Submitter : **Mr. Charles Carey** **Date: 03/06/2007**

Organization : **All Children's Hospital**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

To even consider these cuts...is wrong!

As my Grandma always said " For Shame...For Shame."

Submitter : Danny McKay **Date:** 03/06/2007

Organization : Noxubee General Critical Access Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-52-Attach-1.DOC

#52

NOXUBEE GENERAL HOSPITAL

P. O. Box 480 Macon, MS 39341 662-726-4231

March 07, 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:

NOXUBEE GENERAL CRITICAL ACCESS HOSPITAL: We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospital and the patients we serve.

The 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 very concerned that, in CMS' 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 no longer be reimbursed.

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

New Definition of "Unit of Government"

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

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

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

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

Insufficient Data Supporting CMS's Estimate of Spending Cuts

CMS is required to examine relevant data to support the need to change current policy. The proposed rule estimates that the policy changes will result in $3.87 billion in spending cuts over the next five years. 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,
NOXUBEE GENERAL CRITICAL ACCESS HOSPITAL

Danny H. McKay
Administrator

Submitter : Mr. David White **Date:** 03/06/2007

Organization : Curry County Health and Human Services

Category : Local Government

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

"See Attachment"

Regulatory Impact Analysis

Regulatory Impact Analysis

"Sec Attachmcnt"

CMS-2258-P-53-Attach-1.DOC

#53

Curry County Health and Human Services

Public Health, Mental Health, Addictions and Developmental Disabilities Programs
29821 Colvin Street, P.O. Box 746, Gold Beach, OR 97444
Telephone (541) 247-4082 **Toll Free** (877)739-4245 **Fax** (541) 247-5058
T.D.D. (800) 735-2900. **Director**: David C. White M.S.W. **Email**: whited@co.curry.or.us

March 6, 2007

Center for Medicaid and Medicare Services
Department of Health and Human Services
Attention CMS-2258-P
P.O. Box 8017
Baltimore MD 21244-1850

To whom it may concern,

My name is David White and I represent Curry County Health and Human Services, a County Mental Health Provider 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 known as the Oregon Health Plan and the impact on Curry County.

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.

Curry County is small and rural with a County population of approximately 22,000. Curry County has a shortage of mental health providers and a substantially higher per capita population of disabled persons than most of the other Counties in Oregon. Curry County is the safety net that ensures that mental health services are available to the Medicaid population. There are no providers available to serve the Medicaid population if Curry County ceased providing services. The County is only able to provide a full continuum of services including rehabilitative and crisis services because we are able to bear risk and reduce use of more intensive services to provide less intensive services close to home for Curry County residents. Without the ability to carry a modest reserve in the budget for higher than expected

costs of purchased specialty services such as crisis center or hospital costs, we would be unable to meet the balanced budget requirements of the State of Oregon.

As currently written, it appears that the drafters of CMS 2258-P did not anticipate risk sharing at the provider level. By restricting, the ability of County Governments to share risk you may inadvertently reduce local government involvement in providing Medicaid services. Medicaid recipients in small rural Counties like Curry County, where there is not a public sector able and willing to provide mental health services for the Medicaid population, would suffer from lack of access to services if not for the willingness of County government to step in and provide services.

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. In a rural County like Curry with a small population, it is more difficult to bear risk than in areas that are more populous. To construct financial barriers that will further restrict County involvement will leave services for Medicaid eligibles dependent on local market dynamics.

This level of federal intervention in the reimbursement and affect it will have on services provided cooperatively between state and local governments appears to be unintended. In essence, the regulation is restricting units of government from entering into Medicaid risk-based contracts and creating a disadvantage for local governments that would desire to provide services where the market is not likely to do so.

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,

David C. White M.S.W.
Director of Health and Human Services

Brookings Offices
306 Wharf Street, P. O. Box 727
Brookings, OR 97415
(541) 469-3007, Toll Free (877) 739-4250
Fax (541) 412-1310

Port Orford Offices
1403 Oregon Street, P. O. Box 1145
Port Orford, OR 97465
(541) 332-8044,Toll Free (877)739-4253
Fax (541) 332-8044

M.I.N.D.S. Clubhouse
29845 Airport Way, P. O. Box 60
Gold Beach, OR 97444
(541) 247-9624
Fax (541) 247-9754

Submitter : **Mr. Roland Migchielsen** **Date: 03/06/2007**

Organization : **Columbia Community Mental Health**

Category : **Other Health Care Provider**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See attachment

CMS-2258-P-54-Attach-1.DOC

#54

My name is Roland Migchielsen and I represent Columbia Community Mental Health, a Behavioral Health organization 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,
Roland Migchielsen, MS, DAPA
Executive Director

Submitter : Dr. Stephen Kliewer **Date:** 03/06/2007

Organization : Wallowa Valley Center for Wellness

Category : Other Health Care Professional

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-55-Attach-1.DOC

#55

My name is Stephen Kliewer, D. Min., and I represent The Wallowa Valley Center for Wellness, a nonprofit organization providing mental health care in Waloowa County 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***

Submitter : Mr. Joel Rhodes **Date:** 03/07/2007

Organization : All Childrens Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Cost cuts would devastate our economy and our childrens health care in this state. Please save our children who undergo enough hardship in this life as it is.

Submitter : **Mrs. Colleen Branam** **Date: 03/07/2007**

Organization : **All Children's Hospital**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I would like to voice my concerns regarding allowing CMS funding cuts to proceed. The proposed funding reductions would be devastating to the health care of Florida's children!
Thank you for taking the time to allow me to voice my opinion in this very important matter.

Submitter : Mrs. Christina Adams **Date:** 03/07/2007

Organization : All Children's Hospital -Audiology Dept

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Fewer and fewer professionals are providing quality care to low income children due to the poor reimbursement. I have been an Audiologist for 19 years and Medicaid rates have never increased during my tenure. We need to provide care to these kids so they have a chance at a successfull, productive life. We should not be thinking about reducing payments & services, we should be increasing them. Thank you for your consideration.

Submitter : Mr. Dan Hamman **Date:** 03/07/2007

Organization : Sparks Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-59-Attach-1.PDF

#59

March 6, 2007

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

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

Dear Ms. Norwalk:

Sparks Regional Medical Center is a 476 bed general acute care hospital, located on the border between Arkansas and Oklahoma. As a border hospital, we receive patients from two state Medicaid programs and are affected greatly by changes to Medicaid programs. We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospital and the patients we serve. We estimate the cuts would jeopardize up to $81 million currently available to Arkansas hospitals. Specifically for Sparks, the cuts would impact the Medicaid Upper Payment Limit program (UPL) payments and the Federal funding for certain children already covered by the State Children's Health Insurance Program (SCHIP), thereby continuing to penalize community hospitals like Sparks that already experience high levels of charity care.

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

1311 South I Street • P.O. Box 17006 • Fort Smith, AR 72917-7006 • 479-441-4000 • 479-441-5397 fax • www.sparks.org

recently, Congress again echoed that opposition, with 226 House members and 43 Senators having signed letters urging their leaders to stop the proposed rule from moving forward.

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

Limiting Payments to Government Providers

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

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. We are very concerned that, in CMS' 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 no longer be reimbursed.

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

New Definition of "Unit of Government"

The proposed rule puts forward a new and restrictive definition of "unit of government," such as a public hospital. Public hospitals that meet this new definition must demonstrate they are operated by a unit of government or are an integral part of a unit of government that has taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Contrary to CMS' assertion,

the statutory definition of "unit of government" does not require "generally applicable taxing authority." This new restrictive definition would no longer permit many public hospitals that operate under public benefit corporations or many state universities from helping states finance their share of Medicaid funding. There is no basis in federal statute that supports this proposed change in definition.

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

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

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

Insufficient Data Supporting CMS's Estimate of Spending Cuts

CMS is required to examine relevant data to support the need to change current policy. The proposed rule estimates that the policy changes will result in $3.87 billion in spending cuts over the next five years. 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,

Dan M. Hamman, CFO
Sparks Health System

Submitter : Mr. R.D. Williams **Date:** 03/07/2007

Organization : Ashe Memorial Hosptial

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-2258-P-60-Attach-1.DOC

#60

March 07, 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:

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

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

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

Existing federal Medicaid regulations allow North Carolina hospitals to receive payments to offset a portion of the costs incurred when caring for Medicaid patients. Even with these payments, however, hospital Medicaid revenues for most North Carolina hospitals still fall significantly short of allowable Medicaid costs. If the proposed rule is implemented and, as a result, this important hospital funding stream is eliminated, those losses would be exacerbated. Hospitals would be forced either to raise their charges to insured patients or to reduce their costs by eliminating costly but under-reimbursed services. The first choice would raise health insurance costs by an estimated four percent. The second would eliminate needed services, not just for Medicaid patients but also for the entire community. Eliminating those services likely

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

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

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

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

Sincerely,

R.D. Williams, CEO
Ashe Memorial Hospital

cc: Senator Elizabeth Dole
Senator Richard Burr
Representative Virginia Foxx

Submitter : Mr. George Hayes **Date:** 03/07/2007

Organization : Medical Center of the Rockies

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-61-Attach-1.PDF

#61

MEDICAL CENTER OF THE ROCKIES
POUDRE VALLEY HEALTH SYSTEM

George E. Hayes
President/Chief Executive Officer

March 7, 2007

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

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

Dear Ms. Norwalk:

I am writing on behalf of Medical Center of the Rockies and, in general, hospitals, patients, and Medicaid recipients throughout the State of Colorado. We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospital and the patients we serve.

The 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 bypass 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.

MEDICAL CENTER OF THE ROCKIES
POUDRE VALLEY HEALTH SYSTEM

George E. Hayes
President/Chief Executive Officer

Limiting Payments to Government Providers

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

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. We are very concerned that, in CMS' 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 no longer be reimbursed.

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

New Definition of "Unit of Government"

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

MEDICAL CENTER OF THE ROCKIES
POUDRE VALLEY HEALTH SYSTEM

George E. Hayes
President/Chief Executive Officer

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,

George E. Hayes
President/Chief Executive Officer

2500 Rocky Mountain Avenue • Loveland, Colorado 80538 • Phone: (970) 624-1201 • Fax: (970) 624-1290 • www.pvhs.org

Submitter : Kevin Campbell **Date:** 03/07/2007

Organization : Greater Oregon Behavioral Health, 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-62-Attach-1.DOC

#62

GREATER OREGON BEHAVIORAL HEALTH, INC

March 7, 2007

My name is Kevin M. Campbell and I represent Greater Oregon Behavioral Health, Inc., a mental health managed care organization 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,

Kevin M. Campbell, CEO

400 East Scenic Drive Suite 2343 The Dalles, Oregon 97058 541 298-2101 Fax 541 298-7996

Submitter : Mrs. Pamela Gehrich **Date:** 03/08/2007

Organization : All Children's Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

This proposed docket will adversely impact our hospital and the care we provide our patients.

Submitter : Mr. Peter Resnick **Date:** 03/08/2007

Organization : Dearborn County Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-64-Attach-1.DOC

#64

March 6, 2007

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

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

Dear Ms. Norwalk:

Dearborn County Hospital appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospital(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 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 very concerned that, in CMS' 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 no longer be reimbursed.

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

New Definition of "Unit of Government"

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

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

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

CPEs are restricted as well, so only hospitals that meet the new definition of public hospital and are reimbursed on a cost basis would be eligible to use CPEs to help states fund their programs. These

restrictions would result in fewer dollars available to pay for needed care for the nation's most vulnerable people.

Insufficient Data Supporting CMS's Estimate of Spending Cuts
CMS is required to examine relevant data to support the need to change current policy. The proposed rule estimates that the policy changes will result in $3.87 billion in spending cuts over the next five years. 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,

Peter V. Resnick
Executive Director

Submitter : Ginger Swan **Date:** 03/08/2007

Organization : Coos 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-65-Attach-1.DOC

#65

Mental Health Department

Member of Jefferson Behavioral Health

1975 McPherson Ste 2 • North Bend, OR 97459

(541) 756-2020 ext 528 • Fax (541) 756-8982

TDD 1-800-735-2900

March 6, 2007

Center for Medicaid and Medicare Services
Department of Health and Human Services
Attention CMS-2258-P
P.O. Box 8017
Baltimore MD 21244-1850

To whom it may concern,

My name is Ginger Swan and I represent Coos County Mental Health Department. 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 known as the Oregon Health Plan and the impact on Coos County.

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.

Coos County is a rural, geographically isolated, county with a population of approximately 62,000. Coos County has the highest per capita population of individuals receiving Social Security for a Mental Health Disability in the State of Oregon. Coos County is the safety net for the provision of mental health services to the Medicaid population. There are no providers available in this area to serve the Medicaid population if Coos County ceased providing mental health services. Coos County is only able to provide a full continuum of services including rehabilitative and crisis services because we are able to bear risk and reduce the use of more intensive services in order to provide less intensive services. Without the ability to carry a modest reserve in the budget for higher than expected costs of purchased specialty services such as hospital costs, we would be unable to meet the balanced budget requirements of the State of Oregon.

