the requirements of the APA, Congress has very explicitly instructed CMS not to adopt policy changes without undertaking notice and comment rulemaking. The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (the 1991 Amendments) contains an uncodified provision stating that:

> "the Secretary may not issue any interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act."

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

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

CMS' Regulatory Impact Analysis is Deeply Flawed

CMS underestimates the administrative burden imposed on states and providers.

The Proposed Rule imposes significant new burdens on health care providers that CMS fails to acknowledge or severely underestimates. In addition to the significant cut in federal funding that many providers face under the Rule, compliance with new requirements, including the reporting requirements, proposed by CMS will place substantial additional costs on states and providers. These costs have not been incorporated into CMS' impact analysis; THA requests that CMS correct this oversight. As acknowledged in the Proposed Rule, Executive Order 12866 requires agencies to assess both the costs and the benefits of the proposed rule.

For example, costs that are unrecognized in the Proposed Rule include the cost to States that have already formulated complex provider reimbursement methodologies and payment processes based upon existing rules that now must be overhauled to

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

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

In addition to the creation and/or modification of these cost reporting systems, states will need to construct new structures for auditing the new cost reports. In the context of CPEs, "periodic State audit and review" is required explicitly, but it is unclear the extent to which CMS expects states to audit and review all cost report submissions. Reviewing these cost reports would require additional staffing by the Tennessee Medicaid agency and additional expenditures for hospitals in order to complete the required submissions.

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

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

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

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

In addition, the Proposed Rule will have a significant economic impact on local communities, as public providers reliant on supplemental Medicaid funding eliminated by this regulation take steps to cut their budgets. Public hospitals typically are a significant economic force in their communities, and their financial health (or lack thereof) has far-reaching ripple effects. Many of these budget cuts will necessarily entail layoffs. The inability to invest in infrastructure will be felt by vendors and contractors in the community. The impact of reduced access will have effects on the health of the community, including the health of the community's workforce, thereby impacting employers throughout the hospital's service area. The community's preparedness for emergencies may suffer because of lack of funding, impacting the ability of the community to attract and retain new businesses and employers crucial to economic vitality. Existing businesses that cater to hospital employees will feel the effects of a shrinking workforce. To the extent that local governments need to step in to fill the gaps caused by the withdrawal of federal funds, every single local taxpayer is affected. A vibrant, dynamic and comprehensive health care safety net is a crucial ingredient in the success of local economies. CMS fails to acknowledge the impact of this Medicaid funding cuts on the economic health of local communities.

THA believes that in its Regulatory Flexibility Act analysis, CMS has seriously underestimated the impact that the Proposed Rule will have. The Proposed Rule will impose significant costs on the TennCare program and hospitals in connection with new administrative burdens it establishes. The cost to Tennessee of developing new

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

Without the matching of Tennessee's certified public expenditures, the TennCare program will be severely under funded. Currently the level of CPE by hospitals is approximately $415 million, which produces $267 million in federal matching dollars for the program. Loss of those funds will force the state to make considerable changes to the program. This could potentially result in additional people being dropped from the roles, cutting other essential services and programs in the state or reductions in reimbursement to providers. If the cut were taken from provider payments, it could reduce annual TennCare payments to Tennessee hospitals by as much as $300 million.

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

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

The THA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or Mary Layne Van Cleave, executive vice president, at (800)258-9541 or mlvc@tha.com.

Sincerely,

Craig Becker, FACHE
President

cc: Rick Pollack, AHA, Executive Vice President

Submitter : **Mr. Steven Renne** **Date: 03/16/2007**

Organization : **Missouri Department of Social Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See attached file.

CMS-2258-P-180-Attach-1.DOC

#180

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 MISSOURI DEPARTMENT OF SOCIAL SERVICES

The Missouri Department of Social Services 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 Missouri and throughout the nation. Missouri has joined in the Joint Comments, submitted this day on behalf of a group of states in opposition to the proposed rules, that set forth the many legal and policy reasons for the Centers for Medicare & Medicaid Services (CMS) to abandon this detrimental proposal.

These comments expand on and supplement the Joint Comments to demonstrate how the proposed rules will affect Missouri specifically. The new rules will seriously impair the State's ability to maintain its current program and impede the State's planned transformation of the current Medicaid program. If finalized, the new rules could derail the State's efforts to cover more uninsured through our "Missouri Health Improvement Act of 2007", which follows the

President's proposal of shifting federal funding to help the uninsured buy private insurance and take ownership of their healthcare, by further cutting federal funding to an already financially strapped program.

I. The Proposed Definition of "Unit of Government" Eliminates Critical Sources of Funding

The State's greatest concern is that the CMS regulation, without justification, will curtail the public entities and sources of public funds that Missouri has long relied on to serve Medicaid beneficiaries. Missouri has historically used certifications of expenditures from its public hospitals and nursing facilities for purposes of claiming federal financial participation. Under the new CMS rules, certification is no longer available to any public entity but only to "units of governments with taxing authority." This will eliminate the ability of many providers to certify their expenditures and thus will decrease the amount of federal funds available to the State and its public providers.

A. Truman Medical Center

The Missouri hospital that will be chiefly affected is Truman Medical Center (TMC), which is the primary health care safety-net entity for the Kansas City metropolitan area, including Kansas City, Missouri, and Jackson County. Its two hospitals, Hospital Hill and Lakewood, serve as the principal teaching hospitals for the University of Missouri-Kansas City School of Medicine. The hospitals are critical providers of services to Medicaid and other low-income patients.

As has previously been explained to CMS, TMC was formed through cooperative agreements between TMC and both Jackson County and Kansas City as part of an effort to replace old city and county hospitals. Under those agreements, the County retained ownership of

the two new hospitals and TMC agreed to retain its predecessor public institutions' obligations to serve the medically indigent population in Kansas City and Jackson County.

Though in corporate form a not-for-profit corporation, TMC looks and acts like a public entity in at least the following ways: it has assumed the obligations of Jackson County and Kansas City to provide services to medically indigent ill citizens of the County and City; the standards for controlling the admission of patients at the facilities are those established by the County; three members of the TMC Board of Directors are appointed by the County, three by Kansas City, and two by the State's University of Missouri-Kansas City; the County owns the land and buildings of both hospitals; TMC has the responsibility to operate the County Health Department, health services at the County Jail, and transportation of the medically indigent to health facilities; TMC construction and equipment have been financed by over $76 million in Jackson County special obligation bonds since 2001 alone; and TMC draws directly from City and County property tax levies imposed by the respective governments specifically to support TMC, their hospital to provide indigent medical care.

On the basis of these facts, Missouri sought confirmation from CMS in 2001 that TMC should be treated as a "non-state government-owned or operated" facility and CMS agreed that it was. As a result, TMC certifies over $150 million annually in total expenditures for services provided to Medicaid patients and the uninsured, and those expenditures have earned a federal match. TMC also makes an intergovernmental transfer of funds (approximately $1 million) to be used as the state share for increased payments to the physicians who practice in its hospitals.

