Submitter : Mr. Larry Naake **Date:** 03/19/2007

Organization : National Association of Counties

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attached cover letter and comments

CMS-2258-P-315-Attach-1.DOC

#315

NACo National Association of Counties

The Voice of America's Counties

March 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
ATTN: CMS-2258-P
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Acting Administrator Norwalk:

On behalf of the National Association of Counties (NACo), the only national organization that represents county governments in the United States, I am writing to express NACo's strong opposition to the Administration's proposed regulation CMS-2258-P restricting Medicaid payments to public providers.

This attempt at administrative changes to the program will do nothing more than reduce funding and shift costs to states and counties. Additionally, the changes will diminish long-standing, legitimate funding mechanisms that CMS has previously approved upon which counties have relied. Medicaid has been the financial foundation for local government providers serving Medicaid-eligible individuals as well as a critical source of supplemental payments to public facilities using disproportionate share hospital (DSH) and upper payment limit (UPL) payments to assist them in their responsibility to care for the uninsured.

Counties are unique in their responsibility to both finance and deliver health services. The myriad ways in which health care is financed, organized, monitored, and delivered are all played out in local communities. The burden to address inequities and system failures falls heaviest on counties, even though counties are often the least able of government jurisdictions to absorb the increased financial responsibility. For example, counties own and operate well over 1,000 hospitals and nursing homes; by capping payments to government providers and narrowing the definition of "public" many of these facilities will be in jeopardy of closing their doors.

These proposed changes, will have an adverse impact on access to critical health services for more than 57 million vulnerable Americans. For these reasons, I urge you to withdraw the proposed rule. More detailed comments are enclosed.

Sincerely,

Larry E. Naake

Larry E. Naake
Executive Director

25 Massachusetts Avenue, NW / Suite 500 / Washington, DC 20001 / 202-393-6226 / Fax 202-393-2630 / www.naco.org

Comments by the National Association of Counties on the Proposed Regulation Restricting Medicaid Payments to Public Providers (CMS-2258-P)

Basis, Scope and Applicability: The rule would restrict the definition of "unit of government" by only allowing those entities with "generally applicable taxing authority" to be able to contribute to the non-federal share of Medicaid through intergovernmental transfers(IGT's) and Certified Public Expenditures (CPE's). NACo believes that this interpretation goes beyond the department's statutory authority which defines a unit of local government as a city, county, special purpose district, or other governmental unit in the State. By adding the taxing authority language, the rule may disqualify many types of providers, including some university hospital systems and other institutions considered currently to be 'public'. CMS should withdraw the proposed definition of unit of government and leave that determination to states.

Funds from Units of Government as the State Share of Financial Participation:
The rule would restrict the types of allowable sources of IGT and CPE funding by limiting IGTs to tax revenues and CPEs only for services documented and reimbursed under a Medicaid cost-based reimbursement method. Congress has acknowledged that the program is a federal, state and county partnership by specifically prohibiting CMS from regulating certain protected IGTs and CPEs. NACo believes that this restriction also goes beyond the department's authority. CMS should withdraw the restriction and continue to allow states and local governments to determine sources funding within the parameters set by Congress.

Cost Limit for Providers Operated by Units of Government: The rule would impose cost limits on Medicaid payments that would have the effect of only covering the cost of the service provided, with no margin for using funds to supplement coverage of the uninsured. Additionally, this limitation could be interpreted as prohibiting disproportionate share hospitals from receiving reimbursement for the general costs associated with maintaining and operating the facilities. The cost definition should include all costs associated with providing care and operating a public hospital.

Effective Date and Waivers: The regulation would become effective September 1, 2007, leaving little time for state legislatures and county governments to enact conforming legislation and administrative changes to their current programs. The rule also applies to states that are operating CMS-approved Section 1115 waiver programs. It appears that the terms and conditions of many of those waivers would have to be changed to comply with the rule, including, if applicable, the use of IGTs and/or CPEs and the overall amount of spending allowed in the waiver. If the proposed regulations are not withdrawn, states should be given ample time to make necessary changes. Additionally, CMS should clarify that changes will be prospective and not retroactive.

25 Massachusetts Avenue, NW / Suite 500 / Washington, DC 20001 / 202-393-6226 / Fax 202-393-2630 / www.naco.org

Submitter : **Ms. Connie Crawford** **Date: 03/19/2007**

Organization : **El Paso County Hospital District**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2258-P-316-Attach-1.TXT

#316

JOSÉ R. RODRÍGUEZ
COUNTY ATTORNEY
EL PASO COUNTY, TEXAS

EL PASO COUNTY HOSPITAL DISTRICT LEGAL UNIT
4815 ALAMEDA
8TH FLOOR, SUITE B
EL PASO, TEXAS 79905

OFFICE: (915) 521-7632
FAX: (915) 521-7209

March 19, 2007

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

RE: 42 CFR Parts 433, 447 and 457
Medicaid Program: Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership

Submitted electronically to http://www.cms.gov/eRulemaking

Dear Acting Administrator Norwalk:

The El Paso County Hospital District (R. E. Thomason General Hospital, El Paso, Texas) appreciates the opportunity to respond to the proposed rule "Medicaid Program: Cost Limit for Providers Operated by Units of Government and Provision to Ensure the Integrity of Federal-State Financial Partnership" published in the Federal Register January 18, 2007.