As currently written, it appears that the drafters of CMS 2258-P did not anticipate risk sharing at the provider level. By restricting, the ability of County Governments to share risk you may inadvertently reduce local government involvement in providing Medicaid services. Medicaid recipients in small rural Counties like Coos County, where there is not a public sector able and willing to provide mental health services for the Medicaid population, would suffer from lack of access to services if not for the willingness of County government to step in and provide services.

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. In a rural County like Coos with a small population, it is more difficult to bear risk than in areas that are more populous. To construct financial barriers that will further restrict County involvement will leave services for Medicaid eligibles dependent on local market dynamics.

This level of federal intervention in the reimbursement and affect it will have on services provided cooperatively between state and local governments appears to be unintended. In essence, the regulation is restricting units of government from entering into Medicaid risk-based contracts and creating a disadvantage for local governments that would desire to provide services where the market is not likely to do so.

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,

Ginger Swan
Director of Coos County Mental Health

Submitter : Mrs. Linda Roney **Date:** 03/08/2007

Organization : High Point Regional Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2258-P-66-Attach-1.DOC

#66

High Point Regional Health System

601 North Elm Street
P.O. Box HP-5
High Point, NC 27261
(336) 878-6000
www.highpointregional.com

March 8, 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, No. 11), January 18, 2006

Dear Ms. Norwalk:

I am writing on behalf of High Point Regional Health System to advise you that we oppose the proposed Medicare and Medicaid Services rules referenced above, and I want to be sure you are aware of the impact that this change in regulation will have on our hospital and our community. If the proposed changes are approved and implemented, the annual negative impact it will have on High Point Regional will be $4,465,140. With this reduction in reimbursement from the program we would anticipate that High Point Regional would lose money from operations, with an estimated loss of over $3 million. Our operating margins are not great due to the increasing number of charity and self-pay patients that we are seeing in our Health System, and we have relied for a number of years on the Medicaid disproportionate share payments to offset significant losses we encounter with these individuals.

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

The proposed rule puts forward a new and restrictive definition of "unit of government." In order for a public hospital to meet this new definition, it must demonstrate that it has generally applicable taxing authority or is an integral part of a unit of government that has generally applicable taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Nowhere in the Medicaid statue, however, is there any requirement that a "unit of government" have "generally applicable taxing authority." This new restrictive definition would disqualify many long-standing truly public hospitals from

certifying their public expenditures. There is no basis in federal statue 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 September 1, 2007. If this devastating rule is not withdrawn, North Carolina hospitals will lose approximately $340 million immediately. The results of that would be disastrous, as we have shared in this comment letter. State Medicaid agencies and hospitals would need time to react and plan in order to even partially manage such a huge loss of revenue. The immediate implementation of this rule would result in major disruption of hospital services in our State.

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

Sincerely,

Linda M. Roney
Vice President

LMR/b
cc: Senator Elizabeth Dole
Senator Richard Burr
Representative Howard Coble
Representative Melvin L. Watt

Submitter : **Date: 03/08/2007**

Organization : **National Association of Public Hospitals**

Category : **Association**

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-67-Attach-1.DOC

#67

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

March 8, 2007

Leslie Norwalk, Esq., Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Administrator Norwalk:

The National Association of Public Hospitals and Health Systems (NAPH) is pleased to submit the attached comments expressing our serious concern about the devastating impact of the above-referenced Proposed Rule on the nation's health system. NAPH represents more than 100 metropolitan area safety net hospitals and health systems. Our members fulfill a unique and critical role in the health care system providing high intensity services—such as trauma, neonatal intensive care, and burn care—to the entire community. NAPH members are also the primary hospital providers of care in their communities for Medicaid recipients and many of the more than 46 million Americans without insurance. NAPH hospitals represent only 2 percent of the acute care hospitals in the country but provide 25% of the uncompensated hospital care provided across the nation. Our members are highly reliant on government payers, with nearly 70% of their net revenue from federal, state, and local payers.

We strongly believe that the Proposed Rule will very seriously compromise the future ability of NAPH members and other safety net hospitals to serve Medicaid patients and the uninsured and to provide many essential, community-wide services. The harm that will be inflicted on the health safety net by this rule will also inflict fiscal crises on many states and increase the numbers of uninsured, at a time when we should be searching for ways to improve (not diminish) access and coverage.

In 2000, the Institute of Medicine issued a landmark report, *America's Health Care Safety Net: Intact but Endangered*, which recommended that, "Federal and state policy makers should explicitly take into account and address the full impact (both intended and unintended) of changes in Medicaid policies on the viability of safety net providers and the populations they serve." Last fall, the IOM reconvened the commission that produced the report and emphatically restated the findings and recommendations from 2000. Even without the Proposed Rule, the situation of the health safety net is more fragile than ever.

The attached NAPH comments detail many specific concerns about the Proposed Rule. However, please be aware that our primary recommendation is that CMS withdraw the Proposed Rule and work with the Congress and with state and local stakeholders to develop policy alternatives that would strengthen -- not undermine -- the nation's health safety net (and with it, the entire health system).

NAPH appreciates the opportunity to submit these comments. If you have any questions, please contact me or Charles Luband or Barbara Eyman at NAPH counsel Powell Goldstein (202) 347-0066.

Respectfully,

President

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

March 8, 2007

COMMENTS BY THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS ON 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

Prepared on behalf of NAPH by Powell Goldstein, LLP

The National Association of Public Hospitals and Health Systems (NAPH) urges the Centers for Medicare and Medicaid Services (CMS) to withdraw Proposed Rule CMS-2258-P (the Proposed Rule). The Proposed Rule exceeds the agency's legal authority, defies the bipartisan opposition of a majority of the Members of Congress and would, in short order, dismantle the intricate system of Medicaid-based support for America's health care safety net, seriously compromising access for Medicaid and uninsured patients. Without any plan for replacement funding, CMS would eliminate billions of dollars of support payments that have traditionally been used to ensure that the nation's poor and uninsured have access to a full range of primary, specialty, acute and long term care. The cuts would restrict funding that has ensured that our communities are protected with adequate emergency response capabilities, highly specialized but under-reimbursed tertiary services (such as trauma care, neonatal intensive care, burn units and psychiatric emergency care), and trained medical professionals. The result of this regulation would be a severely compromised safety net health system, unable to meet current demand for services and incapable of keeping pace with the fast-paced changes in technology, research and best practices that result in the highest quality care.

NAPH endorses CMS' stated goal of ensuring accountability and protecting the fiscal integrity of the Medicaid program. Over the years, Congress and CMS have taken a series of steps to advance these goals with respect to both provider payments and non-federal share financing. These efforts have included restrictions on provider taxes and donations, statewide and hospital-specific limitations on Disproportionate Share Hospital (DSH) payments and a series of modifications to regulatory upper payment limits. All of these steps were taken by or with the consent of Congress.

Over the last three years, CMS has significantly increased its oversight of payment methodologies and financing arrangements in state Medicaid programs, working with states to restructure their programs as necessary to eliminate inappropriate federal matching arrangements. Officials from the Department of Health and Human Services (HHS) have repeatedly claimed success from this initiative, stating that they have largely eliminated "recycling" from those programs under scrutiny. Indeed, since the publication of the Proposed Rule, it is our understanding that CMS provided to Members of Congress data indicating that its efforts have been enormously successful, with 22 states listed as using intergovernmental transfers (IGTs) appropriately, 30 listed as having removed

"recycling" from their programs and 23 with no IGT financing.[1] According to these data, there are only three states about which CMS has any remaining concerns. Clearly the steps taken by Congress and CMS to date have addressed the concerns CMS has raised about state financing mechanisms and it is unclear why CMS feels the need to proceed with this rulemaking. Nor does the agency explain how the restrictive policies in the Proposed Rule will further its stated goals. Instead, the Proposed Rule imposes payment and financing policies that go far beyond merely institutionalizing the oversight procedures CMS has used successfully to date. These policies would cut deep into the heart of Medicaid as a safety net support program with no measurable increase in fiscal integrity.

In its Regulatory Impact Analysis, CMS asserts that the Proposed Rule will not have a significant impact on providers for which relief should be granted, and it projects "this rule's effect on actual patient services to be minimal."[2] It estimates $3.9 billion in federal savings from the Proposed Rule over five years, but provides no detail on how it derived this estimate. From NAPH's survey of its own members, it is clear that CMS has significantly understated the impact of the Proposed Rule on providers, on patients and on total federal Medicaid funding provided to states. Although we do not have sufficient nationwide data to estimate the total amount of funding cuts imposed by the Proposed Rule, data from just a few NAPH members and states illustrates how grossly understated CMS' projections of the impact are.

For example, Florida estimates that its hospitals will lose $932 million. The estimated statewide loss of federal dollars is at least $253 million in Georgia, at least $350 million in New York and is $374 million in Texas. These state programs are not ones that CMS has identified as abusive; on the contrary, CMS has reviewed these hospital payment and financing programs and approved them as legitimate. Despite their current legitimacy, the Proposed Rule will cut payment rates and eliminate approved sources of non-federal share funding in each of these programs. As a result, safety net health systems' ability to serve Medicaid and uninsured patients will be compromised and state Medicaid programs will face substantial budget shortfalls with no apparent gain in fiscal integrity. Moreover, CMS would impose these cuts immediately, effective September 1, 2007, providing no time for state legislators to overhaul their program financing to come into compliance with the new requirements.

CMS's response to concerns about lost funding for important health care needs is that it is Congress' job to determine whether such federal support is needed. NAPH respectfully submits that Congress has already determined that such federal support is needed and that states may use their Medicaid programs to provide it. Above-cost Medicaid payments based on Medicare rates have been part of the Medicaid payment

[1] *Summary of State Use of IGTs and Recycling,* as of 11/14/06. Several states are listed in more than one category as they have structured different IGT programs for different types of services.
[2] 72 Fed. Reg. at 2245.

system for years. Congress has explicitly rejected CMS' proposals to impose provider-specific cost-based payment limits;[3] it has required the adoption of regulations with aggregate rather than provider-specific limits;[4] it long ago freed states from mandatory cost-based payment systems to allow for the proliferation of payment systems more tailored to localized needs;[5] and it has acquiesced with no expressed concern in the development of supplemental Medicaid payment systems in which states have used the Medicaid program as the primary source of federal support for safety net health care. If Congress is the only entity that can authorize replacement funding, then Congress should also be the entity to consider the types of sweeping payment and financing changes that CMS proposes.

In the wake of President Bush's FY 2007 budget proposal to restrict funding and payment flexibility by regulation, a substantial majority of the House and Senate went on record urging the Administration not to move forward administratively. Members of the 110th Congress have had a similar response. The National Governors Association has also expressed its deep concern about the impact of the Proposed Rule on the governors' ability to implement health reform options and expand affordable health insurance coverage. Given the overwhelming bipartisan opposition to this Proposed Rule and the means by which it is being adopted, CMS should withdraw its proposal immediately.

After a brief summary in the first section, the second section of these comments raises significant legal and policy concerns about three major aspects of the Proposed Rule:

- The limit on payments to governmental providers to the cost of Medicaid services;
- The definition of a unit of government; and
- The restriction on sources of non-federal share funding;

Thereafter, we raise several technical concerns, comments and questions about various aspects of the Proposed Rule, and comment on CMS' Regulatory Flexibility Act analysis.

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[3] Budget of the United States Government, Fiscal Year 2005, pages 149-150; Budget of the United States Government, Fiscal Year 2006, page 143; Letter from Michael O. Leavitt, Secretary of Health and Human Services, to the Honorable Richard B. Cheney, President, United States Senate, August 5, 2005 (transmitting legislative language to Senate implementing the fiscal year 2006 proposals); Letter from Michael O. Leavitt, Secretary of Health and Human Services, to the Honorable J. Dennis Hastert, Speaker of the House of Representatives, August 5, 2005 (transmitting legislative language to House of Representatives implementing the fiscal year 2006 proposals). Congress has rejected each of these proposals.

[4] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), H.R. 5661, 106th Cong., (enacted into law by reference in Pub. L. No. 106-554, § 1(a)(6)), Section 705(a).

[5] Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173.

I. SUMMARY OF COMMENTS

NAPH's major concerns about the Proposed Rule center around (1) the cost limit on Medicaid payments to governmental providers, (2) the new and restrictive definition of a "unit of government" and (3) the restrictions on sources of non-federal share funding.

The cost limit would impose deep cuts in funding for the health care safety net, with serious repercussions on access and quality for low-income Medicaid and uninsured patients. The cuts would not result in any measurable improvement in the fiscal integrity of the Medicaid program. Cost-based payments and limits are inherently inefficient, rewarding providers with high costs. The current upper payment limits, based on what Medicare would pay for the same services and calculated in the aggregate for each category of hospital, are reasonable (Medicare does not pay excessive rates) and allows states appropriate flexibility to target support to communities and providers where it is most needed.