The recognition of TMC as a governmental entity is an important component in supporting the provision of hospital care to Medicaid patients and the uninsured in the Kansas

City area. However, because it does not have independent taxing authority (and is not formal part of another governmental entity with taxing authority), TMC would not be considered a unit of government under the new rules and its expenditures and transfers would no longer be eligible for federal financial participation. This will be a devastating blow to a critical Missouri provider.

TMC has direct access to tax funds through its interdependent relationship with Kansas City and Jackson County. TMC today receives approximately $25 million from the Kansas City health levy tax, which was first imposed in 1989. The ballot question at that time was specifically whether to authorize "an increase in the tax levy for . . . Truman Medical Center . . . and other public health programs and facilities." A further health tax levy increase was funneled to TMC again in 2005. The ballot question in 2005 was whether the City could act "by increasing the existing tax levy by 22 cents per $100.00 assessed valuation [distributing] . . . the revenue derived from 15 cents of the levy to Truman Medical Center." In other words, TMC has an absolute right to specified revenues from the City tax.

While TMC does receive subsidies from Jackson County and Kansas City that can be certified as expenditures by the County and City under the new rules, that is not sufficient to support the mission of TMC to serve the citizens of western Missouri. TMC is supported not only by subsidies from Jackson County and the city of Kansas City, but also by grants, operating revenue, and revenue from other operations. These funds have traditionally become public funds once expended by TMC, and CMS and its predecessor agency have knowingly authorized the State to count these expenditures toward the state share of Missouri Medicaid costs. There is no reason in law, and the State sees no valid reason in policy, for not allowing this to continue.

B. Other Public Hospitals

While TMC is the hardest hit, there are 33 additional public hospitals in Missouri that have certified over $73 million in annual expenditures for services provided to Medicaid and the uninsured. These hospitals are established pursuant to state statute which provide for establishment of hospital districts by voters of the jurisdiction in question: Revised Statutes of Missouri (RSMo), chapter 205 (authorizing the establishment of county hospitals) (19 hospitals); chapter 206, RSMo (providing for the establishment of hospital districts) (9 hospitals); chapter 96, RSMo (providing for the establishment of city hospitals) (5 hospitals). The hospitals' governing boards are elected by the voters. The boards may contract with other entities for operation of the hospitals but retain power over major expenditures and personnel and retain the power to cancel the contracts at any time. The boards have the power to issue bonds. Hospitals established under chapters 96, 205, and 206 do have taxing authority. However, taxes are not the sole source of the revenue that supports the expenditures that are certified. It is not clear from the proposed rule whether the expenditures of these public hospitals would continue to be eligible for federal financial participation or whether all such certifications will be limited to the tax revenue collected under the proposed rule.

II. The Rule Fails to Take Account of the Substantial Administrative Burdens Associated With Cost-Based Reimbursement

The State also objects to the proposal that all payments to public providers be limited to cost, which will impose substantial and unnecessary reporting burdens on public providers that are already operating with extremely limited resources.

Two important public providers in Missouri are public school districts, which perform administrative activities and provide medical services to thousands of school-children, and cities and counties that provide non-emergency medical transportation to those who need

such transportation in order to access their health care services. Medicaid reimburses for these activities and services at rates that are set to reflect costs. Payments for school activities are set according to random moment time studies applied to reported costs. Payments for transportation are set according to the local entity's transportation budget and the estimated number of trips it expects to provide each year. It appears from these proposed rules that even though these payments are established to cover costs, CMS will require a whole new system of cost-reporting and reconciliation to ensure that the amounts paid did not exceed each provider's actual, individual costs. As set forth in the Joint Comments, this is exactly the type of cumbersome, bureaucratic requirement that Medicaid has been moving away from for years. It would represent a huge step backward in efficient rate setting and impose onerous paperwork burdens.

Missouri also makes Medicaid payments to physicians employed by public entities, including those employed by the University of Missouri at Columbia (UMC), the University of Missouri at Kansas City (UMKC), and TMC. UMC physicians are paid the amount of their charges; UMKC and TMC physicians are paid at a percentage of Medicare, determined to be equivalent to the amounts received from commercial payers. The new rule would apparently require that all of these payments be reconciled to costs, which will be a record-keeping nightmare on professionals who already spend far too much of their time filling out paper rather than treating the ill.

It is also the case that Missouri pays some of its public hospital providers up to the amount that Medicare would pay for the same services, as calculated under the current upper payment limit rules, even if those amounts exceed the hospital's costs in serving Medicaid patients. These payments help offset some of the hospital's other uncompensated costs -- including non-allowable costs, physician staffing, costs of serving indigent patients, bad debt,

etc. -- coverage of which helps ensure that the hospital will remain open and available to Medicaid patients. (All of these payments stay with the hospital providers; Missouri is not affected by that aspect of the proposal).

Depending on which hospitals meet CMS's new "unit of government test" the new cost-based cap will eliminate $16 to $38 million in UPL payments to Missouri hospitals. As stated in the Joint Comments, there is no basis for CMS's position that a State Medicaid program cannot pay at the same level that Medicare pays but must instead cap all payments at cost. That approach effectively precludes any facility from conserving its resources to invest in its future.

* * * * *

For the past several years, Missouri has been operating under a Partnership Plan with CMS under which CMS reviews all of the State's funding sources in advance of each state fiscal year to ensure consistency with federal requirements. CMS is aware of and has worked with the State on each of the reimbursement programs described above and has concluded that they are consistent with its rules and regulations -- yet all are thrown into jeopardy by the new proposals, which taken together will impose huge new administrative burdens on the State and its public providers, and could take hundreds of millions of federal funds out of the Missouri Medicaid program. There is no justification for those results.

For these reasons, and the reasons set forth in the Joint Comments, we urge that the proposal be rejected in its entirety.

The Missouri Department of Social Services appreciates the opportunity to submit comments on the Proposed Rule on Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership. We welcome

questions or comments you may have. Please contact Steven E. Renne, Interim Director, Division of Medical Services, at 573/751-6922 if you wish to discuss further.

Submitter : Mr. Tom Marks **Date:** 03/16/2007

Organization : University of Michigan Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-181-Attach-1.DOC

#181

University of Michigan
Hospitals and
Health Centers

Accounting and Reimbursement Services
2500 Green Rd. Suite 100
Ann Arbor, Michigan 48105-1500
734-647-3321

March 16, 2007

Leslie Norwalk, Esq.
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:

University of Michigan Health System (UMHS) appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our health system and the patients we serve.

UMHS is an operating unit of the University of Michigan, a public university. Our Health System includes a 913 bed hospital, a large ambulatory care network, and a medical school that is responsible for the education of 2,700 medical and graduate students, residents and fellows. We are one of the largest Medicaid providers in the State of Michigan. Through our extensive primary care network and through innovative partnerships with the State and local governments we provide a medical home for tens of thousands of needy citizens in our local community. As a major academic medical center, we offer the most extensive array of specialty services in the region which allows us to serve Medicaid patients from every county in the State.