The rules unfairly target public providers and are an ill-disguised cut in crucial Medicaid funding that would have a devastating impact on this community's already fragile health care safety net.

Only public providers would be affected by the rules, necessitating new state funding, an unlikely prospect in a relatively poor state such as Texas, or, more likely, cuts in programs to serve those who most need health care services. There appears to be no logical basis for punishing pubic hospitals, which provide a disproportionate share of care to the uninsured, provide critical services to the community such as trauma care and neonatal intensive care, play a critical role in

emergency preparedness, are at the forefront of establishing neighborhood clinics and are leaders in providing culturally sensitive care.

While purportedly addressing concerns with certain Medicaid financing practices the rules are, in actuality, a Medicaid funding cut that will hurt individuals and communities rather than solve some ill-defined problem. Because a significant percentage of the patient population at Thomason Hospital is self-pay, the cuts targeted at public providers would make it even more difficult for this institution to provide health care services to the uninsured who compromise 33 % of the population of El Paso County. In fact, the proposed rules would undermine the federal requirement to assure access to care and services for Medicaid recipients that is equal to that available to the general population.

The Board of Managers and Administration of the El Paso County Hospital District urge you to withdraw the proposed rules and allow safety net hospitals to fulfill their mission of providing quality, cost effective health care to those in our society who are the least able to afford it.

Sincerely,

Connie Crawford
Assistant County Attorney

Submitter : Mr. Robert Hall **Date:** 03/19/2007

Organization : American Academy of Pediatrics

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachement

CMS-2258-P-317-Attach-1.PDF

CMS-2258-P-317-Attach-2.DOC

#317

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

AAP Headquarters
141 Northwest Point Blvd
Elk Grove Village, IL 60007-1098
Phone: 847/434-4000
Fax: 847/434-8000
E-mail: kidsdocs@aap.org
www.aap.org

Reply to
Department of Federal Affairs
Homer Building, Suite 400 N
601 13th St NW
Washington, DC 20005
Phone: 202/347-8600
Fax: 202/393-6137
E-mail: kids1st@aap.org

March 19, 2007

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

Dear Ms. Norwalk:

The 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists of the American Academy of Pediatrics submit this comment to the Proposed Rule "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership," as published in the *Federal Register* on January 18, 2007. Because we are deeply committed to protecting the health of infants, children, adolescents, and young adults receiving health care in the United States, we wish to register our concern regarding the impact on access to care this regulation will have on some of our nation's poorest children.

CMS indicates that this Notice of Proposed Rulemaking addresses a number of key Medicaid financing issues. According to the regulation, the proposed rule seeks to ensure that statutory requirements within the Medicaid program are met, specifically by: (1) reiterating that only units of government are able to participate in the financing of the non-Federal share of Medicaid payments; (2) establishing minimum requirements for documenting cost when using a certified public expenditure; (3) limiting providers operated by units of government to reimbursement that does not exceed the cost of providing covered services to eligible Medicaid recipients; (4) requiring that providers receive and retain the total computable amount of their Medicaid payments; and (5) making conforming changes to the State Child Health Insurance Program (SCHIP) regulations.

The regulation seeks to redefine three types of Medicaid financing mechanisms: intergovernmental transfers; certified public expenditures; and the use of state and local tax revenue.

The Academy is disappointed that CMS chose to issue this new rule immediately after passage and in the midst of implementation of the Deficit Reduction Act of 2005. Implementation of this rule on top of the new burdens placed on states, such as the costly burdens of documenting citizenship and identity, would pose an undue financial burden on states in the midst of reorganizing programs designed to support the sickest and poorest children in this nation. Such a large cost shift to the states, at this time, will hamper efforts to expand access to care to all children qualifying for Medicaid and SCHIP and other states who hope to reach those children not currently eligible.

Additionally, those medically disenfranchised children who receive care in community health centers, and at local, regional and state hospitals, will face further impediments to access by implementation of this rule.

Pediatricians share the goal of clear and fair funding of Medicaid for all states and territories. However, the proposed rule will have an adverse impact on the most vulnerable children. In closing, we appreciate the opportunity to comment on this matter. As always, the American Academy of Pediatrics looks forward to working with CMS in its continued efforts to ensure access to care for our most vulnerable children.