Moreover, governmental providers, who disproportionately serve the uninsured, should not be subject to a more restrictive limit than private providers. Imposing a cost limit would undermine important policy goals shared by the Administration and providers alike – such as quality, patient safety, emergency preparedness, enhancing access to primary and preventative care, reducing costly and inappropriate use of hospital emergency departments, adoption of electronic medical records and other health information technology and reducing disparities. Finally, the cost limit would violate federal law in at least four respects. First, it will prevent states from adopting payment methodologies that are economic and efficient and that promote quality and access in contravention of Section 1902(a)(30)(A) of the Social Security Act (SSA); second, it defies simplicity of administration and ignores the best interests of Medicaid recipients that states are required to safeguard pursuant to Section 1902(a)(19); third, it would violate Section 705(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 by adopting upper payment limits that are not based on the proposed rule announced on October 5, 2000; and fourth, it would prohibit states from adopting prospective payment systems for their governmentally-operated federally qualified health centers and rural health clinics as required by Section 1902(bb) of the SSA. CMS should not modify the current upper payment limits.

We also believe 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 carry out 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.

In asserting that intergovernmental transfers (IGTs) can only be derived from tax revenues, the preamble to the Proposed Rule ignores the much broader nature of public funding. States, local governments and governmental providers derive their funding from a variety of sources, not just tax proceeds, and such funds are no less public due to their source. Limiting IGTs to tax revenues will deprive states of long-standing funding sources for the non-federal share of their programs, leaving them with significant budget gaps that can only be filled by diverting taxpayer funds from other important priorities or cutting their Medicaid programs. Moreover, CMS does not have authority to restrict local sources of funding under Section 1902(a)(2) of the SSA without explicit congressional authorization to do so. CMS should allow all public funding, regardless of its source, to be used as the non-federal share of Medicaid expenditures.

NAPH also raises several more technical issues and concerns about the regulation. Our recommendations in this regard include:

Cost Limit

- CMS should clarify that the limit based on the "cost of providing covered Medicaid services to eligible Medicaid recipients" does not exclude costs for disproportionate share hospital payments or payments authorized under Section 1115 demonstration programs.
- The definition of allowable costs should not be restrictive and should include all costs necessary to operate a governmental provider.
- CMS should confirm that graduate medical education costs would be allowable.
- CMS should clarify that the cost limit applies only to institutional governmental providers and not professional providers that may be employed by or affiliated with governmental entities.
- CMS should allow states to calculate the cost limit on a prospective basis.
- CMS should allow states to make direct payments to governmental providers for unreimbursed costs of serving Medicaid managed care enrollees.

Unit of Government Definition

- CMS should eliminate the requirement that units of government have taxing authority and should defer to state law determinations of public status.
- CMS should clarify that it is not altering federal or state law interpretations of public status outside of the provisions of the Proposed Rule.

Certification of Public Expenditures

- CMS should allow the use of certified public expenditures (CPEs) to finance payments not based on costs.
- CMS should confirm the mandatory and permissive nature of various steps in the reconciliation process.

Retention of Payments

- CMS should clarify whether the retention provision applies to CPEs.
- CMS should eliminate the provision providing authority for the Secretary to review "associated transactions."

Section 1115 Waivers

- CMS should clarify that states may maintain current levels of funding for the safety net care pools, low income pools and expanded coverage established through Section 1115 demonstration projects notwithstanding the new cost limit.
- CMS should clarify that other states may use waivers to adopt similar pools or coverage based on savings incurred by reducing governmental payments to cost.

Upper Payment Limit (UPL) Transition

- CMS should revise the regulation to ensure that it has no impact on transition payments made pursuant to upper payment limit regulations revised in 2001 and 2002.

Provider Donations

- CMS should clarify that it will not view transfers of taxpayer funding as provider donations.

Effective Date

- CMS should extend the effective date of the regulation and provide at least a ten-year transition period.
- CMS should clarify that all parts of the regulation will be imposed prospectively only.

Consultation with Governors

- CMS should immediately consult with states on the Proposed Rule and modify or withdraw it based on state concerns.

Finally, NAPH believes that in its Regulatory Flexibility Act analysis, CMS has seriously underestimated the impact that the Proposed Rule will have. The Proposed Rule will impose significant costs on states and providers in connection with new administrative burdens it establishes. The cost to states of developing new payment systems, adopting new financing mechanisms to pay for the non-federal share, developing new cost reporting systems and administering and auditing them will be significant. The cost to providers of complying with these new requirements is also substantial. More importantly, however, CMS vastly understates the direct and significant impact that the Proposed Rule will have on patient care, as providers and states struggle to cope with multi-million 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.

II. MAJOR LEGAL AND POLICY CONCERNS

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

NAPH objects to the new cost limit on Medicaid payments to government providers under the Proposed Rule on a number of grounds.

1. The cost limit under the Proposed Rule imposes deep cuts in safety net support without addressing financing abuses.

Rather than adopting a narrowly tailored solution to identified concerns with inappropriate Medicaid financing practices, CMS proposes to impose a cost limit on governmental providers that is simply a straightforward funding cut. According to CMS' own data, it has largely eliminated the "recycling" that the cost limit purports to address. Even if recycling were occurring, however, a cost limit would not eliminate it; it would simply limit the net funding for governmental providers. Yet the regulation grossly overreaches by imposing the restrictive limit for governmental providers in states that

have removed or never relied on inappropriate financing arrangements. In these cases, the new limit imposes a deep cut to rectify a non-existent problem.

2. *The cost limit imposes inappropriate and antiquated incentives and unnecessary new administrative burdens.*

A payment limit based on costs represents a sharp departure from CMS' efforts to bring cost-effective market principles into federal health programs. Prospective payment systems are structured to encourage health care providers to eliminate excess costs by allowing them to keep payments above costs as a reward for efficiency. Increasingly, CMS is considering new payment models, which would include incentives for providing high quality care as a means to better align payment and desired outcomes. The Proposed Rule would require a return to cost-based reporting and reimbursement that is inconsistent with the efforts of Congress and CMS over the past twenty years to move away from cost-based methodologies and the inefficient incentives these methodologies entail. It would incentivize providers to increase costs and eschew efficiencies in order to preserve revenues. It would also impose enormous new administrative burdens on states and providers, as they engage in cost reconciliation processes that could last for years beyond when services are provided. The massive diversion of scarce resources into such unnecessary bureaucracy is ill-advised at a time when the demands on the health care safety net are greater than ever.

3. *The Medicare upper payment limit is not excessive.*

In proposing the new cost limit, and asserting that it is necessary to ensure economy and efficiency in the program, CMS is effectively stating that the current limit, based on Medicare rates, is unreasonable. Given the substantial effort put into creating the Medicare payment system by both Congress and CMS, it is surprising that CMS would consider payments at Medicare levels to be unreasonable. Moreover, CMS' claim that the Medicare limit is unreasonable for governmental providers is undermined by its perpetuation of that very limit for private providers.

For many providers, Medicare reimbursement, while not excessive, is higher than the direct costs of services for Medicare patients. The prospective payment system is deliberately delinked from costs and is intended to establish incentives for providers to hold down costs by allowing them to retain the difference between prospectively set rates and their costs. Moreover, Medicare reimbursement explicitly recognizes additional costs that are incurred by some providers for public goods from which the entire community benefits, such as operating a teaching program or providing access to a disproportionate share of low income patients. The Medicare reimbursement system is not unreasonable.

Moreover, the adoption of aggregate limits within specified groups of governmental and private providers allows states sufficient flexibility to target additional Medicaid reimbursement to individual providers to achieve specified policy objectives. In the preamble to the Proposed Rule, CMS raises concerns about some governmental providers receiving payments that are higher than those for other governmental providers. But variation in payment rates across providers has been a hallmark of Medicaid payment policy since the early 1980s when Congress eliminated the requirement that providers be reimbursed based on reasonable costs and allowed states flexibility to tailor reimbursement to localized needs. Today, state Medicaid programs feature a variety of targeted supplemental payments: for rural providers, children's hospitals, teaching hospitals, public hospitals, financially distressed providers, trauma centers, sole community providers and the like. Eliminating the aggregate nature of the payment limit restricts states' flexibility to address local needs through reimbursement policies. Such action runs counter to the Administration's commitment, and Congress' efforts, to enhance state flexibility in managing their Medicaid programs.

4. Hospitals cannot long survive without positive margins.

In any competitive marketplace, no business can survive simply by breaking even, earning revenues only sufficient to cover the direct and immediate costs of the services it provides. Any well-run business needs to achieve some margin in order to invest in the future, establish a prudent reserve fund, and achieve the stability which will allow it access to needed capital. Organizations that lose money on one line of business need to make up those losses on other lines in order to survive. These fundamental business concepts are equally applicable to the hospital industry. Margins are essential to survival; they are even more essential to a community-oriented mission.

The proposed cost limit would prohibit governmental hospitals from earning any margin on their largest line of business. Moreover, governmental hospitals, as compared to the hospital industry as a whole, are much more likely to have a line of business – care for the uninsured – in which they must absorb significant losses. For example, in 2004, NAPH members provided, on average, over $76 million in uncompensated care per hospital. Their average margin that same year was a mere 1.2 percent (the industry average was 5.2 percent). Under the Proposed Rule, public hospitals still may be able to achieve a small margin on Medicare and perhaps a slightly larger margin on commercially insured patients, but these two revenue sources constitute less than 45 percent of average NAPH net revenues. With self-pay patients comprising 24 percent of NAPH members' patient populations, margins on Medicare and commercial insurance alone are not sufficient to keep these hospitals afloat if CMS denies any margin on Medicaid patients. CMS would not expect a private business to operate with revenues no greater than direct costs. It should not expect public hospitals, with their disproportionate share of uninsured patient populations, to survive and thrive under this limit.

5. *It is unreasonable to impose a lower limit on governmental providers than private providers.*

It is unclear why CMS believes that rates that the agency would continue to allow states to pay private providers under the Proposed Rule are excessive with respect to government providers. The needs of governmental providers are often significantly greater than those of private providers as they typically provide a disproportionate share of care to the uninsured and offer critical yet under-reimbursed community-wide services (such as trauma care, burn care, neonatal intensive care, first response services, standby readiness capabilities, etc.). For example, the members of NAPH represent 2 percent of the nation's hospitals but provide a full 25 percent of uncompensated hospital care. A report issued in December by the Congressional Budget Office confirmed that governmental hospitals provide significantly more Medicaid and uncompensated care and other community benefits than private hospitals.[6] Moreover, governmental providers' payer mix is markedly different from that of private providers, with greater reliance on Medicaid revenues to fund operations and a lower share of commercially insured patients on which uncompensated costs can be shifted. By cutting Medicaid reimbursement for governmental providers, the Proposed Rule would slash their primary funding source.

6. *The cost limit would have a particularly devastating effect on hospitals in low DSH states.*

Medicaid disproportionate share hospital payments help to offset some of the unreimbursed costs that hospitals incur in caring for uninsured patients, but the adequacy of DSH allotments is declining as costs climb and insurance coverage drops. As a percentage of Medicaid expenditures, DSH has fallen dramatically in the last decade, declining from 14 percent of overall Medicaid expenditures in 1993 to approximately 6 percent in 2004. As DSH falls further and further behind growing uncompensated costs, other types of supplemental payments become an even more important source of support for safety net hospitals. This is especially true for hospitals in "low DSH states," where the statewide DSH allotment is significantly lower than the hospitals' need. Yet it is these non-DSH supplemental Medicaid payments that the proposed cost limit would impact most significantly, undermining the ability of governmental hospitals to continue to provide high volumes of care to the uninsured.

7. *The cost limit undermines important public policy goals.*

At a time when the federal government is calling on providers to improve quality and access, and to invest in important new technology, now is not the time to impose unnecessary funding cuts on governmental providers. Although disproportionately reliant on governmental funding sources, NAPH members have, in recent years, made

[6] Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits*, December 2006.

significant investments in new (and often unfunded) initiatives that are in line with HHS' policy agenda.

For example, NAPH members have invested millions of dollars in adopting electronic medical records and other new information systems that have a direct impact on quality of care, patient safety and long-term efficiency, all goals promoted by HHS. Similarly, in the heightened security-conscious post-9/11 world, public hospitals have played a critical role in local emergency preparedness efforts, enhancing their readiness to combat both manmade and natural disasters and epidemics. HHS has focused on expanding access to primary and preventative services -- particularly for low-income Medicaid and uninsured patients -- and reducing inappropriate utilization of emergency departments. NAPH members have been at the forefront of this effort, establishing elaborate networks of off-campus, neighborhood clinics with expanded hours, walk-in appointments, assigned primary care providers and access to appropriate follow-up and specialty care. (In 2004 alone, 89 NAPH member hospitals provided 29 million non-emergency outpatient visits.) HHS is striving to reduce the disparities in care provided to minority populations. With an extremely diverse patient population, NAPH members have been leaders in providing culturally sensitive and welcoming care, in providing access to translation and interpretation services, and in adopting innovative approaches to treating the specific needs of different minority groups. All of these initiatives require substantial investments of resources. CMS does not appear to have considered the impact of the cut imposed by the cost limit on shared policy initiatives that HHS itself has established as key goals of America's complex health care system.