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

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

Limiting Payments to Government Providers

The rule proposes to limit reimbursement for government hospitals to the cost of providing services to Medicaid patients, and restricts states from making supplemental payments to these safety net hospitals through Medicaid Upper Payment Limit (UPL) programs. The rationale for this limit is that it may reduce the opportunity for states to engage in what CMS believes are abusive financing mechanisms. Rather than addressing the situations that CMS believes are abusive, the proposal is simply a funding cut that will selectively impact only governmental hospitals and potentially cause significant harm to many critical safety net providers. We believe it is clearly inappropriate to single-out one sector of the provider community and impose a harsh, rigid limit that may not even address the issues that CMS is concerned about.

Nearly 27 years ago, Congress moved away from cost-based reimbursement for the Medicare program, arguing that the reasonable cost-based reimbursement formula contained no incentives for efficient performance. Since then, hospital reimbursement systems have evolved following the model of the Medicare program and its use of prospective payment systems. These reimbursement systems are intended to improve efficiency by rewarding hospitals that can keep costs below the amount paid. Many state Medicaid programs have adopted this method of hospital reimbursement, yet CMS is proposing to resurrect a cost-based limit that Congress long ago declared less efficient.

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

UMHS estimates that its costs allocable to Medicaid exceeded Medicaid revenue from all sources by $30 million last year. However, it is very possible that under the rule, it could be determined that UMHS received significantly more than cost and therefore incur a payment reduction. This perplexing and illogical outcome could be caused by the following:

1. The majority of UMHS' loss on Medicaid activity is from services to Medicaid Managed Care beneficiaries. However, CMS' proposal is to exclude Medicaid Managed Care from its calculation of the cost limit.
2. Michigan Medicaid makes separate payments to teaching hospitals for graduate medical education, which are below UMHS' GME costs. If GME is excluded from the calculation of the cost limit, another element of UMHS' Medicaid loss would not be recognized.
3. There are differences in the way an entity would account for certain transactions in its GAAP financial reports, such as UPL-based payments, IGTs and provider taxes, that vary from the way a Medicare cost report analysis would treat the same transactions. The result may be a significant difference in net Medicaid revenue and cost.
4. Medicare allowable cost is less than actual cost, because of a number of Medicare provisions from the 1960s and 1970s that require exclusion of many expenses.

UMHS recommends that CMS withdraw the proposed cost limit on government hospitals in its entirety. If CMS persists in its effort to limit payment to government hospitals to cost, it should recognize that applying traditional Medicare cost reimbursement principles could have adverse consequences, and allow hospitals to include the costs incurred under Medicaid Managed Care programs.

New Definition of "Unit of Government"

The proposed rule puts forward a new and restrictive definition of "unit of government," such as a public hospital. Public hospitals that meet this new definition must demonstrate they are operated by a unit of government or are an integral part of a unit of government that has taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Contrary to CMS' assertion, the statutory definition of "unit of government" does not require "generally applicable taxing authority." This new restrictive definition would no longer permit many public hospitals that operate under public benefit corporations or many state universities from helping states finance their share of Medicaid funding. There is no basis in federal statute that supports this proposed change in definition.

UMHS is an operating unit (not a separate legal entity) of the University of Michigan. The University is established by the State of Michigan constitution, has a publicly elected governance, receives a large part of its funding from state general fund appropriations, and is subject to many of the laws affecting governmental units such as the Freedom of Information Act. However, the University has no taxing authority, and therefore would not meet CMS' definition of a unit of government. This is clearly a shortcoming of the proposed rule.

UMHS opposes this restrictive new definition and urges CMS to allow states to determine which entities are units of government pursuant to state law.

Restrictions on Intergovernmental Transfers (IGTs) and Certified P ublic Expenditures (CPEs)

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

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

UMHS recommends that CMS eliminate these unnecessary and inappropriate restrictions on IGT and CPE mechanisms.

Insufficient Data Supporting CMS's Estimate of Spending Cuts

CMS is required to examine relevant data to support the need to change current policy. The proposed rule estimates that the policy changes will result in $3.9 billion in spending cuts over the next five years. However, CMS fails to provide any relevant data or facts to support this conclusion. CMS claims to have examined Medicaid financing arrangements across the country

and has identified state financing practices that do not comport with the Medicaid statute. CMS, however, provides no information on which states or how many states are employing questionable financing practices. The public, without access to such data, has not been given the opportunity to meaningfully review CMS' proposed changes, calling into question CMS' adherence to administrative procedure.

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

Sincerely,

Thomas Marks
Senior Director of Finance
University of Michigan Hospitals and Health Centers

Submitter : Mr. Stephen McKernan **Date:** 03/16/2007

Organization : University of New Mexico Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-182-Attach-1.PDF

#182

THE UNIVERSITY OF NEW MEXICO • HEALTH SCIENCES CENTER
UNM HOSPITALS

March 16, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

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

Dear Ms. Norwalk:

On behalf of the University of New Mexico Hospital (UNMH), I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P (the Proposed Rule). The Proposed Rule jeopardizes at least $17 million in critical Medicaid support payments for UNMH, funding that has been essential to our ability to serve as a major safety net health care system in our community.

As the major safety net provider, UNMH's heath care system not only cares for the majority of the indigent and uninsured populations in New Mexico but also operates as New Mexico's only Level One Trauma center for both children and adults in the state. As a Level One trauma center we provide specialty services such as trauma care, burn care, and treatment of traumatic brain injuries. UNMH provides advanced medical services; including kidney transplant services, high-risk neonatal and maternity services.

UNMH also provides pediatric specialty care, through the Children's Hospital of New Mexico, a division within the hospital. We provide the highest level of care for children and premature infants in the state as well as operate the only Pediatric Emergency Room in the State. Each year, we treat more than 41,000 of New Mexico's children.

The Hospital has the state's only extra-corporeal membrane oxygenation unit, which is used to treat respiratory failure in pediatric patients, as well as in adult patients who contract Hanta virus. UNMH provides services for many clinical research programs conducted by HSC investigators

related to diagnosis and treatment of infectious diseases, cancer, diabetes, neurological conditions, and many other medical conditions.

UNMH is New Mexico's only academic medical center and provides primary, secondary, tertiary, and quaternary care to residents throughout the State. Each year more than five hundred residents are trained throughout our facilities.

UNMH and its hospital-based clinics is also a leading provider of primary and preventative care. Last year UNMH rendered over 364,000 non-emergency outpatient clinic visits and was a key referral source for hard-to-access specialty care services, particularly for the uninsured.

As the major safety net provider in New Mexico, we strongly oppose the Proposed Rule, and respectfully request you to withdraw it immediately. Moreover, we endorse the comments on the Proposed Rule by the National Association of Public Hospitals and Health Systems, submitted to the Centers for Medicare and Medicaid Services (CMS) on March 8, 2007. Below we provide more detailed comments on specific aspects of the rule, along with a description of how we believe these provisions would impact our hospital, our patients and our community.