Sincerely,

Jay E. Berkelhamer, MD, FAAP
President

cc: Secretary Michael O. Leavitt

Submitter : Dr. Andrew Allison **Date:** 03/19/2007

Organization : Kansas Health Policy Authority

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-318-Attach-1.DOC

#318

KHPA
Kansas Health Policy Authority
Coordinating health & health care for a thriving Kansas

MARCIA J. NIELSEN, PhD, MPH
Executive Director

ANDREW ALLISON, PhD
Deputy Director

SCOTT BRUNNER
Chief Financial Officer

March 19, 2007

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

RE: Comments on 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)

Dear Ms. Norwalk:

These comments are submitted on behalf of the State of Kansas Health Policy Authority (KHPA). KHPA is responsible for coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies. All health insurance purchasing by the State is combined under the Authority, including publicly funded programs (Medicaid, SCHIP and Medikan) as well as the State Employee Health Benefits Plan (SEHBP).

In addition to our general support for the comments submitted by the NASMD, we want to emphasize several areas of concern in the proposed rules referenced above including:

Distinction between Public and Private Entities for Reimbursement Purposes

The proposed rules at § 447.206 would limit the reimbursement to providers that are operated by a unit of government to no more than the cost of providing covered Medicaid services to eligible Medicaid recipients. We request CMS to consider several issues prior to finalizing the rule:

1) The proposed rule is taking a narrow view on reimbursement to providers operated by units of government. These providers are critical to the viability of the entire health care delivery system in our state. They provide access to care in rural areas, serving a large volume of Medicaid, and providing the vast majority of services to the uninsured. The proposed rule would limit reimbursement for Medicaid services to these facilities to an overly-strict definition of cost, impinging on the state's ability to reimburse government providers for their cost of care for the uninsured.

2) Our state has paid institutional providers on a prospective basis for many years under an approved state plan. These prospective payment systems have proven to be effective, and create appropriate incentives for providers to control their costs. To now force states to revert back to an outdated retrospective settlement for government operated facilities creates an inequity between our government facilities and non-government operations. In fact, the proposal would require us to treat our government operations at a distinct disadvantage as compared to the non-government operations.

3) The proposed rules also require that allowable cost definition be based on the Medicare cost report, or a similar cost finding process. It should be noted that this method of cost finding treat many unavoidable costs as non-allowable. By limiting Medicaid payments to Medicare definitions of allowable cost, this will result in an additional shift of costs to the states.

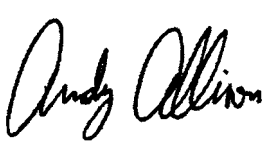
Overly Restrictive Definition of Units of Government

The proposed rules at § 433.50(a)(1)(i), would define a unit of government as a "state, a city, a county, a special purpose district, or other governmental unit in the State that has generally applicable taxing authority." Furthermore § 433.50(a)(1)(ii) limits the inclusion of a health care provider as a unit of government to those that either have "generally applicable taxing authority", or "the health care provider is able to access funding as an integral part of a unit of government with taxing authority..." This definition narrows the definition provided in section 1903(w)(7)(G) of the act, which define a "unit of local government" as a "State, a city, county, special purpose district, or other governmental unit in the state."

Regulatory Impact Analysis

The regulatory impact analysis included in the proposed rules fails to adequately account for the increased administrative burden placed on states in conducting retrospective cost settlements for all providers that are considered a unit of government. In addition to the administrative burden of calculating the cost settlements, the proposed rules will likely force states to revert to retrospective cost reimbursement of governmental providers which will inherently be more inflationary than current reimbursement models.

Sincerely,



Dr. Andrew Allison, Deputy Director
Acting Medicaid Director

AA:ah

Submitter : **Mr. John Bluford** **Date: 03/19/2007**

Organization : **Truman Medical Centers**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-319-Attach-1.PDF

#319

TMC
TRUMAN MEDICAL CENTERS

Department of
Corporate Finance
2301 Holmes
Kansas City, MO 64108

816-404-3528

March 19, 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

Dear Ms. Norwalk:

On behalf of Truman Medical Centers ("TMC"), I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes $37 million in Medicaid funding that has been essential to TMC's ability to survive as Western Missouri's safety net hospital system.

Comprised of TMC Hospital Hill, TMC Lakewood, and TMC Behavioral Health, about three in four of TMC's patients are Medicaid-eligible or uninsured. TMC serves almost 100,000 individual patients each year. In FY 06, TMC provided $92 million in uncompensated care services, and over $140 million in Medicaid services. TMC treats our community's most vulnerable, such as the elderly, low-income families, and those with chronic illness such as diabetes, asthma, HIV/AIDS, sickle cell, and mental illness. In addition, TMC delivers about one-third of the babies born yearly in Kansas City, Missouri and operates one of the community's busiest neonatal intensive care units.

HOSPITAL HILL

LAKEWOOD

BEHAVIORAL HEALTH NETWORK

TMC is Western Missouri's Tier I trauma center, staffed to accept critically ill and injured patients 24/7. TMC is the community's lead partner in ensuring homeland security and monitoring disease trends. TMC is the primary teaching hospital for the medical school of the State's University of Missouri-Kansas City, and trains large numbers of resident and students, the main source of physicians in this region.