8. The proposed cost limit violates federal law.

The proposed cost limit violates section 1902(a)(30)(A) and 1902(bb) of the Social Security Act (SSA) and section 705(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).[7] CMS is therefore without legal authority to impose the limit by regulation.

Under section 1902(a)(30)(A), state Medicaid programs are required:

> to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.[8]

Many states will be unable to meet the requirements of this provision given the restrictive limits imposed by CMS. By incentivizing providers to maximize costs in order to secure a higher reimbursement limit, the proposal clearly does not promote efficiency or

[7] H.R. 5661, 106th Cong., enacted into law by reference in Pub. L. No. 106-554, § 1(a)(6) ("BIPA").
[8] 42 U.S.C. § 1396a(a)(30)(A).

economy. By removing tools to promote efficiency (such as through prospective payments systems that encourage providers to reduce costs), CMS has hampered states' ability to provide the assurances required by the statute. Similarly, the cost limit thwarts states' efforts to ensure quality of care by eliminating flexibility to provide targeted above-cost incentives to promote and reward high quality care, particularly for providers identified by the state as having particular needs or faced with unique challenges. Finally, to the extent that the cost regulation prohibits states from paying rates that they have determined are necessary to ensure access for Medicaid recipients, CMS's proposed regulation undermines the statutory requirement that states assure access to care and services at least equal to that available to the general population.

Similarly, Section 1902(a)(19) requires states to provide safeguards to assure that "care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients."[9] The Proposed Rule hinders states' ability to make both assurances. Far from streamlining administration, the regulation would require states and providers to engage in elaborate cost reporting and reconciliation processes regardless of the volume of services provided. More importantly, however, CMS' single-minded focus on limiting states' use of local dollars to fund Medicaid and in cutting payments to the largest providers (governmental providers) of Medicaid services, the Proposed Rule patently ignores the best interests of recipients. In fact, it is Medicaid recipients who will be most directly and most severely harmed by this regulation.

The proposed cost limit also ignores Congress's explicit instructions to CMS in Section 705(a) of BIPA to adopt an aggregate Medicare-related upper payment limit (UPL). Adopted shortly after CMS proposed a regulation establishing aggregate UPLs within three categories of providers – state owned or operated, non-state owned or operated and private -- BIPA required that HHS "issue ... a final regulation based on the proposed rule announced on October 5, 2000 that ... modifies the upper payment limit test ... by applying an aggregate upper payment limit to payments made to governmental facilities that are not State-owned or operated facilities." The proposed cost limit for government providers deviates significantly from Congress's clear mandate in BIPA that the upper payment limits: (1) be aggregate limits and (2) include a category of facilities that are "not State-owned or operated." The proposed regulation is provider-specific, not aggregate, and eliminates ownership as a factor in determining whether a facility is a government facility. Moreover, in requiring that the final regulation be based on the proposed rule issued on October 5, 2000, Congress explicitly endorsed the establishment of a UPL based on Medicare payment principles, not costs.

Finally, Section 1902(bb) requires states to pay for services provided by federally qualified health centers (FQHCs) and rural health clinics (RHCs) through rates that are prospectively determined (based on historical costs). FQHCs and RHCs had previously

[9] 42 U.S.C. § 1396a(a)(19).

been guaranteed cost-based reimbursement under Title XIX, but through the Balanced Budget Act of 1997, Congress began phasing out this guarantee.[10] Before the phase-out was complete, Congress stepped in again in 2000 to require a new payment methodology for FQHCs that was specifically *not* cost reimbursement.[11] This evolution of FQHC and RHC payment policy – away from cost reimbursement and towards a prospective payment system that encourages efficiency – is the most recent articulation of Congress' intent with regards to Medicaid reimbursement. The Proposed Rule would require states to reconcile prospectively made payments to public FQHCs and RHCs and to require the clinics to return any "overpayment" (payments that in retrospect turn out to be in excess of cost). This required reconciliation process is in direct conflict with Section 1902(bb).

Recommendation: CMS should retain the aggregate upper payment limits based on Medicare payment principles for all categories of providers.

B. Defining a Unit of Government (§ 433.50)

NAPH urges CMS to reconsider its proposed new definition of a "unit of government." This proposal would usurp the traditional authority of states to identify their own political subdivisions and exceed the authority provided in the Medicaid statute. The new definition would undermine efforts to date by states to make units of government more efficient and less reliant on public tax dollars.

1. 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 in their communities, including services for 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 -- 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 and fire departments 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

[10] *See* Balanced Budget Act of 1997, § 4712.
[11] BIPA, § 702,

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 entities. 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.

These restructurings have taken a wide variety of forms. Many governments have created hospital authorities, with a separate governing board, appointed by elected officials and dedicated solely to governing the hospital. Other states created hospital districts, public benefit corporations or non-profit corporations 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 the establishment of a separate and independent budget and accounting system for the hospital, in which revenues earned by the hospital are retained by the hospital and 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 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.

2. CMS does not have statutory authority to restrict the definition of a "unit of government."

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)[12] 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.*"[13] 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

[12] 42 U.S.C. § 1396b(w)(7)(G).
[13] Proposed 42 C.F.R. § 433.50(a)(1)(i) (emphasis added).

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.[14]

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."[15] 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.

3. 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.

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

[14] 42 U.S.C. § 1396b(d)(1).
[15] 42 U.S.C. § 1396b(w)(6)(A).

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

Traditionally, states have 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), notwithstanding a large body of state law to the contrary.[16] Rather, the regulation (or at least its preamble) 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.

The preamble to the Proposed Rule states explicitly that, with respect to intergovernmental transfers, "the source of the transferred funds [must be] State or local tax revenue (which must be supported by consistent treatment on the provider's financial records)."[17] While the proposed regulatory language itself refers only to "*funds* from units of government"[18] 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 preamble does not specify the reason for this restriction, nor whether it would serve to bar federal Medicaid match for support provided by a local government to a hospital derived from such routine governmental funding sources such as the proceeds from bond issuances, revenue anticipation notes, tobacco settlement funds and the like. Moreover, if the regulation does indeed bar the use of such funding sources, how does CMS expect to be able to track the precise source of local support funding, given the fungibility of governmental funding?

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, starved for

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[16] *See, e.g. Adams County Record v. Greater North Dakota Association*, 529 N.W.2d 830, 834 (N.D. 1995) ("public funds" include "all funds derived from taxation, fees, penalties, sale of bonds, or from any other source, which belong to and are the property of a public corporation or of the state ...."); *Kneeland v. National Collegiate Athletic Association*, 850 F.2d 224, 227 (1988) (all revenues, except for trust funds, received by public colleges and universities, as well as various types of property of public colleges and universities are public funds).

[17] 72 Fed. Reg. at 2238

[18] Proposed 42 C.F.R. § 433.51(b).

resources. These funding 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.

In imposing this new restriction on the source of IGTs, 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,[19] 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.[20] 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.

III. THE PROPOSED RULE INCLUDES TECHNICAL ERRORS, AMBIGUITIES AND MISGUIDED POLICY CHOICES

The best course, from a legal and policy perspective, would be for CMS to withdraw the Proposed Rule altogether. To the extent that the agency goes forward with the rule, there are several technical issues that need to be clarified, modified or otherwise addressed in the final rule. NAPH raises the following concerns:

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

1. *The Proposed Rule inappropriately limits reimbursable costs to the "cost of providing covered Medicaid services to eligible Medicaid recipients." (§ 447.206(c)(1))*

Proposed 42 C.F.R. § 447.206(c)(1) provides that "[a]ll health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider's cost of providing ***covered Medicaid services to eligible Medicaid recipients***." By its terms, this provision would prohibit *any* Medicaid reimbursement to

[19] Pub. L. No. 102-234, 105 Stat. 1793.
[20] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 1989 U.S.C.C.A.N. (103 Stat.) 2106; Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 1990 U.S.C.C.A.N. (104 Stat.) 1388.

governmental providers for costs of care for patients who are *not* eligible Medicaid recipients, or for services that are not covered under the state Medicaid plan. Taken literally, states could no longer pay public hospitals for unreimbursed costs for uninsured patients or for non-covered services to Medicaid patients through the disproportionate share hospital program. Similarly, the authority of several states to make payments to public providers pursuant to expenditure authority received through section 1115 demonstration projects to pay for otherwise unreimbursable costs to the uninsured, for infrastructure investments and for other purposes not covered under the state plan would be called into question (including Safety Net Care Pool payments authorized in California and Massachusetts, and Low Income Pool payments authorized in Florida). The cost limit could also extend to Medicaid reimbursement received by governmental providers from managed care organizations (despite CMS' disavowal of any such intent in the preamble). The problem is exacerbated because the regulation defines its scope as applying broadly to all "payments made to health care providers that are operated by units of government ...."[21] By contrast, the UPL regulations are carefully drafted to limit their scope to "rates set by the agency,"[22] and they include an explicit exemption for DSH payments.[23]

We assume that it is CMS' intention either (1) to apply the cost limit only to fee-for-service payments by the state agency for services provided to Medicaid recipients while relying on separate statutory or waiver-based authority to impose cost limits on DSH or demonstration program expenditures, or (2) to apply the cost limit at 42 C.F.R. §447.206 more broadly than the language of the Proposed Rule would suggest. In either case, modifications to the language of the regulation are needed to clarify its scope and the corresponding allowable costs. If the limit is to apply only to fee-for-service rates for Medicaid patients, DSH should be explicitly exempted. If the limit is to be more broadly applied, the language must be expanded to allow costs for the uninsured or non-covered Medicaid services for purposes of DSH payments. In addition, preamble guidance regarding the ongoing validity of expenditure authority granted through existing demonstration projects would help reduce confusion about the intended scope.

Recommendation: CMS should clarify that the limitation to cost of Medicaid services for Medicaid recipients is not intended to limit Medicaid DSH payments or CMS-approved payments under demonstration programs that expressly allow payment for individuals or services not covered under the state Medicaid plan.

[21] Proposed 42 C.F.R. § 447.206(a)
[22] 42 C.F.R. § 447.272(a), § 447.321(a).
[23] 42 C.F.R. § 447.272(c)(2).

2. *CMS should clarify that allowable costs will include all necessary and proper costs associated with providing health care services. (§ 447.206)*

The calculation of cost for purposes of applying the cost limit is not well-defined under the Proposed Rule. Since the magnitude of the cut imposed by the cost limit will depend on which costs CMS will and will not allow states to reimburse, NAPH requests that CMS provide further guidance on how Medicaid costs would be determined and in particular clarify that any determination of Medicaid "costs" will include all costs necessary to operate a governmental facility. For governmental hospitals, these costs must, at a minimum, include:

- costs incurred by the hospital for physician and other professional services (e.g. salaries for employed professionals, contractual payments to physician groups for services provided to hospitals, physician on-call and standby costs);
- capital costs necessary to maintain an adequate physical infrastructure;
- medical education costs incurred by teaching hospitals;
- investments in information technology systems critical to providing high quality, safe and efficient hospital care;
- investments in community-based clinics and other critical access points to ensure that Medicaid and uninsured patients have adequate access to primary care;
- costs of a basic reserve fund critical to any prudently-operated business enterprise; and

In addition, some costs on a hospital's cost report are allocated to cost centers judged to be unreimbursable for purposes of Medicare reimbursement, but are appropriately reimbursed under Medicaid or DSH. For example, a hospital may have a clinic that exclusively serves Medicaid and uninsured patients that may have been excluded for Medicare purposes, but are appropriately reimbursed under Medicaid. Similarly, some costs that may not be included in a particular reimbursable cost center for purposes of the Medicare cost report should be included under a cost-based Medicaid reimbursement system (including but not limited to interns and residents, organ acquisition costs, etc.). CMS must ensure that states may make appropriate adjustments to the Medicare cost report to accurately capture all costs reasonably allocated to Medicaid – whether or not Medicare fiscal intermediaries have allowed them.

In addition, NAPH strongly believes that allowable costs should also include 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 such costs rather than placing the full burden on 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.

3. The costs of graduate medical education must be allowable costs.

The President's FY 2008 budget request includes an administrative proposal to eliminate Medicaid reimbursement for graduate medical education (GME) costs. Given the long-standing policy to permit GME payments (as of 2005, 47 states and the District of Columbia provided explicit GME payments to teaching hospitals, according to the Association of American Medical Colleges[24]) and the dozens of approved state plan provisions authorizing such payments, NAPH was surprised to see this proposal described as an administrative rather than legislative initiative. We question CMS' authority to adopt such a policy change without statutory authorization. To the extent that CMS intends to change the policy administratively, however, we assume that the agency would undertake a full notice and comment rulemaking process. In particular, we assume that CMS will allow governmental providers to include all of the costs of their teaching programs in the cost limits under the Proposed Rule unless and until the law is changed to prohibit Medicaid payments for GME. Please confirm our understanding that full GME costs will be includable as reimbursable costs.