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

Under current regulations, states are permitted to provide Medicaid reimbursement to hospitals and other providers up to the amount that would be payable using Medicare payment principles. The Proposed Rule would reduce that limit to Medicaid costs for governmental providers only. It is unclear to us whether UNMH would be determined to be governmental under the terms of the regulation. If we were deemed governmental and subject to the cost limit, the impact on the services we provide would be swift and substantial. We estimate that the cost limit alone could reduce Medicaid funds for UNMH by $17 million annually, a cut that we simply cannot absorb while maintaining current service levels.

We currently receive direct and indirect graduate medical education payments from New Mexico Medicaid, along with supplemental "upper payment limit" ("UPL") payments. The amount of the UPL payment is determined based on an estimate of payments we would have received using Medicare payment methodologies; it is set so that the aggregate of our claims payments, our GME and IME and our UPL payments do not exceed the upper payment limit (calculated in New Mexico on a hospital-specific rather than an aggregate basis). It is a straightforward methodology, and one that can in no way be described as resulting in "excessive" payments to UNMH. We simply receive the equivalent of what we would have been entitled to under Medicare payment principles.

Similarly, the financing of these payments is entirely appropriate. Our medical education payments (as well as our disproportionate share hospital (DSH) payments) are funded with state general revenues. The only payments that are financed by our funds are the UPL payments. We certify our public expenditures in connection with these payments.

While the calculation and financing of these payment amounts is straightforward and conservative, the critical nature of the support that they provide to UNMH cannot be overstated.

These funds are essential to our ability to serve as New Mexico's primary safety net health system, to act as a statewide referral center for critical tertiary care needs, to provide access to care for low income Medicaid and uninsured patients with few other options, to training the next generation of New Mexico's doctors and other health professionals and to fulfilling our key role in the state's emergency response system. If these supplemental payments are subject to the cut envisioned in the Proposed Rule, we will be forced to drastically scale back the scope of these activities, as they are not fully reimbursed and we do not have unlimited access to other sources of funding to replace the Medicaid cuts.

Limiting Medicaid payments to cost for governmental safety net providers is, in our view, extremely short-sighted public policy. Governmental providers have a special role in our health care system, one that is entirely compatible with the goals of the Medicaid program. CMS should not single out governmental providers for such a particularly harsh and rigid reimbursement limit. We urge you to retain the current regulatory upper payment limits.

Defining a Unit of Government (§ 433.50)

The Proposed Rule would impose a new definition of a "unit of government" on states. Entities that are not units of government (or providers operated by units of government) would be prohibited from contributing funding to the non-federal share of Medicaid expenditures through intergovernmental transfers ("IGTs") or certification of public expenditures ("CPEs"). It is particularly inappropriate for the federal government to be dictating to states which entities are considered to be subdivisions. This is a determination that should be made by the state. UNMH urges CMS to defer to states with regard to defining "units of government" for purposes of participating in Medicaid financing.

Effective Date (§§447.206(g); 447.272(d)(1); 447.321(d)(1))

CMS proposes to implement the Proposed Rule as of September 1, 2007 – an astonishingly ambitious schedule given the sweeping nature of the changes proposed. Assuming that a final regulation is not issued until this summer, states will have very little time to adopt the changes necessary to come into compliance. In our state, for example, the legislature is only in session through March. It would not be able to properly consider the changes in our program that may be required under the regulation in time to meet the deadline. Nor would our Medicaid agency have time to develop and obtain approval for any state plan amendments that may be required or to adopt changes to state rules and provider manuals. Establishing appropriate cost-reporting mechanisms as envisioned in the Proposed Rule will, in and of itself, require months of work.

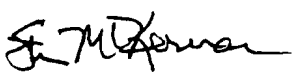
Moreover, given the longstanding payment policies and financing arrangements that would be disrupted by the Proposed Rule, CMS should provide a generous transition period for states and providers to adjust to these enormous changes. We would recommend a minimum transition period of at least ten years.

* * *

We appreciate the opportunity to comment on the Proposed Rule. Given the potentially devastating impact that it would have on safety net providers across the country and the patients that rely on them for care, we request that you withdraw the regulation immediately.

If you have any questions about this letter, please feel free to contact me at (505)-272-2121.

Sincerely,



Steve McKernan
Chief Executive Officer
UNM Hospitals
Vice President, Hospital Operations
University of New Mexico Health Sciences Center

Submitter : Ms. Phyllis Schwebke **Date:** 03/16/2007

Organization : County of Winnebago, DBA River Bluff Nursing Home

Category : Long-term Care

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

The proposed rule to limit certain payments to costs creates a double standard of reimbursement between government and non-government providers. Non-government providers could be paid above costs, while government providers could no.

The proposed rule will actually encourage inefficiency. A fixed reimbursement rate provides a target by which public providers attempt to control spending, and if efficient, spend below. Capping payments to costs encourages inefficient increases in costs.

CMS has historically allowed states to define their payment methodologies through Medicaid state plans. The proposed rule will constrain the flexibility of states to address critical issues of access.

The proposed rule inappropriately limits the sources of public funding. Taxes are just one of many sources available to units of local government.

GENERAL

GENERAL

It appears this rule will have an adverse effect on Winnebago County's ability to continue to provide care to its frail, elderly indigent population which has been the mission of the county's River Bluff Nursing Home.

Submitter : Mr. Art Huber **Date:** 03/16/2007

Organization : Via Christi Regional Medical Center

Category : Hospital

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

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

CMS-2258-P-184-Attach-1.DOC

#184

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:

As vice-president of Facilities for the Via Christi Wichita Health Network, which includes Via Christi Regional Medical Center, the largest tertiary hospital in Kansas, I appreciate having the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. The leadership of the Via Christi Wichita Health Network opposes this rule as we believe the proposed policy changes will harm 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 providers and beneficiaries alike. And, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

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

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

Limiting Payments to Government Providers

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

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. We are concerned that in its zeal to reduce federal Medicaid spending, important costs such as graduate medical education and physician on-call services or clinic services would not be recognized and therefore would not continue to be reimbursed.

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

New Definition of "Unit of Government"

The proposed rule puts forward a new and restrictive definition of "unit of government," such as a public hospital. Public hospitals that meet this new definition must demonstrate they are operated by a unit of government or are an integral part of a unit of government that has taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Contrary to CMS' assertion, the statutory definition of "unit of government" does not require "generally applicable taxing authority." This new restrictive definition would no longer permit many public

hospitals that operate under public benefit corporations or many state universities from helping states finance their share of Medicaid funding. There is no basis in federal statute that supports this proposed change in definition.

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

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

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

Insufficient Data Supporting CMS's Estimate of Spending Cuts

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

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

Sincerely,

Art Huber
Vice President, Facilities
Via Christi Wichita Health Network

Submitter : Mr. Tom McDougal **Date:** 03/16/2007

Organization : Parkway Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2258-P-185-Attach-1.DOC

#185

PARKWAY MEDICAL CENTER

March 16, 2007

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

Via electronic mail to: www.cms.hhs.gov/eRulemaking

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

I am writing on behalf of Parkway Medical Center to express our opposition to the above-referenced regulation. We have grave concerns that if the rule is implemented as proposed, the Alabama Medicaid Agency could lose as much as one fourth of the Agency's total budget. And since the vast majority of Alabama's Medicaid program is federally mandated, losing such a significant amount of the funding could literally shut down the Medicaid program. Such a move could mean the loss of health care coverage for almost one million Alabamians.