As you probably know, the Missouri House of Representatives has adopted House Concurrent Resolution 25, specifically asking CMS to withdraw the portion of the Proposed Rule that would eliminate TMC's current status as a public hospital.

We, too, strongly oppose the Proposed Rule. Following, we comment on specific aspects of the Rule.

Defining a Unit of Government (§ 433.50)

The Proposed Rule would impose a new definition of "unit of government" that would prohibit entities without independent taxing authority from contributing funding to the non-federal share of Medicaid expenditures.

TMC should be viewed and treated as a public entity, among other things, because it 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 authorized a "tax levy for . . . Truman Medical Center . . . and other public health programs and facilities." An increase in that tax levy was funneled to TMC in 2005 by a public ballot which determined that 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. [Emphasis added above.]

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 additional ways: 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; and TMC construction and equipment have been financed by over $76 million dollars in Jackson County special obligation bonds since 2001 alone.

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. In a letter from the US DHHS Regional Office to the Missouri Department of Social Services, dated May 11, 2001, HHS stated that "[c]onsultation with HCFA Central Office has provided concurrence that the new category 'non-State Government-owned or operated' hospital as defined in the revised UPL regulations is applicable to TMC." Now the government proposes to move the target again.

Medicaid has always recognized our funding as public, and has allowed our funds to be used as the non-federal share of Medicaid expenditures. The matching of our funds is essential to our ability to carry out the safety net role described above.

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

TMC certifies over $150 million annually in expenditures for services provided to Medicaid patients and the uninsured. Those expenditures have earned a federal match.

We object to the discussion in the preamble of the regulation (not repeated in the text) that units of government that are providers may only certify their expenditures if they are paid on a cost basis. 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. Please rescind the preamble discussion requiring providers to be paid on a cost basis in order to certify expenditures as the non-federal share.

TMC is also a nominal charge provider. Due to the population we serve, we keep our charges well below market rates. By eliminating § 447.271, which waives the lower of cost or charge provision for nominal charge entities, CMS would penalize nominal charge entities for maintaining affordable charge structures.

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 little time to analyze the rules and adopt the changes necessary to come into compliance. 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.

CMS should provide a generous transition period for states and providers to adjust to these enormous changes. We would recommend at least ten years.

* * *

Given the devastating impact the Proposed Rule would have on the TMC, our patients and our community, we request that you withdraw the regulation.

If you have any questions about this letter, please contact Gerard Grimaldi at (816) 404-3505.

Sincerely,

Allen M. Johnson
Chief Financial Officer
Truman Medical Centers

Submitter : Mrs. Nancy Galvagni **Date:** 03/19/2007

Organization : Kentucky Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-320-Attach-1.DOC

#320

March 19, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare and 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 all hospitals in the Commonwealth of Kentucky, the Kentucky Hospital Association (KHA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals.

With respect to the use of IGTs and CPEs, KHA concurs with the proposed rule's requirement that providers must keep 100% of payments made through use of an IGT, without any rebate of a portion of those payments to the state. We also concur that all states should be held to the standard that IGTs and CPEs cannot be used to fund non-Medicaid costs, but rather, only Medicaid covered services provided to Medicaid recipients. However, KHA is strongly opposed to application of a cost-based reimbursement limit to government-operated providers. Imposition of this limit would reduce payments by more than $20 million annually to several safety net hospitals in Kentucky, including the hospital which provides the largest volume of services to Medicaid patients in the state.

Cost-Based Limit for Public Hospitals

The proposed rule would limit reimbursement for government-operated hospitals to the cost of providing Medicaid services to Medicaid recipients. However, the rule does not even specify how "cost" would be determined - only that the Secretary will set forth a reasonable method. The regulation references use of Medicare cost finding principles only "as appropriate", leaving open the potential for imposing additional payment reductions on the basis of restricting the definition of "cost." The cost limit would also be imposed on payments to governmental hospitals that do not involve CPEs

to finance those payments. Finally, the rule changes the upper payment limit for governmental hospitals by limiting payment to each individual provider's cost, whereas the current UPL regulations provide an aggregate limit based on the UPL facility group. KHA is opposed to the disparate treatment of governmental, safety net hospitals since the use of an aggregate UPL for privately operated facilities would remain unchanged.

Currently, Medicaid reimbursement for all hospitals is constrained by the upper payment limit, which prohibits a state Medicaid agency from paying more than what Medicare would pay for the same services, or a hospital's charges. Since Medicare has implemented payment rates and systems designed to achieve economy and efficiency, Kentucky's Medicaid agency has generally adopted hospital payment methodologies that are the same as or are similar to Medicare. Imposing a payment limit at cost will reduce payments to governmentally operated critical access hospitals in Kentucky and the University of Kentucky Medical Center.