Recommendation: CMS should clarify that graduate medical education costs will be includable in the cost limit under the Proposed Rule.

4. The Proposed Rule does not specify whether and under what circumstances professional providers would be considered to be governmentally operated.

The Proposed Rule applies the cost limit to "health care providers that are operated by units of government."[25] It is clear from the text of the regulation that it applies not just to hospital and nursing facility providers, but also to "non-hospital and non-nursing facility services."[26] Beyond this clarification, the scope of the term "providers" is unclear. It might be possible for a state to determine that the cost limit extends as far as

[24] Tim M. Henderson, *Direct and Indirect Graduate Medical Education Payments By State Medicaid Programs* (Association of American Medical Colleges), Nov. 2006, at 2.
[25] Proposed 42 C.F.R. § 447.206(a).
[26] Proposed 42 C.F.R. § 447.206(c)(4).

professionals employed by governmental entities. CMS should clarify that it does not intend the regulation's reach to extend this far. Cost-based methodologies are particularly inappropriate for professional services.

Recommendation: CMS should clarify that the cost limit applies only to institutional government providers and not to professionals employed by or otherwise affiliated with units of government.

5. *A less costly, equally effective alternative to multiple cost reconciliations is available that would reduce the administrative burden on providers.*

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.[27] 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.[28] 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. NAPH 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.

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[27] Proposed 42 C.F.R. § 447.206(e).
[28] Proposed 42 C.F.R. § 447.206(d)

6. 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.[29] 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, NAPH urges CMS to reconsider the scope of the exception to the direct payment provision. NAPH 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.

Recommendation: CMS should amend 42 C.F.R. § 438.6(c)(5)(v) and § 438.60 to allow direct payments to governmental providers for unreimbursed costs of Medicaid managed care patients.

B. Defining a Unit of Government (§ 433.50)

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:

1. 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***."[30] A provider 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***

[29] 42 C.F.R. §438.60.
[30] Proposed 42 C.F.R. § 433.50(a)(1)(i).

authority."[31] 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 Part II of these comments, states and 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 indicia of public status to determine whether an entity is governmental.[32] 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. NAPH 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.

2. *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."[33] A Medicaid managed care organization that is a "public entity" is exempt from certain otherwise applicable solvency standards.[34] "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.[35] 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

[31] Proposed 42 C.F.R. §433.50(a)(1)(ii).
[32] *See e.g.,* Colorado Associate of Public Employees v. Board of Regents, 804 P. 2d 138 (1990) (the court based its determination that the hospital was a public entity on the State's role in establishing the hospital and its continued involvement in the control of the hospital's internal operations). Woodward v. Porter Hospital, Inc. 217 A.2d 37, 39 (1966)("a public hospital is an instrumentality of the state, founded and owned in the public interest, supported by public funds, and governed by those deriving their authority from the state.").
[33] 42 U.S.C. § 1396b(a)(2)(A).
[34] 42 U.S.C. §1396b(m)(1)(C)(ii)(II).
[35] 42 U.S.C. §1396b(i)(3).

"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.

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

1. 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. Because the payment is limited to $90, however, only $90 of the certification would be eligible for federal match. When payment is not based on a cost methodology, CMS should allow providers to certify costs associated with care to Medicaid patients not to exceed the amount of payments provided under the state plan methodology.

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

2. *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.

D. Retention of Payments

NAPH supports CMS' attempts to ensure that health care providers retain the full amount of federal payments for Medicaid services. We do not believe, however, that the requirement in the Proposed Rule that providers receive and retain all Medicaid payments to them is enforceable. Nor do we believe that this provision will have a major impact on the funding of safety net providers. Although CMS asserts that governmental providers will benefit from the Proposed Rule in part because of the retention provision, this new requirement does not come close to undoing the significant damage caused by the cuts to payments and changes in financing required by other provisions of the Proposed Rule.

1. *CMS should clarify whether states will be required to pay all federal funding associated with provider-generated CPEs to the provider.*

The retention provision requires providers to "receive and retain the full amount of the total computable payment provided to them."[36] It is unclear whether this requirement applies to *all* payments, whether financed through IGTs, CPEs, general state revenues or otherwise. Currently, some states claim certified public expenditures based on costs incurred by public providers, but do not pass the federal matching payments to the provider. Would this practice be prohibited under the retention provision and would states be required to pay any match received on public provider CPEs to the provider?

Recommendation: CMS should clarify whether the retention provision applies to payments financed by CPEs.

[36] Proposed 42 C.F.R. § 447.207(a).

2. CMS' does not have the authority to review "associated transactions" in connection with the retention provision.

The retention provision is drafted broadly, requiring, without qualification, providers to "retain" all payments to them, and providing CMS with authority to "examine any associated transactions" to ensure compliance. Taken to extremes, the requirement to retain payments would prohibit providers from making expenditures with Medicaid reimbursement funds. Certainly, any routine payments from providers to state or local governmental entities for items or services unrelated to Medicaid payments would come under suspicion. NAPH members typically have a wide array of financial arrangements with state and local governments, with money flowing in both directions for a variety of reasons. We are concerned that CMS' new authority to examine "associated transactions" will jeopardize these arrangements, and that CMS may use its disallowance authority to pressure public providers to dismantle such arrangements.

CMS' review and audit authority is limited to payments made under the Medicaid program. It does not have authority over providers' use of Medicaid payments received.[37]

Recommendation: CMS should delete the authority claimed by CMS to review "associated transactions."

E. 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.

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[37] *See Englund v. Los Angeles County*, 2006 U.S. Dist. LEXIS 82034, at *26 (E.D. Cal. 2006). When analyzing supplemental Medicaid funding paid to Los Angeles County, the Court noted that "once the County received the [Medicaid] payment it was not limited to how it used the money" (*citing* testimony of Bruce Vladeck, Administrator of Health Care Financing Administration, 1993-1997). The Court also cited Mr. Vladeck's statement that, "money is fungible. Once it was paid to the hospitals, if it was paid for services that were actually being provided, at that point our [HCFA's] sort of formal jurisdiction over it and interest of what became of the funds ended." *Id.* at 27.

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.

F. UPL Transition

The Proposed Rule preamble states that "transitional UPL payments ... are unchanged under this policy."[38] However, the Proposed Rule does implement changes to the UPL endpoint -- reducing it for governmental hospitals from the aggregate estimate of what would be paid under Medicare payment principles to the individual provider's cost of providing Medicaid services to eligible Medicaid recipients. Therefore, transition period payments would appear to be significantly impacted, since the transitional UPLs are largely based on the UPL endpoint. If CMS truly intends that transition period UPL payments be unchanged, CMS must revise the regulatory language to make that clear.

Recommendation: CMS should revise the regulatory language to ensure no diminution of transitional UPL payments.

G. Provider Donations

If the Proposed Rule is finalized in its current form, a number of providers that were previously considered public and that provided IGTs or CPEs to help finance the non-

[38] 72 Fed. Reg. at 2245.

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. We are particularly concerned in this respect about a passage in the preamble stating that "[h]ealth care providers that forego generally applicable tax revenue that has been contractually obligated for the provision of health care services to the indigent ... are making provider-related donations."[39] A local government must have full authority to redirect taxpayer dollars to the state Medicaid agency for use as the non-federal share.

For example, a county which provides $20 million to support the provision of indigent care at a hospital deemed to be private under the Proposed Rule should be permitted instead to transfer that funding to the State Medicaid agency for use as the non-federal share of a $40 million DSH payment to the hospital. The preamble language appears to indicate that CMS could view such a transfer as a provider donation even though it is transferred from an entity that is clearly governmental and even though the funds transferred are derived from tax revenues. When taxpayer funding is transferred by a unit of government to the Medicaid agency for use as the non-federal share, CMS should provide federal financial participation without question.

Recommendation: CMS should clarify that it will not view the transfer of taxpayer funding as an indirect provider donation.

H. Effective Date

1. The September 1, 2007 effective date is not achievable.

The stated effective date of the new cost limit is September 1, 2007.[40] An effective date for other portions of the regulation is not provided. Given that many states will need to overhaul their provider payment systems and plug large budgetary gaps resulting from the required changes in non-federal share financing, the proposed effective date is not feasible. State plans 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 2009 budgets). For many states, funding levels have already been set. Many state legislatures are in session for a limited period of time, and some meet every other year. Elimination of federal funding of the magnitude proposed in this regulation cannot possibly be incorporated and absorbed at this late date. Moreover, to

[39] *Id.*
[40] Proposed 42 C.F.R. § 447.206(g); § 447.272(d)(1); § 447.321(d).

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 states 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 at least ten years.

Recommendation: CMS should revise the effective date of the Proposed Rule and establish a ten-year transition period so that states, health care providers, and other affected entities are provided adequate time to come into compliance.

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

NAPH 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.[41] 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

[41] 5 U.S.C. § 553.

> funds as a source of State share of financial participation under title XIX of the Social Security Act.[42]

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.

I. Consultation with Governors

Section 5(c) of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991[43] requires the Secretary to "consult with the States before issuing any regulations under this Act." The preamble of the Proposed Rule does not mention any such consultation with states. Did the agency comply with this statutory mandate, and if so, how and when? Given that the National Governors Association sent a letter on February 23, 2007 to Congressional leadership strongly opposing the Proposed Rule, we also request information on whether the states' concerns have been taken into consideration at all in the formulation of this policy.

Recommendation: CMS should immediately consult with states on the Proposed Rule and modify or withdraw it based on state concerns.

IV. CMS' REGULATORY IMPACT ANALYSIS IS DEEPLY FLAWED

1. 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 proposed by CMS, including the reporting requirements, will place

[42] Pub. L. No. 102-234, §5(b), 105 Stat. 1793, 1804.
[43] Pub. L. No. 102-234.

substantial additional costs on states and providers. These costs have not been incorporated into CMS' impact analysis; NAPH 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 with existing cost reporting systems for hospital providers that do not comply with the Proposed Rule's requirements will be required either to modify their current Medicaid cost report system or to create new ones 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"[44] is required explicitly, but it is unclear the extent to which CMS expects states to audit and review all cost report submissions.

[44] Proposed 42 C.F.R. § 433.52(b)(4).

Reviewing these cost reports would require additional staffing by state Medicaid agencies and additional expenditures by providers in order to complete the required submissions.

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.

2. *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.[45] As noted above, NAPH members have estimated state-level impacts that anticipate cuts of tens and hundreds of millions of dollars annually per state. With this 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.

3. *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

[45] 72 Fed. Reg. at 2245.

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.

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 Part II of these comments.

Submitter : Mr. h ray gibbons **Date:** 03/08/2007

Organization : teton medical center

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-68-Attach-1.DOC

#68

Teton Medical Center

915 4th St. N.W.
Choteau, Montana 59422
(406) 466-5763
www.tetonmedicalcenter.net

March 6, 2007

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

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

Dear Ms. Norwalk:

Teton Medical Center is a frontier combined facility that includes the following primary entities:

- 12 bed Critical Access Hospital (i.e. CAH)
- 34 bed Skilled Nursing / Nursing Facility (i.e. SNF/NF)

The population in our primary service area is approximately 3000 and the nearest PPS tertiary facility has a population of approximately 90,000 65 miles to the southeast. Teton County is federally designated as a frontier county within which the governmental hospital district only includes a portion of the county. Teton Medical Center receives 6 mills of tax support which equates to approximately $65,000 annually. This rule impacts the SNF/NF operation therefore I will limit my comments to only this operation. The annual revenue for the SNF/NF is approximately $ 1.5 million which includes the Montana IGT program approved by CMS as recently as 2006 and the Teton County mill levy support. The annual expense is approximately $ 1.5 million.

I oppose this rule and strongly encourage CMS to permanently withdraw the rule. The rule would likely eliminate the Montana IGT program which would place the burden of approximately $ 50,000 - $ 70,000 either on the local property owners or the tax payers of Montana. The reality that this rule would impose is the frontier communities would bear the brunt of cost reductions when the choice may be closure because there is a limit to what property owners can endure. This rule that "singles out" only the governmental SNF/NF operations for a significant change in payment rules makes no sense to this frontier operator.

The specific potential impacts of this rule on TMC SNF/NF per my understanding of the rule would be as follows:

- **Limiting payments to governmental providers:**
  - When TMC is efficient and can bring the cost of operations for the SNF/NF to just below break even to be limited to the cost of operations as defined by Medicare reasonable cost definitions makes no sense.
  - To create a new payment system only for governmental SNF/NF through the rule making process instead of legislative does not allow for provider or public assistance. The ability to only provide comment on the rule by its nature sets up antagonistic positions instead of collaborative and creative programs.
- **New definition of "Unit of Government":**
  - 2001 Montana statutes eliminated the ability of hospital districts to levy taxes and consolidated this ability with the county commissioners.
  - Hospital districts by definition are defined in Montana statutes as related to school districts.
  - The rule in this area is unclear to me but it does seem to indicate that TMC would not qualify as a "unit of government". This may mean loss of our tax mill levy support by this definition which would create a discussion on creating another type of entity.
- **Restrictions on Intergovernmental Transfers (IGTs) and Certified Public Expenditures (CPE's)**
  - Limiting payments to governmental providers and the new definition for a unit of government would likely reduce the number of Montana SNF/NF entities that could qualify to participate in the Montana IGT program.
  - Reduction in the number of participating entities would likely make the program collapse totally.
  - This is clearly in my mind an elimination of a program implemented as intended in Montana without the due diligence of the legislative process.