Medicaid, as it is presently constituted, and Alabama hospitals form a strong partnership for Alabama citizens. Parkway Medical Center alone, in 2006, provided Inpatient healthcare to 626 Medicaid patients, close to 20% of our total admissions. We provided Outpatient healthcare to 7,031 Medicaid patients, again nearly 20% of our total outpatient registrations. These patients would have great difficulty obtaining non-emergent care without Medicaid to assist in covering the costs of their care. The need is great to continue Alabama's Medicaid program without diminishing it's impact on Alabama citizens and hospitals.

The proposed rule is a significant change from long-standing Medicaid policy. It would impose new restrictions on how Alabama funds its Medicaid program, and further restricts how Alabama may reimburse hospitals, including Parkway Medical Center. In addition, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

We urge CMS to permanently withdraw this proposed rule. Our most significant concerns include the proposed new and very restrictive definition of "unit of government", such as a public hospital. Hospitals that do not meet this new definition would not be allowed to certify expenditures to our Medicaid program. In addition, only hospitals that meet the new definition of public hospital and are reimbursed on a cost basis would be eligible to use Certified Public Expenditures (CPEs) to help states fund

1874 Beltline Road – P. O. Box 2211 – Decatur, AL 35609 – 256-350-2211

their programs. This would result in fewer dollars being available to pay for needed care in Alabama.

Lastly, as previously mentioned, CMS has failed to provide information of which states or how many states are employing questionable financing practices. Alabama is in compliance with current financing requirements. The insufficient data calls into question the need to change current policy.

Parkway Medical Center, its leaders and staff, oppose this proposed rule and encourage CMS to permanently withdraw it. For the sake of Alabama's Medicaid citizens and our healthcare system, we urgently request that the Medicaid program that is working now be allowed to continue as is.

Sincerely,

Tom R. McDougal, Jr., FACHE
Chief Executive Officer

TRM/es

Copy to: Gregg Everett, General Counsel & SVP
Alabama Hospital Association

1874 Beltline Road – P. O. Box 2211 – Decatur, AL 35609 – 256-350-2211

Submitter : Dr. James Hoekstra **Date:** 03/16/2007

Organization : Society for Academic Emergency Medicine

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-186-Attach-1.PDF

#186

Society for Academic Emergency Medicine

901 N. Washington Ave. • Lansing, MI 48906 • (517) 485-5484 • FAX (517) 485-0801

March 16, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-2258-P

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

Dear Ms. Norwalk:

On behalf of the Society for Academic Emergency Medicine (SAEM) and its 6000 members, we ask CMS to rescind the Medicaid cost limit draft regulation published January 18, 2007 in the *Federal Register* and replace it with a more modest proposal that reduces negative financial effects on safety net providers and the patients they serve. SAEM represents the emergency physicians, students and residents who practice and are trained in academic medical centers, teaching hospitals, and safety net hospitals. As such, these proposed changes are critical to the welfare of our members and, most importantly, their patients.

The issue of eligible state funds used for the non-federal share of Medicaid has been under increasing scrutiny over the past several years. As you know, Medicaid provides access to health care for over 50 million Americans and is critical to safety net hospitals and other providers serving this vulnerable population. SAEM understands the Administration's goal of improving the fiscal integrity of the Medicaid program and in ensuring that states are held accountable for sources and amounts of funds used to secure federal matching dollars. However, we take issue with the restrictions in the proposed definitions of the sources of eligible state funds and what is considered as an allowable payment to public providers. There is no question that this proposal will jeopardize the viability of public and other safety net hospitals. It will also jeopardize the viability of our emergency medicine teaching programs, which has long-reaching downstream effects on the quality of emergency care in this country.

For a number of years, Medicaid payment policy permitted payment to public hospitals that was greater than actual costs in recognition of the burden public hospitals bore for uncompensated care and for the fact the Medicaid payment rates are often below provider costs. In many cases these policies have been approved by CMS in annual state plan amendments. This regulation is estimated to reduce payments by nearly $5 billion over the next five years with no transition period whatsoever. It is unrealistic for the federal government to expect that states will be able to

fund this shortfall and we are concerned that states will limit eligibility, further reduce provider payments, or be forced to reduce benefits.

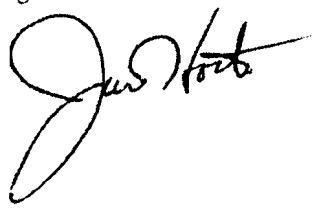
In addition to safety net hospitals, cuts of this magnitude will have an effect on emergency physicians' ability to provide care. According to the CDC, emergency physicians provided care to over 110 million patients in 2004 representing an average increase of 1.5 million visits per year in the ten previous years. Nearly 25 million of those visits represented Medicaid/SCHIP patients whose visit rate is 80 visits per 100 enrolled persons, much higher than Medicare (47 visits/100 enrollees) or other populations. In addition, the 47 million uninsured use the nation's emergency departments as a frequent source of care, which further burdens the safety net.

As Medicaid physician payment continues to lose ground to growing practice costs, fewer physicians will accept Medicaid and more recipients will end up in the ED, leading to what the recent Institute of Medicine report on the future of emergency care predicts is an over crowded emergency care system staggering under growing levels of uncompensated physician and hospital care. This burden will fall disproportionately on public providers, and we believe that Medicaid cuts of the magnitude projected under this proposed rule will adversely affect access and the viability of our nation's safety net providers.

We therefore recommend that the Agency meet with various stakeholders to discuss challenges to the program from both state and federal funding perspectives, and draft a new regulation that phases in some of the policy proposals described in this draft.

SAEM appreciates the opportunity to offer these comments and looks forward to continuing to work cooperatively with CMS to address these important issues in an equitable manner. Please do not hesitate to contact me at any time if you have any questions about our comments and recommendations.

Regards:



James Hoekstra, MD
President
Society for Academic Emergency Medicine

Submitter : Chris Underwood **Date:** 03/16/2007

Organization : CO Department of Health Care Policy and Financing

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.

Submitter : **Debra Falvo** **Date: 03/16/2007**

Organization : **Valley Mental Health**

Category : **Health Care Industry**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachments

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachments

CMS-2258-P-188-Attach-1.DOC

#188

March 16, 2007

RE: Proposed regulation CMS 2258-P

My name is Debra L. Falvo and I represent Valley Mental Health, an organization in the State of Utah. I am writing to comment on the impact that proposed regulation CMS 2258-P will have on the Medicaid system in Utah, with specific emphasis on the Medicaid Mental Health System.