Critical Access Hospitals

Kentucky Medicaid pays critical access hospitals using Medicare rates. In recognition of the importance of maintaining the viability of critical access hospitals, which have a small volume of patients that are predominately on government programs, Medicare pays CAHs at 101% of their cost. Likewise, Kentucky Medicaid payments to all critical access hospitals are at 101% of cost. IGT and CPEs are not used to finance payments to any Kentucky critical access hospital, yet the proposed cost limit would require Kentucky Medicaid to reduce payments to the few governmentally operated critical access hospitals from 101% of cost (consistent with Medicare) to 100% of cost, while continuing to pay other critical access hospitals at the higher rates. Reducing payments to these safety net hospitals merely undermines their safety net mission, reduces access, and creates a financial strain on the sponsoring governmental entities that could ultimately result in their inability to maintain operation of these hospitals which serve a vital role in their rural communities.

State Teaching Hospitals

The proposal to limit governmental hospital payments to the facility's "costs" rather than to the amount they would be paid by Medicare will result in substantial harm to Kentucky's largest Medicaid hospital provider, the University of Kentucky Medical Center by reducing payments by approximately $20 million annually. Under the current UPL, the hospital can receive payments based on the amount Medicare would pay, including payment for graduate medical education, indirect medical education, organ transplant costs, and disproportionate share. The Medicare program provides these additional payments in recognition of the added costs incurred by hospitals for medical education and training, operating a transplant program, and service to a disproportionate number of low income patients. This facility serves the largest number of Medicaid patients – with more than 20,000 inpatient days annually, and serves as a referral center for the transfer of Medicaid patients from other hospital throughout the state. The University of Kentucky Medical Center trains the majority of the state's future physicians

and serves as the tertiary referral center for the Eastern half of the state. University Hospital is also one of the largest safety net hospitals for the uninsured and medically indigent, providing more than $30 million in indigent care costs annually. Approximately thirty percent of these costs are not covered by Medicaid DSH payments, which are capped under federal law to Kentucky hospitals. Limiting Medicaid payment to cost, rather than Medicare payment levels, will eliminate vital funding used to support the hospital's safety net mission, including indigent care, a Level I trauma center (of which Kentucky only has three), and the training of physicians and other allied health care practitioners. The hospital will be unable to recoup from other patients the magnitude of losses resulting from imposition of a Medicaid cost limit due to the extremely high volume of Medicaid and indigent patients that it serves.

There is simply no rationale basis for requiring state Medicaid agencies to reduce payments to governmentally operated hospitals, while paying private hospitals at higher levels. In fact, the policy to limit governmental hospital payment to cost is contrary to those hospitals having higher unpaid costs due to the fact that, as governmentally operated facilities, they serve a higher proportion of governmental and indigent patients and have higher uncompensated care costs that cannot be recovered from privately insured patients.

KHA concurs with the comments submitted by the American Hospital Association pertaining to the cost limit and the lack of statutory authority for CMS to adopt regulations to impose this limit. We also support AHA's comments that CMS's proposal to apply a different, hospital specific UPL to governmentally operated hospitals, as opposed to an aggregate limit, is contrary to the requirement of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).

In summary, the cost limit would also be damaging to several governmentally owned critical access hospitals in Kentucky. The loss of Medicaid funding, coupled with significant unfunded indigent care, will subject these hospitals with substantial losses that will detrimentally impact on patient access to care. For these reasons, KHA urges CMS to eliminate its proposed cost-based limit changes for governmental hospitals and retain the existing upper payment limit rule if it continues forward with other regulatory changes that address states' use of IGTs and CPEs.

Sincerely,

Nancy C. Galvagni
Senior Vice President

The federal government should be concerned with protecting the viability of safety net providers who are necessary to provide care to the Medicaid population – and getting lower payments (because a they have less private business to make up governmental payment shortfall and higher indigent care where there is no payment whatsoever). States should be allowed to use IGTs and CPEs to pay these governmentally operated providers up to the current upper payment limit.

Submitter : Mr. Robert Gibbons **Date:** 03/19/2007

Organization : Massachusetts Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#321

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. Ervin Brinker **Date:** 03/19/2007

Organization : Summit Pointe

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

see Attachment

CMS-2258-P-322-Attach-1.PDF

#322

March 19, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
Mail Stop C4-26-005
7500 Security Boulevard
Baltimore, MD21244-1850

Ladies & Gentlemen:

My name is Erv Brinker and I represent Summit Pointe, a Behavioral Health organization in the St Michigan. I am writing to comment on two specific ways the proposed regulation CMS 2258-P will i the Medicaid Behavioral Health System in a number of states.

Summit Pointe is a host board of a five county Michigan Prepaid Inpatient Health Plan (PIHP) wit responsibility for Specialty Services (Developmental Disabilities, Mental Health, Substance Abus county region with 73,000 Medicaid eligibles, a $63 million annual budget and a 3,000 square mil area.

Cost Limit Provisions in States with At-Risk Provider Contracts
A large number of county governments provide substantial amounts of Medicaid Behavioral Health S under 1915(b), 1915(c) or 1115 waivers across the country. In many cases the counties are the cr net provider, treating the most seriously disabled Medicaid enrollees in their communities.