In summary as a frontier SNF/NF governmental operator I find it difficult to accept a significant reduction in Medicaid payments by CMS just because CMS can make rule changes on governmental units. **We take care of residents who were the "back bone" of this community during their working years. To make a rule that could displace them away from family, friends and where they lived is just wrong. Please do the "right thing" and permanently withdraw this rule.**

Thank you for this opportunity to provide my comments.

Sincerely;

H. Ray Gibbons, FACHE
Administrator/CEO

Submitter : **Date: 03/09/2007**

Organization :

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-69-Attach-1.DOC

#69

To: **Centers for Medicaid and Medicare Services**
Department of Health and Human Services

From: **NH School Administrators Association**
Dr. Mark Joyce, Executive Director
mark@nhsaa.org

NH Association of Special Education Administrators
Dr. P. Alan Pardy, Director
alan@nhasea.org

Date: **3/20/2007**

Re: **Public Comment File Code CMS-2258-P**

Please accept these comments to the proposed regulations at 72 Federal Register 2236, published on January 18, 2007. It is our position that these proposed regulations would be unduly burdensome in New Hampshire, because of the unique funding formula of education by local property taxes in our state. Since Medicaid reimbursement in NH is based upon actual expenditures on a per-unit, per-Medicaid eligible child basis, the cost reports proposed in these regulations are unnecessary to demonstrate the requisite "public expenditures." School districts in New Hampshire pay, "up front," 100% of the costs of delivering covered health related services via local property taxes, (not including monies available under the IDEA) and then seek Medicaid reimbursement via Federal Financial Participation. If requested in an audit, NH school districts could produce auditable financial statements demonstrating the cost to provide the services without having to justify the expenditure of local seed via the completion of proposed cost reports. The "one-size-fits-all" approach of these proposed regulations requiring cost report completion would unnecessarily burden school districts with reporting data that is already easily accessible and verifiable. Requiring the execution of the cost reports on a yearly basis would only add administrative burden to already overworked district staff with the revelation of no real new data. NH possesses a high level of justification of Medicaid Federal Financial Participation relative to the expenditure of local funds because of a direct and verifiable correlation between local expenditures and Medicaid reimbursement of those expenditures on a per unit, per Medicaid eligible child basis.

In addition, these proposed regulations would appear to negate some of the benefits that would be gained through the passage of the recently proposed bipartisan bill (SB 578) protecting the Medicaid to Schools Program. (Primary sponsor Senator Kennedy).

Our approach here will be to reproduce certain sections of the preamble and proposed regulations, and provide editorial comments in red font, where we attempt to raise questions that cause concern in our mind.

> "... the rule proposes to modify § 433.51(b) to require that a CPE must be supported by auditable documentation in a form approved by the Secretary that will minimally: (1) Identify the relevant category of expenditure under the State plan; (2) explain whether the contributing unit of

> government is within the scope of the exception to the statutory limitations on provider-related taxes and donations; (3) demonstrate the actual expenditures incurred by the contributing unit of government in providing services to Medicaid recipients or in administration of the State plan; and (4) be subject to periodic State audit and review.
> To implement this rule, the Secretary would issue a form (or forms) that would be required for governments using a CPE for certain types of Medicaid services where we have found improper claims (for example, schoolbased services). These forms will be published in the **Federal Register** using procedures consistent with the Paperwork Reduction Act requirements. In preparing the way for these forms, this rule would serve to enhance fiscal integrity and improve accountability with respect to CPE practices in the Medicaid program.
> Costs that are certified by units of government for purposes of CPE cannot include the costs of providing services to the non-Medicaid population or costs of services that are not covered by Medicaid...." [1]

We agree with the overall Certified Public Expenditure (CPE) requirement, although we think the requirement of a CPE in the school setting is unnecessary. School districts pay for 100% of total costs of providing health related services to children with IEPs "up front". While it is true that some of those costs are offset by Federal IDEA funds, the majority of the expenditures are out of the pocket of the local taxpayer in the first instance, with Medicaid claiming operating only to offset some of the costs through reimbursement at the FFP. In our state, the Medicaid reimbursement is driven exactly by the outlay to provide for the service on a per Medicaid child basis. School districts are not making money on Medicaid reimbursement relative to outlay of actual costs.

> *"Tool To Evaluate the Governmental Status of Providers*
> With the issuance of this proposed rule, we recognize the need to evaluate individual health care providers to determine whether or not they are units of government as prescribed by the rule. States will need to identify each health care provider purportedly operated by a unit of government to CMS and provide information needed for CMS to make a determination as to whether or not the provider is a unit of government. We have developed a form questionnaire to collect information necessary to make that determination. The questionnaire will be published in connection with this proposed rule. For new State plan amendments that will reimburse governmentally operated providers or rely on the participation of health care providers for the financing of the non-Federal share, States will be required to complete this questionnaire regarding

[1] 72 Fed. Reg. 2241 (2007) (to be codified at 42 C.F.R. §433.51) (proposed January 18, 2007)

> each provider that is said to be governmentally operated. For any existing arrangement that involves payment to governmentally operated providers or relies on the participation of health care providers for the non-Federal share, States will be required to provide the information requested on this form questionnaire relative to each applicable provider within three (3) months of the effective date of the final rule following this proposed rule."[2]

Our concern in relation to the "Tool to Evaluate the Governmental Status of Providers" is in the administration of "the questionnaire." It appears that all existing school districts that are enrolled as providers will need to execute this cumbersome four-page questionnaire within three months of the effective date of the final rule. It does not appear that the State Medicaid Agency will have the authority to review the questionnaire and deem the submitted school district qualified to execute a CPE. It appears rather, that only CMS will have the authority to review the questionnaire and determine whether or not a school is a "unit of government," qualified to execute a CPE. What is not clear is how long the review process by CMS will take and whether or not Medicaid reimbursements will be interrupted in any way during this period of review. Additionally, the execution of the questionnaire will create an unnecessary administrative burden on the school districts by requiring the districts to take the time to answer all of the questions. We think it obvious that a school meets the definition indicated in the regulations of a "unit of government," and should not have to be subject to this administrative burden and potential interruption of Medicaid reimbursement while CMS reviews the information submitted on the questionnaire. It would seem to us that CMS will have hundreds if not thousands of these documents to review nationwide, and without increased federal resources, these applications will not be processed in a timely manner. We find it interesting that CMS offers no comment on the time impact that the requirement of the filling out of the questionnaire will have on "units of government" under the analysis required under the "Paperwork Reduction Act of 1995," and we suspect it will involve increased time.

> *"Cost Limit for Providers Operated by Units of Government (§ 447.206)*
> Section 447.206(e) states that each provider must submit annually a cost report to the Medicaid agency which reflects the individual providers cost of serving Medicaid recipients during the year. The Medicaid Agency must review the cost report to determine that costs on the report were properly allocated to Medicaid and verify that Medicaid payments to the provider during the year did not exceed the providers cost. The burden associated with this requirement is the time and effort for the provider to report the cost information annually to the Medicaid Agency and the time and effort involved in the review and verification of the report by the Medicaid Agency. We estimate that it will take a provider 10 to 60 hours to prepare and submit the report annually to the Medicaid Agency. We estimate it will take the Medicaid Agency 1 to 10 hours to review and verify the information provided. We are unable to identify the total number of

[2] 72 Fed. Reg. 2242 (2007) (to be codified at 42 C.F.R. §433.50) (proposed January 18, 2007)

> providers affected or the estimated total aggregate hours of paperwork burden for all providers, as such figures will be a direct result of the number of providers that are determined to be governmentally operated."[3]

The excerpts listed above are the sections of the proposed rules that cause us the greatest concern. We believe the submission of a cost report by each school district on an annual basis to support a CPE is unduly burdensome and unnecessary. We think that the CMS estimate of time required to complete the cost reports is too optimistic as the amount of time to do cost reports on an annual basis will be substantial. School districts do not have the resources available to execute a cost report necessary to execute a CPE. The point is that they are spending 100% of the cost up front. In New Hampshire, the schools must calculate based on each individual practitioner, and major resources have to be committed to that task on an annual basis.

> "For purposes of Executive Order 13132, we also find that this rule will have a substantial effect on State or local governments."[4]

Ultimately, schools would need to hire highly qualified financial specialists, such as Certified Public Accountants, just to execute the cost reports each year and the State Medicaid Agencies would also have to employ such financial specialists to review all of the submitted cost reports to see if recoupments would be necessary because of a lack of balance between what was reimbursed and what was reflected on the cost report.

In summary, we appreciate very much your taking the time to review our thoughts and suggestions. We certainly believe that these proposed rules are going to have a substantial impact on schools nationwide relative to the administrative burden it will place on them as they move forward with executing their CPEs on an annual basis, especially when one considers the amount of reimbursement actually received from Medicaid is fractional when compared with the actual cost of delivering health related services to Medicaid eligible children with IEPs.

Respectfully submitted,

Dr. Mark V. Joyce
Executive Director
NH School Administrators Association

Dr. P. Alan Pardy
Director
NH Association of Special Education Administrators

Cc: Senator Edward M. Kennedy
Senator Olympia Snowe
Senator John E. Sununu
Senator Judd Gregg
Representative Carol Shea-Porter
Representative Paul Hodes
Lyonel B. Tracy, Commissioner, Department of Education
John A. Stephen, Commissioner, Department of Health and Human Services

[3] 72 Fed. Reg. 2243 (2007) (to be codified at 42 C.F.R. §§433.51, 447.206) (proposed January 18, 2007)
[4] 72 Fed. Reg. 2244 (2007) (to be codified at 42 C.F.R. §§433.51, 447.206) (proposed January 18, 2007)

National Educational Agencies

Submitter : Mr. Arthur Johnson **Date:** 03/09/2007

Organization : Broome County Mental Health Department

Category : Local Government

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

On behalf of Broome County's Department of Mental Health, I am commenting on the proposed rule published in the Federal Register of January 18,, 2007 on pages 2236-2248
My Department, County Administration, and the consumers and
providers of my Department s Community Services Board are
concerned that the proposed rule would seriously undermine mental hygiene services in my county in two primary ways

a: new limitations proposed in the regulatory definition of allowable costs for providers which are units of government would be particular harmful to the continuing viability of the range of services available to seriously mentally ill adults and children living in my community

b: new limitations on allowable services under the rehabilitation option would be particular harmful to mentally retarded and developmentally disabled persons in my community, including children currently receiving health-related specialty services which allow them to participate meaningfully and in a more mainstreamed manner in the public educational system

Submitter : Mrs. Bernadette Spong **Date:** 03/09/2007

Organization : Rex Healthcare

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

 #71

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. Kelly Williams **Date:** 03/09/2007

Organization : Montana Dept of Public Health & Human Services

Category : State Government

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

Source: Proposed rule, 72 FR 2236, Jan. 18, 2007.

GENERAL

GENERAL

See Attachment

CMS-2258-P-72-Attach-1.PDF

#72

Subject: MONTANA COMMENT - CMS-2258-P

MONTANA COMMENT - CMS-2258-P Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership

Source: Proposed rule, 72 FR 2236, Jan. 18, 2007.

42-CFR Parts 433, 447, and 457

Under this NPRM, a cost-based UPL test is applied on an individual facility basis for each facility in the "unit of government" category that requires that it not be paid more than cost. The NPRM language on page 2241(42-CFR Part 447.206) of the proposed rule states "consequently, this rule proposes to limit reimbursement for governmentally operated providers to amounts consistent with economy and efficiency by establishing a limit of reimbursement not to exceed cost." The NPRM language on page 2242 (42-CFR Part 447.206) of the proposed rule reads "when states do not use CPE's 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 cost."

These "Unit of Government" providers must submit cost reports to the state Medicaid agency, which must review them to determine that all costs are properly attributed to Medicaid. All interim payments must be reconciled with the cost reports, which must be used to determine future interim payment rates. Payments to "Unit of government" providers for Medicaid activity would not be allowed to exceed the documented costs. The rule would apply to services rendered on or after September 1, 2007.

The new facility specific cost limit establishes a cost based UPL for "unit of government" facilities that not only limits IGT payments, but also limits Medicaid prospective reimbursement payments to those facilities at levels not to exceed cost and would be applied to any other type of add-on reimbursement that would be available to all Medicaid participating providers irrespective of IGT payment programs. Is it CMS's intent to limit Medicaid prospective reimbursement rates for all facilities that meet the "units of government" definition to cost?