Utah has organized the Medicaid Mental Health Services under the State's 1915(b) waiver into nine Prepaid Inpatient Health Plans (PIHPs). A number of these PIHPs have been set up as government entities by one county or a group of counties to manage the risk-based Medicaid mental health PIHP contract. Under this arrangement, local dollars are paid to the PIHP 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 PIHPs do not meet the definition of a "unit of government" because the PIHPs were not given taxing authority and the counties have not been given legal obligation for the PIHPs debt. 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 Utah of preventing bona fide local dollars from being used 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>

Sincerely,

Debra Lynn S. Falvo, MHSA, RN.C.
CEO / President
5965 S. 900 East
SLC, UT 84121-1720
801-263-7102

Submitter : Chris Underwood **Date:** 03/16/2007

Organization : CO Department of Health Care Policy and Financing

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-189-Attach-1.PDF

#189

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. jerry fuller **Date:** 03/16/2007

Organization : dept.of health and social services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2258-P-190-Attach-1.DOC

State of Alaska, Department of Health and Social Services comments regarding the CMS 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

SCHIP Providers
The preamble (at FR/Vol. 72, No. 11, pages 2236 and 2240) states that "....SCHIP providers are not subject to the cost limit provisions of this regulation". Correspondingly, the proposed regulation at 457.628 (a) does not apply the proposed cost limit provisions at section 447.206 to the state's SCHIP programs.

The proposed regulations do not define; what is an SCHIP provider. Alaska implemented Title XXI (SCHIP) as a Medicaid program expansion. Providers are not uniquely enrolled to provide services to the SCHIP population as differentiated from the Medicaid population. Additionally, provider payment rates for services provided the SCHIP and Medicaid populations are exactly the same. Are those states which selected the option to implement the SCHIP as a Medicaid expansion being retroactively penalized for not implementing the SCHIP as a stand alone program in their state?

What is an SCHIP provider? Given the SCHIP program implementation options included by Congress in the statute; these proposed regulations must clearly define the criteria and characteristics of what is; and, what is not an SCHIP provider for application of the regulation's provisions; especially the cost limit provisions.

Are Alaska's providers considered SCHIP providers when they provide the same service package to both Medicaid and SCHIP eligibles for the same payment rates?

If Alaska's Medicaid providers are considered to be SCHIP providers they are exempt from the cost limit provisions of 447.206 for that unit of government or governmental health provider.

If Alaska's Medicaid providers are not considered to be SCHIP providers, and are therefore required to meet the cost limit provisions of 447.206 for that unit of government or governmental health provider; do the regulations allow the Medicaid Agency to exclude both the SCHIP costs and reimbursements when making the Medicaid cost limit and overpayment determination?

Secretary's Responsibilities
The proposed regulations at 447.206 (c)(2) states that "Reasonable methods of identifying and allocating costs to Medicaid will be determined by the Secretary in accordance with sections 1902, 1903, and 1905 of the Act, as well as 45 CFR 92.22 and Medicare cost principles when applicable." Will the Secretary prospectively establish the "reasonable methods" to identify and allocate Medicaid costs?

447.206(c)(4) requires the Secretary to approve the form of auditable documentation consistent with 433.51(b)(1-4) which must be used to support non-hospital and non-nursing facility services. Will the Secretary prospectively provide the form(s) of auditable documentation to support the non-hospital and non-nursing facility services; or, will the states have to develop the form(s) and hope that their form(s) will meet with the Secretary's retrospective approval? The latter unfairly affords CMS the opportunity to reinterpret these regulations over and over as states submit their documentation, which has been our similar experience in the State Plan process and would serve to circumvent the public regulatory process.

One of the most difficult problems faced by any Medicaid program is client access to medical services. Many variables impact client access to medical services including payment rates, services restrictions, client demeanor, local economics, and administrative requirements. A cursory review of the state's Medicaid Management Information System (MMIS) provider file identified a number of providers which may be units of government or governmental health providers providing other than hospital or nursing home services such as case management or personal care. Of course these providers are in the less populated areas of the state, which have fewer medical services available to their Medicaid clients thereby exacerbating the already poor provider access. Requiring these smaller units of government or governmental health providers to prepare and file cost reports may result in their discontinuing provision of these services for Medicaid eligibles. CMS should acknowledge the true impact of these proposed regulations on the smaller units of government or governmental health providers and provide some floor criteria below, which the regulations do not apply. Suggestions for floor criteria include the number of facility beds, Medicaid eligible population in some mile radius, number of Medicaid clients served by the unit of government or governmental health provider and population base in the unit of government's area.

433.50(a)(1) Applicable Taxing Authority

The proposed regulations require a unit of government to have applicable taxing authority or, if a governmental health provider, to be able to access funding as an integral part of a governmental unit with applicable taxing authority. The language of the Social Security Act, especially Section 1903 which CMS references in the preamble, does not once mention or refer to "taxing authority", so we question CMS's statutory basis for such a requirement.

There is no known Congressional direction to the Executive Branch to define "public agency" let alone as narrowly as CMS proposes to do. CMS is attempting to define public agencies exclusively as governmental entities with "applicable taxing authority." What is "applicable" taxing authority? CMS neither defines "applicable" in the regulatory language; nor discusses it in the preamble. Without definition of this term or criteria with which to make a determination, will CMS arbitrarily decide whether or not each of the individual taxes in each of the nation's thousands of units of government or governmental health providers may be "applicable" and therefore eligible as the state portion of match through IGTs or CPEs. CMS is clearly stating that the federal government's interests out

weighs the state's interests in the federal-state partnership. States would be required to meet an undefined and unsupported standard; one at constant risk of arbitrary interpretation and reinterpretation by CMS.

Although people commonly think of governments as raising revenue through taxes, this is by no means the only source of revenue to governments. Governments raise money through user fees, sale or lease of public resources (minerals, timber, land), fines, legal settlements, etc. In fact, the federal government assists states in the funding of education and care of the mentally ill through land grants. For example, in Alaska we have a public entity, the Alaska Mental Health Trust that is a government body funded entirely by legal settlements and the revenue derived from the use and sale of land. As established, it happens to reside in the Executive Branch; but it could also be a quasi-independent body.

In addition, the proposed regulation overlooks the potential for intermediate units of government between the taxing authority and the provider. These units of government may be funded by revenue sharing (again, not all revenue may be tax revenue). Consider the case of an independent school district that receives funds from the state foundation formula and local governments. The school district might not be an integral part of any single governmental unit with applicable taxing authority. This proposed regulation will increase the burden on states to find alternative funding to replace match currently provided by schools. In many cases, for many states, this will effectively end schools' ability to bill Medicaid because the increase in general fund expenditures cannot be supported.

The proposed "Form CMS-10176 Governmental Status of Health Care Provider" developed by CMS provides little more than yes/no responses to the points of the regulation language and therefore, does not lead a state to an obvious conclusion. For example; "2) Does the unit of government that operates the health care provider have generally applicable taxing authority?" Check the yes or no box. "If no, move to number 7. If yes: Describe type of taxing authority. Describe source(s) of tax revenue." CMS offers no practical direction for the preparation and submission of the form to assist the state in analyzing the complex financial and organization relationships which exist in the many and varied units of government in each state. Frustratingly, CMS proposes to only support the 50 state medicaid programs with an archaic paper exchange system for determination and authorization of units of government or governmental health providers. Further, CMS fails to identify any processing or review standards (other than the form itself) or timeframes within which to complete its reviews of a state's request and the approval or denial of that request. CMS should amend the proposed regulations to provide effective criteria and practical direction for the states to make the determination that a unit of government or governmental health provider meets the regulations, which CMS may review or audit.