In many of these systems, the Medicaid health plans use risk-bearing payment mechanisms where co are sub-capitated or case rated for all or a portion of the Medicaid enrollees. Under these fina arrangements the counties are responsible for meeting the behavioral health needs of enrollees r 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 necessaril costs in a given month, quarter, or year, and risk reserves are necessary to ensure financial vi 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 arrangements between the MCO and the provider organization. By limiting allowable Medicaid payme cost, using a cost reporting mechanism that doesn't take into account a risk reserve, it appears

assumed that all risk is being held by the MCOs/PIHPs. This is not the case in a significant num waiver states.

The Cost Limits for Units of Government provision, as currently written, would render all of the capitation arrangements with counties financially unsustainable due to the fact that there would mechanism for building a risk reserve and managing the mismatch of revenue and expense across fi 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 appears to be unintended. In essence, the regulation is creating a de facto rule that provider o that are units of government cannot enter into Medicaid risk-based contracts.

I am writing to request that this be corrected through a modification of the proposed regulation

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

Intergovernmental Transfers in States with Government-Organized Health Plans
A second issue concerns a number of states where Medicaid Behavioral Health Plans have been set
government entities by one county or a group of counties to manage the risk-based contract. Unde
arrangement, local dollars are paid to the health plan for Medicaid match and these funds are th
to the state to cover the match.

In reviewing the proposed regulation, specifically pages 22 - 23, it appears that the intergover
agreements that set up the Medicaid Health Plans do not meet the definition of a "unit of govern
because the plans were not given taxing authority and the counties have not been given legal obl
the plan's debts. Thus, it appears that the regulation would render the flow of local dollars, t
which is to supply Medicaid match, unallowed match, simply because of the chain of custody of th
dollars.

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

Best regards,

Ervin R. Brinker
CEO

Submitter : Mrs. Berna Bell **Date:** 03/19/2007

Organization : Ohio Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-323-Attach-1.DOC

#323

OHIO HOSPITAL ASSOCIATION

March 19, 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

Dear Ms. Norwalk:

On behalf of our more than 170 hospitals and health systems, the Ohio Hospital Association (OHA) appreciates the opportunity comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals. The OHA opposes this rule and would like to point out that it would be detrimental to Ohio hospitals, disregard congressional consensus, and violate the principle of separation of powers to states.

Current restrictions limit Medicaid payments to what Medicare would pay for the same service. This cap prevents states from "gaming" the system and has served both the federal government and states without complaint until now. We see no compelling reason for CMS to change the rule.

The rule would also drastically limit the definition of a "public" hospital to those institutions run by a government entity that has taxing authority. This asserted re-definition by a federal agency seems to violate the State of Ohio's authority to define what constitutes a public hospital within our state.

The proposed rule also would result in reduced federal funding for hospitals. Extrapolating from the most recent Medicaid hospital cost report data, OHA estimates the CMS rule would result in a net annual loss of more than $40 million in federal reimbursement to public hospitals in Ohio. These vital institutions would be compelled to make up these losses through their own limited resources and increased levies or taxes upon the local population. The rule would have ripple effects, as well, by drawing disproportionate share funds distributed under Ohio's Hospital Care Assurance Program (HCAP) away from private hospitals.

Moreover, the CMS proposed rule undermines stated congressional consensus. As part of its Fiscal Year 2007 budget, the Administration proposed cutting Medicaid payments to hospitals over the next five years by nearly $6 billion. Neither the House nor the Senate FY07 budget resolutions included these cuts. In fact, nearly 300 Members of Congress and 55 Senators sent letters to HHS Secretary Leavitt last year asking him not to implement a rule similar to CMS-2258-P.

If you have any questions, please do not hesitate to contact me at the number listed below.

Yours truly,

Berna L. Bell
Health Policy Analyst

155 East Broad Street, Floor 15 Columbus, Ohio 43215-3620 www.ohanet.org 614.221.7614 614.221.4771 fax

Submitter : **Mr. Robert Gobbons** **Date: 03/19/2007**

Organization : **Massachusetts Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-324-Attach-1.PDF

#324

MHA

Massachusetts Hospital
Association

March 16, 2007

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

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

Dear Ms. Norwalk:

On behalf of our 89 member hospitals and health systems the Massachusetts Hospital Association (MHA) wishes to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals. The MHA opposes this proposed rule because of the harm it could cause to our state's hospitals and the patients they serve.

The rule reverses 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. And, 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 result in a reduction of $3.9 billion in federal funds to this nation's state Medicaid programs over five years--a cut for safety-net hospitals and state Medicaid programs that bypasses the congressional approval process and comes on the heels of vocal congressional opposition to the Administration's plans to regulate in this area. Last year, 300 representatives and 55 senators signed letters to Health and Human Services (HHS) Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. Recently, Congress restated its position with 226 representatives and 43 senators having signed letters to the House and Senate leadership urging them to stop this proposed rule from moving forward.