The IGT program in Montana was approved to generate additional financial support to maintain access to "at risk" county affiliated nursing facilities who are predominantly rural and are the only nursing facility in their community or county or who provide a significant share of nursing facility services in their county. Decreasing or capping reimbursement to county-owned facilities and to any facilities that provide care to a disproportionate share of individual with higher acuity and complex health issues will have an adverse impact in rural Montana.

Considering that CMS recognizes the value of maintaining access to small rural health care providers through methodologies that recognize reimbursement in excess of cost, such as critical access hospitals, does this rule create a disadvantage to small, rural, governmental nursing facilities by imposing such a cost limitation?

Submitter : **Mr. James Russell** **Date: 03/09/2007**

Organization : **Mid-Valley Behavioral Care Network**

Category : **Other Health Care Provider**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

see attached

GENERAL

GENERAL

see attached

Regulatory Impact Analysis

Regulatory Impact Analysis

see attached

CMS-2258-P-73-Attach-1.DOC

#73

behavioral care network

Mid-Valley Behavioral Care Network

1660 Oak Street SE, Suite 230 ▪ Salem, Oregon ▪ 97301
PHONE: (503) 361-2647 ▪ FAX: (503) 585-4989 ▪ www.mvbcn.org

Memorandum

To: Centers for Medicare and Medicaid Services
From: James D. Russell, Executive Manager, MVBCN
Date: March 9, 2007
Subject: Proposed regulation CMS 2258-P

I am the head of an intergovernmental organization of five counties in western Oregon. I am writing to comment on the impact that proposed regulation CMS 2258-P will have on our ability to provide Medicaid mental health services in our region.

Since 1997 the MVBCN has had a capitated contract with Oregon to provide services for Oregon Health Plan members in our region. Currently we have approximately 62,000 Oregonians enrolled with us as their provider of any necessary mental health services. For these past ten years MVBCN has contracted responsibility for the outpatient services to each of our counties on a risk-basis, a per member per month payment for the Oregon Health Plan members in that county. Under these financial arrangements the counties are responsible for meeting the outpatient mental health needs of enrollees regardless of whether sufficient sub-capitation revenue is available in a given year. The great majority of these services are provided by the county government's community mental health program. As with any risk-bearing arrangement for the provision of healthcare, revenues do not necessarily match costs in a given period and risk reserves are necessary to ensure financial viability, which in this case is the county community mental health program.

As currently written, it appears that the drafters of CMS 2258-P did not envision this type of payment arrangement between an MCO and a governmental provider organization. By limiting allowable Medicaid payments to cost, and 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 for MVBCN. In fact, the Cost Limits for Units of Government provision, as currently written, would make it financially impossible to continue with subcapitation to the counties and this would substantially diminish their ability to meet the ongoing needs of their Medicaid members. The MVBCN was formed by these counties because of their commitment to serve the high-risk, most vulnerable Medicaid members in their communities. 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 request that this be corrected with a modification of the proposed regulation so that governmental entities can retain an actuarially sound risk reserve.

Thank you for addressing this matter.

Submitter : **Dr. Roderick Calkins** **Date: 03/11/2007**

Organization : **Marion County Health Department**

Category : **Other Health Care Provider**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

CMS-2258-P-74-Attach-1.DOC

#74

Re: CMS 2258-P

My name is Roderick P. Calkins, and I represent the Marion County Health Department, part of a county government in the state of Oregon. I am writing to comment on the proposed regulation CMS 2258-P. As currently written, I feel this regulation will have an unintended and negative impact on Medicaid mental health services provided by county governments in Oregon.

Oregon county governments provide a substantial amount of mental health services in our state. In general, county governments are the critical safety net provider of services for the most vulnerable of our citizens. In Oregon, some counties provide all of the Medicaid mental health services under Oregon's 1115 demonstration waiver. While Marion County provides some of these services and contracts for others, Marion County maintains the ultimate responsibility for providing Medicaid mental health services within the available resources.

In most of Oregon's 22 counties served by government providers, the Managed-Care Organizations (MCO's), or Medicaid Prepaid Inpatient Health Plans, use risk-bearing payment mechanisms where counties sub-capitated for all or a portion of services to Medicaid enrollees. Counties are responsible for meeting the mental health needs of enrollees regardless of whether sufficient sub-capitation revenue is available for any given year.

Risk-bearing payment arrangements for the provision of health care do not guarantee that revenues for any given period of time (month, quarter, year) will match the cost of services which must be provided during the time. Risk reserves are essential to ensure the financial viability of the entity bearing the financial risk -- in this case health departments of county governments.

In reading the proposed regulation CMS 2258-P, it appears that county governments will be excluded from the risk-bearing payment arrangements described above. By limiting allowable Medicaid payments to cost and using a cost reporting mechanism that does not take into account the need to maintain risk reserves, counties will be unable to enter into the types of sub-capitation payment arrangements currently used in Oregon and other states. In drafting the proposed regulation, it appears that CMS has assumed that all risk will be held by the MCO's/PIHP's, but this is not the case in Oregon and other states which have waivers for their Medicaid mental health systems.

The ability to build a risk reserve in order to manage the mismatch of revenue and cost across the school years is a core requirement for all risk bearing entities. In Oregon, many county governments such as Marion County are currently risk bearing entities in the provision of Medicaid mental health services. The Cost Limits for Units of Government provision of CMS 2258-P, as currently written, would render the current sub-capitation arrangements with counties undoable.

In essence, the proposed regulation is creating a de facto rule that provider organizations which are units of government will not be able to enter into Medicaid risk-based contracts. I am hopeful that this consequence of the proposed regulation is unintended and can be remedied through revision. I am writing to request a modification of the proposed regulation. Specifically, I request that the Cost Limits for Units of Government section of the regulation be revised to include, as allowable costs, and asked warily sound provision for risk reserves when a unit of government such as Marion County enters into a risk-based contract with an MCO or PIHP.

I appreciate your consideration of my request.

Submitter : Ms. Maggie Reilly **Date:** 03/12/2007

Organization : All Children's Hospital

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

We have many, many children in physical therpay who need CMS and Medicaid funds in order to continue to get services. Without these funds they will be lost, with no access to necessary services and equipment. Please be the voice for those who cannot speak for themselves and insure that they continue to be able to be served. Thank you.

Submitter : Mr. Michael Anaya **Date:** 03/12/2007

Organization : Colorado Plains Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-76-Attach-1.DOC

#76

Colorado Plains Medical Center

1000 Lincoln Street, Fort Morgan CO 80701

March 12, 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:

Colorado Plains Medical center appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our 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 very concerned that, in CMS' 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 no longer be reimbursed.

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

New Definition of "Unit of Government"

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

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

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

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

Insufficient Data Supporting CMS's Estimate of Spending Cuts

CMS is required to examine relevant data to support the need to change current policy. The proposed rule estimates that the policy changes will result in $3.87 billion in spending cuts over the next five years. 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 Anaya

Michael Anaya, FACHE
Chief Executive Officer
Colorado Plains Medical center

Submitter : Mr. J Michael Philips **Date:** 03/12/2007

Organization : San Juan Regional Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-77-Attach-1.DOC

#77

SAN JUAN REGIONAL MEDICAL CENTER
Together, we're building a healthy future for San Juan County.

801 West Maple Street • Farmington, NM 87401
Telephone: (505) 325-5011 • www.sanjuanregional.com

March 8, 2007

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

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

Dear Ms. Norwalk:

I am writing as the Chief Strategy Officer for San Juan Regional Medical Center, Farmington, New Mexico, a 182 staffed bed rural hospital in the four corners area of the Southwest. We are a level 3 trauma center servicing the four state area of northwest New Mexico, southwest Colorado, southeast Utah and northeast Arizona. We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospital(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 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. If this rule is implemented it will reduce reimbursements to San Juan Regional Medical Center by $8,000,000. This will obviously force San Juan Regional Medical Center to curtail and eliminate services that we have been providing to the citizens of this area.

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.

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,

/J Michael Philips/

J Michael Philips
Chief Strategy Officer

Submitter : Nancy Probst

Date: 03/12/2007

Organization : Catholic Family & Child Service

Category : Other Health Care Provider

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attached

GENERAL

GENERAL

See Attached

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attached

CMS-2258-P-78-Attach-1.DOC

#78

CATHOLIC FAMILY & CHILD SERVICE
Diocese of Yakima

March 12, 2007

My name is Nancy Probst and I represent Catholic Family & Child Service, a community mental health agency in the State of Washington. I am writing to comment on two specific ways the proposed regulation CMS 2258-P will impact the Medicaid Behavioral Health System in a number of states.

Cost Limit Provisions in States with At-Risk Provider Contracts

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

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

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

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

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

I am writing to request that this be corrected through a modification of the proposed regulation. **Specifically I am requesting the Cost Limit section of the regulation be revised to include,**

as allowable cost, an actuarially sound provision for risk reserves when a Unit of Government has entered into a risk-based contract with an MCO or PIHP.

Intergovernmental Transfers in States with Government-Organized Health Plans

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

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

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

Sincerely,

Nancy Probst, MA
Clinical Director

Submitter : Mr. Pete Acker **Date:** 03/12/2007

Organization : Carolinas Medical Center Lincoln

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2258-P-79-Attach-1.DOC

CMS-2258-P-79-Attach-2.DOC

#79

March 12, 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:

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

The 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. Carolinas Medical Center Lincoln 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.

Carolinas Medical Center Lincoln urges CMS to withdraw its proposed regulation, or in the alternative revise it substantially by among other things adopting applicable state law to define the public hospitals (or units of government). If the regulation is not withdrawn or adequately revised, Carolinas Medical Center Lincoln 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,

Pete Acker
President/Chief Executive Officer
Carolinas Medical Center Lincoln

cc: Senator Elizabeth Dole
Senator Richard Burr
Representative Patrick McHenry

Submitter : Carla Terry **Date:** 03/12/2007

Organization : Idaho Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-80-Attach-1.DOC

#80

Idaho Hospital Association
P.O. Box 1278, Boise, ID 83701

March 12, 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 Idaho Hospital Association 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 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 bypass 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 estimate that these changes could affect Idaho hospitals negatively by as much as 6 million dollars.

We urge CMS to permanently withdraw this rule, and we would like to outline our most significant concerns, which include: (1) the limitation on reimbursement of governmentally operated providers; (2) the narrowing of the definition of public hospital;

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

Limiting Payments to Government Providers

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

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. We are very concerned that, in CMS' 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 no longer be reimbursed.

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

New Definition of "Unit of Government"

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

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

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

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

Insufficient Data Supporting CMS's Estimate of Spending Cuts

CMS is required to examine relevant data to support the need to change current policy. The proposed rule estimates that the policy changes will result in $3.87 billion in spending cuts over the next five years. 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,

Carla Terry
VP Finance

Submitter : Ms. Sherri Taylor **Date:** 03/12/2007

Organization : Grant Mental Healthcare

Category : Local Government

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-81-Attach-1.DOC

CMS-2258-P-81-Attach-2.DOC

"To promote healthy communities through the provision of quality mental healthcare"

#81

Grant Mental Healthcare

March 12, 2007

RE: CMS 2258-P

My name is Sherri Taylor, and I am the Executive Director of Grant Mental Healthcare, a community mental health clinic in Washington State. I am writing to comment on a specific way the proposed regulation CMS 2258-P will affect the Medicaid Behavioral Health System in our state.

Cost Limit Provisions in States with At-Risk Provider Contracts

A large number of county governments provide substantial amounts of Medicaid Behavioral Health Services under 1915(b), 1915(c) or 1115 waivers across the country. In our case, Grant Count is the critical safety net provider, treating the most seriously disabled Medicaid enrollees in our communities. In our system, the Medicaid health plan uses risk-bearing payment mechanisms where we are sub-capitated for our Medicaid enrollees. Under this financial arrangement, our county is responsible for meeting the behavioral health needs of enrollees, regardless of whether sufficient sub-capitation revenue is available in a given year.

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

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

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

This level of federal intervention in the reimbursement and clinical designs of state and local governments appears to be unintended. Essentially, the regulation is creating a de facto rule that provider organizations that are units of government, like Grant Mental Healthcare, 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 request that 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, such as Grant County, Washington, has entered into a risk-based contract with our PIHP.**

I thank you for taking the time to read this.

Sherri M. Taylor
Executive Director

PO BOX 1057
840 E. PLUM
MOSES LAKE, WA 98837
Phn: 509-765-9239
Fax: 509-765-1582

PO BOX 25
203 CENTRAL AVE .S.
QUINCY, WA 98848
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Fax: 509-787-1031

PO BOX 565
322 FORTUYN RD.
GRAND COULEE, WA 99133
Phn: 509-633-1471
Fax: 509-633-2148

Submitter : **Ms. Ellen Kugler** **Date: 03/12/2007**

Organization : **National Association of Urban Hospitals**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-82-Attach-1.DOC

#82

March 9, 2007

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8017
Baltimore, MD 21244-8017

Subject: File Code CMS-2258-P

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to express our concern about selected aspects of the proposed regulation entitled "Medicaid Program: Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership," which was published in the *Federal Register* on January 18, 2007.