In the preamble and the proposed "Form CMS-1076", CMS places great weight on the consolidated annual financial report of the governmental unit as the information source necessary to complete the form. It is incongruous that CMS fails to make references in either the preamble or the body of the regulatory changes to the Governmental

Accounting Standards Board statements or pronouncements as the basis upon which the determinations that a unit of government or governmental health provider is eligible to provide IGTs or CPEs will be made. CMS's failure to provide objective criteria and standards with which a state can prospectively evaluate whether a public agency is a unit of government or a governmental health provider before submitting the form to CMS for its determination will only result in unnecessary and protracted litigation of CMS's apparently arbitrary determinations. The delays and inefficiencies to program administration will result in diminished access to and quality of recipient care.

Real life examples of the absence of common criteria and standards are: What is the definition of a "component unit" on the consolidated annual financial report referenced in the preamble at page 2240? Would an "Enterprise Fund" entry on the consolidated annual financial report qualify? In this example, would a contract between the entities support or eliminate this relationship as a unit of government or a governmental health provider? What about the situation where a city owns a hospital facility and contracts for the management and operation of the hospital? Is that a unit of government or a governmental health provider? Another example would be a city through its health department contracting for the provision of speech or physical therapy services. What is the status of such entities under this proposed rule?

433.50(a)(1) Indian Tribes

The proposed regulations require Indian tribes to have generally applicable taxing authority to be considered a unit of government or a governmental health provider. This requirement clearly flies in the face of over 100 years of treaties, statutes, executive orders, and court decisions recognizing and cementing the unique government-to-government relationship the United States has with Tribal governments. Some Indian tribes have, and some of those exercise their taxing authority; but Alaska Native tribes and tribal organizations neither have, nor exercise taxing authority. Identifying only those Indian tribes exercising their generally applicable taxing authority (which remains undefined) as a unit of government or as a governmental health provider for purposes of the Medicaid program is both morally wrong and quite possibly not legal. This is especially troubling when CMS in 433.51(c) allows federal funds authorized by federal law to be used as match for the Medicaid program. Federal funding received under the Indian Self-Determination and Education Assistance Act (ISDEAA) Public Law 93-638 is specifically allowed to match other federal funds.

Even more troubling is that it appears CMS has failed to act in "good faith" with the state Medicaid agencies and the Indian tribes in those states. CMS issued State Medicaid Director Letter #05-004 (SMDL) October 18, 2005 to respond to questions about using expenditures certified by Tribal organizations to fulfill the state matching requirements for activities under the Medicaid program. The letter described CMS's policy regarding the conditions and criteria under which tribal organizations can certify expenditures as the non-federal share of Medicaid expenditures for administrative functions. It also described the Tribes and Tribal Organizations which could participate pursuant to ISDEAA. Just over 7 months later in response to state and tribal comments CMS and IHS jointly issued SMDL #06-014 on June 9, 2006 to clarify the conclusion stated in

footnote 1 of SMDL #05-004. SMDL #06-014 clarified that federal funds awarded under ISDEAA may be used to meet matching requirements. And just 6 months after that, January 18, 2007 CMS reversed itself by publishing these proposed regulations which would only allow this federal matching if the tribe has generally applicable taxing authority. It appears that CMS purposefully and willfully misdirected the states and the Indian tribes; while simultaneously developing and working these regulations through the Executive Branch's internal regulation clearance processes; which took much longer than the 6 months between June 2006 and January 2007 to complete. These regulations appear to redefine for the Medicaid program only, the government to government relationship between the United States and Indian Tribes and Tribal Organization. In terms of this redefinition and the development of these regulations, when during the processes did the Tribal Consultation required of CMS in its own Tribal Consultation Policy (December 2005) occur? What were the results of that Tribal Consultation? Did CMS violate its own Tribal Consultation Policy by not consulting with the Tribe through the Tribal Technical Advisory Group (TTAG) until a month after these proposed regulations were published?

Under (ISDEAA) PL 96-638, Tribes and Tribal organizations are clearly afforded governmental functions and responsibilities and receive substantial amounts of funds to do so through contracting or compacting with the federal government. Has CMS determined that consistent with their policy articulated in the State Medicaid Director Letters that for purposes of these regulations Indian Tribes and Tribal Organizations are units of government or governmental health providers because they are a part of the federal government which has taxing authority and contracts or compacts for the provision of federally funded health services to tribal beneficiaries? And therefore, the federal government has the legal obligation to fund the expenses, liabilities and deficits of the tribal health care delivery system through the Indian Health Service and the annual Congressional appropriations? If so, the proposed rule does not reflect this decision.

CMS should rewrite the proposed regulations with separate paragraphs as necessary to affirm their existing policy regarding Indian Tribes and Tribal Organizations as expressed in the SMDL #05-004 and #06-014. The rewrite would remove the requirement that to be considered a unit of government or a governmental health provider, Indian Tribes must have taxing authority (generally applicable or otherwise); or the rewrite should specifically acknowledge the unique nature and circumstances of Indian Tribes and Tribal Organizations such that they are deemed to have met the taxing authority requirement.

Section 447 Payments for Services
447.206 Cost limits for providers operated by units of government.
This paragraph requires annual cost reporting by all units of government and governmental health providers for all Medicaid services it provided during the year; the state Medicaid Agency's review and retrospective determinations of whether the Medicaid payments to that unit of government or governmental health provider exceeded its costs to deliver the Medicaid service(s); and if so, refund of the overpayment to CMS.

CMS's sudden development of a double standard between the Medicare and Medicaid programs is an especially troubling aspect of this proposed regulation. Medicare pays for services based on prospectively determined rates. Historically, CMS has aggressively pushed state Medicaid Agencies to prospectively set payment rates to end retroactive provider settlement. CMS is now reversing course to require states to implement interim rate methodologies with retrospective determination of whether the payments exceeded the provider's cost to provide the services. Development and implementation of these processes for units of government, governmental health providers and state Medicaid Agencies will result in significantly increased administrative and auditing workloads.

In this context, the State of Alaska is faced with a unique problem in terms of services provided to Medicaid clients by units of government and governmental health providers. While most states have some cross-border purchasing of Medicaid services in neighboring states, it is generally limited in scope and duration to the same providers in the neighboring state(s). Alaska does not share a border with any other state and as a frontier state lacks the full range of medical services infrastructure available in-state as compared with what is available in most of the other states. This situation results in a broad range and volume of Medicaid services necessarily being purchased out-of-state (in the lower 48 states) and this regulation will create a dramatic new workload.