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

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

In its comment letter to you on this issue, the American Hospital Association provided a detailed discussion of concerns relating to the following aspects of the proposed rule.

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

MHA seconds AHA's comments. We believe that the Medicaid policy changes proposed by CMS would be damaging to Massachusetts safety net and health care services for thousands of our state's most vulnerable residents. We urge CMS to permanently withdraw its proposed rule.

Sincerely,

Robert E. Gibbons
Interim President and Chief Executive Officer
Massachusetts Hospital Association

Submitter :

Date: 03/19/2007

Organization :

Category : **Hospital**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See attached.

#325

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 : Dr. John Daly **Date:** 03/19/2007

Organization : Temple University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-326-Attach-1.DOC

#326

School of Medicine
TEMPLE UNIVERSITY

John M. Daly, M.D.
Dean, School of Medicine

102 Medical Research Building
3420 North Broad Street
Philadelphia, PA 19140
(215) 707-8773
Fax: (215) 707-8431
E-mail: johndaly@temple.edu

March 19, 2007

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

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

Dear Ms. Norwalk:

Temple University School of Medicine appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) above referenced proposed rule.

Temple University School of Medicine objects to CMS' replacement of the term "public" with the new and more restrictive term "unit of government". For a provider to be public under this revised definition, the provider must either have direct taxing authority or have the ability to access funding from an entity with taxing authority. The provision further holds that the taxing entity would be required to have the legal obligation to fund the health care provider's expenses, liabilities and deficits outside any contractual obligation.

We believe that this definition is far too restrictive to recognize providers that carry out predominantly public functions but do not have direct taxing authority or direct access to an entity with taxing authority. The School of Medicine of Temple University and its physician group serve as a safety net care provider for the residents of north Philadelphia as well as for the greater Philadelphia region. That more than thirty-five (35) percent of the patient care services rendered by Temple are to Medicaid recipients or the uninsured attests to the public nature of Temple's mission in the Pennsylvania health care system. Clearly Temple is serving a public function. The fact that Temple has no direct taxing authority nor direct access to an entity with taxing authority does not reduce or diminish in any way the public work Temple carries out in the Philadelphia region.

In spite of this, should financial events occur such that Temple's services and operations were in financial jeopardy, we believe that the Commonwealth would find the resources to assure Temple's continued ability to serve its indigent population. While no legal obligation exists for this eventuality, it is certainly in the best interests of the Commonwealth, the City of Philadelphia and the population of this region for government to intervene under these circumstances. This, in effect, would be an identical outcome to that posed in the proposed rule for a "unit of government" where a taxing entity would assume the expenses, liabilities and deficits of such a provider.

For these reasons we propose that the definition of "unit of government" be modified to include entities such as Temple that both serve a primary public function and that would be maintained by the state or local government if the provider would become financially distressed. We, therefore, suggest the following criteria be used to define a "unit of government" rather than the definition currently included in the proposed rule:

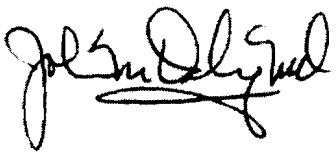
A provider will be recognized as a unit of government if:

1. More than twenty-five (25) percent of its services are provided to individuals eligible for Medicaid, the uninsured or the underinsured; and
2. The provider can reasonably be expected to receive direct government subsidies to maintain operations should the provider be at risk for discontinuing operations.

We believe the above definition appropriately describes the types of entities that CMS should be attempting to identify in its proposed rule. The narrow and restrictive definition in the proposed rule fails to recognize the public nature of providers such as Temple, which clearly should be included under any such provision. We believe the language suggested will remedy this inequity.

Again, we appreciate the opportunity to comment on the proposed rule and hope you will take these comments under serious consideration.

Sincerely,



John Daly, M.D.
Dean, Temple University School of Medicine

Submitter : Ms. Nancy Galvagni **Date:** 03/19/2007

Organization : Kentucky Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-327-Attach-1.DOC

#327

March 19, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare and 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 all hospitals in the Commonwealth of Kentucky, the Kentucky Hospital Association (KHA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals.

With respect to the use of IGTs and CPEs, KHA concurs with the proposed rule's requirement that providers must keep 100% of payments made through use of an IGT, without any rebate of a portion of those payments to the state. We also concur that all states should be held to the standard that IGTs and CPEs cannot be used to fund non-Medicaid costs, but rather, only Medicaid covered services provided to Medicaid recipients. However, KHA is strongly opposed to application of a cost-based reimbursement limit to government-operated providers. Imposition of this limit would reduce payments by more than $20 million annually to several safety net hospitals in Kentucky, including the hospital which provides the largest volume of services to Medicaid patients in the state.