Each authorization for out-of-state service will have to be evaluated to determine if the service will be/was provided by a unit of government or a governmental health provider in the other state. In addition, for those out-of-state services provided by a unit of government or governmental health provider the state Medicaid agency will have to retrospectively, after the provider's fiscal year:

1) request and receive a copy of the provider's annual financial report covering the dates of service,
2) review the financial report,
3) make the subsequent retrospective determination whether Medicaid payments to the unit of government or governmental health provider exceeded its cost to provide the Medicaid service(s),
4) make overpayment collection and
5) transmittal to CMS if indicated, and
6) periodically audit the out-of-state unit of government or governmental health provider.

Even if Alaska accepted the servicing state's Medicaid payment rate(s) for that unit of government or governmental health provider; the proposed regulations would require Alaska to either make the cost limit determination through an audit of the unit of government or governmental health provider; or monitor and accept the servicing state's cost limit determination and make the retrospectively calculated refund of any overpayments to CMS. In either case, additional administrative mechanisms will be needed to provide the monitoring and tracking necessary to support the regulatory processes.

CMS's proposed regulations uniquely penalize Alaska for its lack of the medical infrastructure routinely available in the other states. Its small population base, vast geographic distances, comparatively small Medicaid/SCHIP programs and state budget combine to require a disproportionate administrative response by Alaska to meet the requirements imposed by the proposed regulations, resulting in a corresponding disproportionate increase in program costs to both the state and federal governments.

The proposed 447.206(d)(2) states "Interim reconciliations must be performed by reconciling the interim Medicaid payment rates to the filed cost report for the spending period in which interim payment rates were made." Please clarify that this section is applicable only in a retrospective cost reimbursement methodology and does not apply to a prospective cost reimbursement methodology. Without this clarification, health providers could construe that states are required to pay full costs, rather than that payments are limited to cost, in a prospective cost reimbursement methodology. In those situations where payments were less than cost, the providers would argue an additional Medicaid payment including federal funds at the FMAP would be due the provider.

The proposed 447.206(d)(3) states "Final reconciliation must be performed annually by reconciling any interim payments to the finalized cost report for the spending year in which any interim payment rates were made." Please clarify that the "finalized cost report" may be prepared by the Medicaid agency rather than requiring the Medicaid agency to wait for a Medicare intermediary to finalize the cost report. The Medicaid agency should not have to either wait for an Intermediary generated final, which could change again, or accept the Medicare intermediary's determination of Medicaid costs.

Collection of Information Requirements and Financial Impacts
CMS's impact estimate of 10-60 hours on the part of each governmental provider to complete the approved form(s) to be submitted with a CPE is nothing short of extraordinary fantasy. CMS estimates that it will only take the provider 10-60 hours to prepare and submit the cost report information and an additional 10-60 hours for the state Medicaid Agency to review and verify the cost report information submitted. However, even more extraordinary is CMS's intentional failure to acknowledge the increased Medicaid agency audit activity specifically required by these proposed regulations at 433.51(b)(4), 447.206(c)(4) and 457.220(b)(4).

As of November 2006 there were 18,058 providers on the state's MMIS provider file. Sorting the file by the state listed for the provider's pay-to address identified 7,434 out-of-state providers and 10,624 in-state providers. The present MMIS provider file and provider type table do not capture designations such as unit of government or governmental health providers. As a work around to estimate the impact of these regulations the in-state and the out-of-state provider lists were sorted to identify those providers with one of the following words in the provider's "pay-to" name: state, city, county or borough. These sorts resulted in identification of 123 out-of-state providers and 162 in-state providers with those words in the provider name. Undoubtedly, this methodology understated the numbers of units of government and governmental health providers on the MMIS provider file.

The present MMIS provider file and provider type table does not capture unit of government or governmental health providers as a particular or unique type(s) of provider. Consequently the Department has neither a quick nor efficient methodology to identify unit of government or governmental health providers as a subset of all the Medicaid providers on the MMIS Provider file. To effectively identify the units of government or governmental health providers on the file will be a manual and thus very staff intensive process, ultimately requiring direct contact with each individual provider to determine whether or not the provider is a unit of government or governmental health provider. Alaska's Medicaid provider enrollment application and processes will have to be changed to capture and verify the provider's governmental status.

We estimate that the review of the MMIS Provider File and the subsequent direct contact with providers will require at least 4 FTEs (state or contractor) for 6 months, with a one time cost of $135,800. The activities of at least one of these positions will require a professional level position to interpret the regulations and determine if providers meet the criteria as a unit of government or a governmental health provider, assuming these criteria ever become known.

The MMIS provider file needs reprogramming to record the provider's governmental status. If the Department determines that it will need to make payments at different rates or rates determined by different methodologies then there would be additional programming necessary to the MMIS to accommodate the payment differences to the governmental and non-governmental providers for the same services. To be in compliance with the proposed regulations all of these activities will have to be completed

by December 31, 2007. Any programming to the MMIS and the Medicaid agency's data warehouse to capture the unit of government or governmental health provider status would be in addition to the above estimate. Given that this data element would not be required for claims processing the programming to capture the data element on the file and to pass it to, and record it on the data warehouse is estimated to between $50,000 to $100,000 total cost. This cost will be much more if unique unit of government and governmental health provider payment rate methodologies need to be developed, integrated and implemented in the MMIS. This cost could easily exceed $1,000,000.

Cost Reporting and Auditing

The workload on state Medicaid agencies imposed by these regulations is both new and substantial. To successfully meet these regulatory requirements processes will have to be developed and implemented which identify and record units of government and governmental health providers, monitor and contact those providers for their cost reports and their annual financial reports, review, analysis and determination of provider's cost limit, schedule and conduct the audits, coordinate refund of identified overpayments to CMS, coordinate and resolve any appeals of the audits or subsequent litigation.

Assuming 30 units of government or governmental health providers are identified out of the 162 potentially identified and an audit cycle in which once every 3 years each entity is audited, the Medicaid agency estimates it will have to add 4 new staff to support that workload. $435,900 is the projected annual cost of the additional staff necessary to perform this workload including travel and the other support costs.

If the Alaska Medicaid Agency is precluded from accepting the Medicaid payment rate and cost limit determination of the other state for those services purchased outside of Alaska; the Medicaid agency estimates that out of the 123 providers, an additional 23 units of government or governmental health providers would be added to the workload. The Alaska Medicaid Agency's cost estimate would increase by an additional $224,400 to $658,300.

The Alaska Medicaid Agency estimates financial impact of the proposed regulations to services providers as $4,350,000: $600,000 public hospitals, $3,500,000 schools and $250,000 Alaska Natives tribal organizations.

Joint Comments

Alaska has joined with other states in the Joint Comments being submitted by the Covington and Burling law firm which presents very compelling legal and policy reasons why CMS should withdraw the proposed regulations.

Submitter : Mr. Leonard Forsman **Date:** 03/16/2007

Organization : Suquamish Tribe

Category : Other Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#191

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

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

Submitter : Lester Secatero **Date:** 03/18/2007

Organization : Albuquerque Area Indian Health Board, Inc.

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#192

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

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