Cost-Based Limit for Public Hospitals

The proposed rule would limit reimbursement for government-operated hospitals to the cost of providing Medicaid services to Medicaid recipients. However, the rule does not even specify how "cost" would be determined - only that the Secretary will set forth a reasonable method. The regulation references use of Medicare cost finding principles only "as appropriate", leaving open the potential for imposing additional payment reductions on the basis of restricting the definition of "cost." The cost limit would also be imposed on payments to governmental hospitals that do not involve CPEs

to finance those payments. Finally, the rule changes the upper payment limit for governmental hospitals by limiting payment to each individual provider's cost, whereas the current UPL regulations provide an aggregate limit based on the UPL facility group. KHA is opposed to the disparate treatment of governmental, safety net hospitals since the use of an aggregate UPL for privately operated facilities would remain unchanged.

Currently, Medicaid reimbursement for all hospitals is constrained by the upper payment limit, which prohibits a state Medicaid agency from paying more than what Medicare would pay for the same services, or a hospital's charges. Since Medicare has implemented payment rates and systems designed to achieve economy and efficiency, Kentucky's Medicaid agency has generally adopted hospital payment methodologies that are the same as or are similar to Medicare. Imposing a payment limit at cost will reduce payments to governmentally operated critical access hospitals in Kentucky and the University of Kentucky Medical Center.

Critical Access Hospitals

Kentucky Medicaid pays critical access hospitals using Medicare rates. In recognition of the importance of maintaining the viability of critical access hospitals, which have a small volume of patients that are predominately on government programs, Medicare pays CAHs at 101% of their cost. Likewise, Kentucky Medicaid payments to all critical access hospitals are at 101% of cost. IGT and CPEs are not used to finance payments to any Kentucky critical access hospital, yet the proposed cost limit would require Kentucky Medicaid to reduce payments to the few governmentally operated critical access hospitals from 101% of cost (consistent with Medicare) to 100% of cost, while continuing to pay other critical access hospitals at the higher rates. Reducing payments to these safety net hospitals merely undermines their safety net mission, reduces access, and creates a financial strain on the sponsoring governmental entities that could ultimately result in their inability to maintain operation of these hospitals which serve a vital role in their rural communities.

State Teaching Hospitals

The proposal to limit governmental hospital payments to the facility's "costs" rather than to the amount they would be paid by Medicare will result in substantial harm to Kentucky's largest Medicaid hospital provider, the University of Kentucky Medical Center by reducing payments by approximately $20 million annually. Under the current UPL, the hospital can receive payments based on the amount Medicare would pay, including payment for graduate medical education, indirect medical education, organ transplant costs, and disproportionate share. The Medicare program provides these additional payments in recognition of the added costs incurred by hospitals for medical education and training, operating a transplant program, and service to a disproportionate number of low income patients. This facility serves the largest number of Medicaid patients – with more than 20,000 inpatient days annually, and serves as a referral center for the transfer of Medicaid patients from other hospital throughout the state. The University of Kentucky Medical Center trains the majority of the state's future physicians

and serves as the tertiary referral center for the Eastern half of the state. University Hospital is also one of the largest safety net hospitals for the uninsured and medically indigent, providing more than $30 million in indigent care costs annually. Approximately thirty percent of these costs are not covered by Medicaid DSH payments, which are capped under federal law to Kentucky hospitals. Limiting Medicaid payment to cost, rather than Medicare payment levels, will eliminate vital funding used to support the hospital's safety net mission, including indigent care, a Level I trauma center (of which Kentucky only has three), and the training of physicians and other allied health care practitioners. The hospital will be unable to recoup from other patients the magnitude of losses resulting from imposition of a Medicaid cost limit due to the extremely high volume of Medicaid and indigent patients that it serves.

There is simply no rationale basis for requiring state Medicaid agencies to reduce payments to governmentally operated hospitals, while paying private hospitals at higher levels. In fact, the policy to limit governmental hospital payment to cost is contrary to those hospitals having higher unpaid costs due to the fact that, as governmentally operated facilities, they serve a higher proportion of governmental and indigent patients and have higher uncompensated care costs that cannot be recovered from privately insured patients.

KHA concurs with the comments submitted by the American Hospital Association pertaining to the cost limit and the lack of statutory authority for CMS to adopt regulations to impose this limit. We also support AHA's comments that CMS's proposal to apply a different, hospital specific UPL to governmentally operated hospitals, as opposed to an aggregate limit, is contrary to the requirement of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).

In summary, the cost limit would be damaging to several governmentally owned hospitals in Kentucky. The loss of Medicaid funding, coupled with significant unfunded indigent care, will subject these hospitals with substantial losses that will detrimentally impact on patient access to care. For these reasons, KHA urges CMS to eliminate its proposed cost-based limit changes for governmental hospitals and retain the existing upper payment limit rule if it continues forward with other regulatory changes that address states' use of IGTs and CPEs.

Sincerely,

Nancy C. Galvagni
Senior Vice President

The federal government should be concerned with protecting the viability of safety net providers who are necessary to provide care to the Medicaid population – and getting lower payments (because a they have less private business to make up governmental payment shortfall and higher indigent care where there is no payment whatsoever). States should be allowed to use IGTs and CPEs to pay these governmentally operated providers up to the current upper payment limit.