NAUH is concerned about the implications of limiting Medicaid payments to providers operated by units of government to their actual costs. Specifically, our concerns are as follows:

1. The proposed regulation would reduce the ability of states to draw down federal financial participation for their Medicaid programs, reduce states' overall Medicaid funding, and have serious implications for all providers of care to Medicaid recipients.
2. The proposed regulation would inappropriately cap federal participation in Medicaid payments to public providers at providers' costs.
3. The proposed regulation's definition of what constitutes a provider operated by a unit of government is unclear.

NAUH recognizes that to a significant degree, the proposals to which we object have been formulated by the Centers for Medicare & Medicaid Services (CMS) to prevent states from seeking federal financial participation through widely used mechanisms that are within the letter of the rules of the Medicaid program but appear, in some respects, to violate the spirit of those rules. We also realize that some states may be using these Medicaid funds for non-Medicaid purposes – and even for non-health care purposes. Instead of preventing states from drawing down additional federal funds to help pay for care for low-income residents, however, we urge CMS to develop better means of identifying inappropriate, non-health care uses of federal Medicaid funds and deal with offending states accordingly. We believe this is a situation in which the many states putting such funds to good use should not be penalized for the misdeeds of a few other states. Similarly, we do not believe individual providers should be penalized because of the actions of state governments – actions over which they have no control. This is especially a concern for NAUH because without question, the burden of this penalty would fall most heavily upon public hospitals and urban safety-net hospitals – providers that care for larger numbers of low-income patients than the typical provider and that together constitute the heart of the American health care safety net in this country today.

Keeping in mind that this is the context for the concerns we have about the proposed regulatory changes, we address each of those concerns separately below.

The Proposed Regulation Would Reduce the Ability of States to Draw Down Federal Financial Participation for Their Medicaid Programs
(Issue Identifier: Source of State Share and Documentation of Certified Public Expenditures)

The proposed regulation would reduce state Medicaid resources by preventing states from claiming federal financial participation for payments to public providers that exceed 100 percent of those providers' costs for Medicaid services. This would have the net effect of reducing the overall total of federal Medicaid funds that states receive, which in turn would affect states' ability to compensate providers adequately for the care they provide to their Medicaid patients. This comes at a time when most states' Medicaid payments to providers do not even begin to cover the actual cost of the care for which they ostensibly are paying. Because states with public hospitals will probably favor their public hospitals in the distribution of available resources, we believe that reducing the overall pool of resources available to states may end up hurting private, non-profit safety-net hospitals – hospitals that are as much a part of the health care safety net as their public counterparts. Any reduction in resources made available to private hospitals – whether such reductions take the form of lower payments, limited benefits, or reduced eligibility of Medicaid – may jeopardize the financial health of providers that care for especially large numbers of low-income (Medicaid and uninsured) patients and could, in the long run, threaten the viability of the health care safety net by starving that safety net of the resources it requires to meet the needs of those who depend on it for access to care.

The Proposed Regulation Would Inappropriately Cap Federal Participation in Medicaid Payments to Public Providers at Providers' Costs
(Issue Identifier: Cost Limit for Providers Operated by Units of Government)

Currently, Medicaid regulations permit states to pay providers, both public and private, more than their actual costs for serving their Medicaid patients. This is part of a long tradition in the program and is based on the belief that the states, because they are closer to the health care needs of their residents, are in a better position to decide how best to use their Medicaid resources than the federal government. This proposed regulation, however, effectively rejects this long-held belief and, by limiting payments to public providers to 100 percent of their costs, would increase federal control over how states spend their Medicaid funds. Similarly, among the biggest Medicaid priorities among governors in the U.S. today is their desire to have more flexibility, not less, in how they structure their Medicaid programs and expend their Medicaid resources. In general, the administration has supported this desire. This proposed regulation, however, would reduce states' flexibility, not increase it.

States traditionally pay limited numbers of providers more than their Medicaid costs because those providers are located in areas where, in addition to caring for large numbers of Medicaid patients, they also care for large numbers of uninsured patients. The cost of caring for these uninsured individuals is so great for some providers, however, that without these above-cost payments and other supplemental public funds (including but not limited to Medicaid DSH payments), the financial health of these providers would be in jeopardy – as would their continued ability to serve all of their patients: not just their Medicaid patients, but also their Medicare and privately insured patients. NAUH believes it is entirely appropriate for state Medicaid programs to pay some providers more than their costs and asks CMS to reconsider this aspect of the proposed regulation.

NAUH is concerned that if states cannot pay public hospitals more than their costs for treating Medicaid patients, those public hospitals will have a drastically reduced financial capacity to treat uninsured patients and be forced to turn away some or even many non-emergency, uninsured patients. If those patients turn to private safety-net hospitals, the financial burden of treating them could threaten the financial viability of private safety-net hospitals as well. NAUH believes it is entirely appropriate for state Medicaid programs to pay some providers more than their costs and asks CMS to reconsider this aspect of the proposed regulation.

NAUH opposes, in principle, limiting Medicaid payments to any hospitals to cost. Hospitals that care for large numbers of Medicaid recipients inevitably care for larger numbers of uninsured patients as well; this is certainly the case for public hospitals, as it is for private, non-profit urban safety-net hospitals. Like their public counterparts, private hospitals like these need supplemental funds if the cost of caring for so many uninsured patients is not to overwhelm them and jeopardize their future ability to serve all of their patients – not just their Medicaid and uninsured patients, but their Medicare and privately insured patients as well.

The Proposed Regulation's Definition of What Constitutes a Provider Operated by a Unit of Government is Unclear
(Issue Identifier: Defining a Unit of Government)

NAUH has attempted to apply the proposed regulation's definition of what constitutes a provider operated by a unit government to a number of different hospitals and types of hospitals and has found that the proposed guidelines do not always enable us to reach a definitive conclusion on some providers' status. We respectfully request that the Centers for Medicare & Medicaid Services look into this question and consider revisions that may clarify these guidelines.

About the National Association of Urban Hospitals

The National Association of Urban Hospitals (NAUH) advocates for adequate recognition and financing of private, non-profit, urban safety-net hospitals that serve America's needy urban communities. These private, urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private, urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

* * *

We appreciate your attention to NAUH's suggestions and concerns and welcome any questions you may have about them.

Sincerely,

Ellen J. Kugler, Esq.
Executive Director

Submitter : Melissa Herzberg **Date:** 03/12/2007

Organization : Melissa Herzberg

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I have an ill child. I can't imagine the impact that this will have on others will ill children. We are forgetting that our children are our future. Any cut to medical has the potential of hurting many children. PLEASE think about this before voting for the cut.

Submitter : Ms. **Date:** 03/12/2007

Organization : Ms.

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

The changes proposed in this regulation would have a negative impact on hospitals and the children they serve. 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, my state, Michigan could face a significant Medicaid funding shortfall that could result in cuts to the program. 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. 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. Please keep in mind the impact that these programs have on children and families across our nation as you make these vital decisions. This proposal also seems to be targeting those individuals that may already have obstacles with access to affordable and quality health care such as minorities. In addition, currently many providers do not like participating in the Medicaid program making it difficult to find good providers. I anticipate that decreases in state Medicaid funding may further create a negative impact on having access to good providers.

Submitter : Mrs. Mary Heffelfinger **Date:** 03/13/2007

Organization : Mrs. Mary Heffelfinger

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

My husband and I are strongly opposed to the changes proposed in this regulation. If put into effect, my state, Michigan would face significant Medicaid funding shortfalls. This would result in program cuts that affect the most vulnerable people in our population, children and those living in poverty. Please keep in mind the impact that Medicaid has on children and families and consider other alternatives. Our future, our children, is in your hands.

Submitter : Dr. Floyd Smith **Date:** 03/13/2007

Organization : AuSable Valley CMH

Category : Other Health Care Provider

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-86-Attach-1.DOC

American College of
Emergency Physicians
ADVANCING EMERGENCY CARE

#86

March 20, 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 American College of Emergency Physicians' (ACEP) 25,000 members, I 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.

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. ACEP 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.

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. Further, there seems to have been little or no consultation with affected parties and the proposed implementation date is only six months away (September 1, 2007). 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

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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.

ACEP 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 Barbara Marone, ACEP's Federal Affairs Director at (202) 728-0610 ext. 3017 if you have any questions about our comments and recommendations.

Best wishes,

Brian F. Keaton, MD, FACEP
President

Submitter : Mr. Patrick Tate **Date:** 03/13/2007

Organization : Iowa Association of Community Providers

Category : Other Association

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

I am writing to comment on two specfic ways the proposed regulation CMS 2258-P will impact the Medicaid Behavioral Health System in a number of states. In many cases the counties are the critical safety net provider, treating the most seriously disabled Medicaid enrollees in their communities. Under these financial arrangements the counties are responsible for meeting the behavioral health needs of enrollees regardless of whether sufficient sub-capition revenue is availble in a given year.

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

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

A second issue concerns a number of states where Medicaid Behavioral Health Plans have been set up as government entities by one county or a group of counties to manage the risk-based contract.

Specifically I am requesting the regulation explicity state that local dollars will be considered valid Intergovernmental Transfers IF THEY ORIGINATED AT A UNIT OF GOVERNMENT REGARDLESS OF THE ENTITY THAT SUBMITS THE PAYMENT TO THE STATE>

Submitter : **Date: 03/13/2007**

Organization : **American College of Emergency Physicians**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-88-Attach-1.DOC

#88

American College of
Emergency Physicians
ADVANCING EMERGENCY CARE

March 20, 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 American College of Emergency Physicians' (ACEP) 25,000 members, I 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.

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. ACEP 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.

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. Further, there seems to have been little or no consultation with affected parties and the proposed implementation date is only six months away (September 1, 2007). 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

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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.

ACEP 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 Barbara Marone, ACEP's Federal Affairs Director at (202) 728-0610 ext. 3017 if you have any questions about our comments and recommendations.

Best wishes,

Brian F. Keaton, MD

Brian F. Keaton, MD, FACEP
President

Submitter : **ajkdflll jjlj;** **Date: 03/13/2007**

Organization : **ajkdflll jjlj;**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachmen

 #89

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. Alan Goldbloom **Date:** 03/13/2007

Organization : Children's Hospitals and Clinics of Minnesota

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment."

CMS-2258-P-90-Attach-1.DOC

Children's
HOSPITALS AND CLINICS
of Minnesota

#90

Alan L. Goldbloom, MD
President and Chief Executive Officer
2525 Chicago Avenue South
Minneapolis, Minnesota 55404

(612) 813-6112
fax (612) 813-6807
www.childrensmn.org

March 13, 2007

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

Re: (CMS-2258-P) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (Vo. 72, N0. 11), January 18, 2007

Dear Ms. Norwalk:

On behalf of the children in our community served by Medicaid, Children's Hospitals and Clinics of Minnesota (Children's) 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 Children's and on 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 $3.9 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, Minnesota could face a significant Medicaid funding shortfall that could result in cuts to this vital program. The Minnesota Hospital Association has estimated the potential impact to Minnesota hospitals could be well over $100 million dollars.

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, including Children's Hospitals and Clinics of Minnesota.

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.

Negative 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. In Minnesota, 363,000 children have Medicaid coverage, representing 28% of the state's children. Because children are the majority of Medicaid enrollees any changes made to the financing of the program, such as those in the proposed rule, would have a disproportionate impact on them.

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.

CMS estimates that the rule will cut $3.9 billion in federal spending over five years. This amounts to a budget cut for state Medicaid programs that bypasses the congressional approval process and comes on the heels of vocal congressional opposition to the Administration's plans for regulation 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.

Threatens the Viability of Children's Hospitals – the Safety Net for All Children

The proposed rule not only threatens the financial viability of public safety net providers, it also threatens reimbursement for the nation's children's hospitals, which, on average, devote more than 50 percent of their care to children on Medicaid and provide virtually all the care for children with complex health conditions.

At Children's Hospitals and Clinics of Minnesota, 36.7% of our revenue comes from Medicaid (over 41,000 visits), making Medicaid our single largest source of revenue. Over the past six years, the proportion of our revenue derived from Medicaid has increased by 42%. Further, the cost of providing care to sick children covered by Medicaid now exceeds reimbursement for these services by more than $17 million. Because Medicaid represents such a large portion of our total revenue, this gap between cost and reimbursement undermines our ability to care for all children—not just those insured by Medicaid.

The children we treat rely on Medicaid and the coverage it provides for all medically necessary care. With insufficient federal financing of Medicaid, states would be forced to find new funding sources or to make cuts to the program, which could directly affect

children's eligibility, benefits and services provided, and hospital reimbursement. In the last five years, Minnesota has, in fact, reduced Medicaid eligibility to children and cut reimbursement to hospitals. More Medicaid cuts would have a significant impact on Children's patients and would threaten our ability to provide quality health care to all children. Any efforts to address Medicaid financing mechanisms should consider the significant impact changes would have on children's hospitals' ability to receive adequate reimbursement and continue to provide health care services to all children.

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 Medicaid Upper Payment Limits are still being implemented. 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, they are also 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 nation's health care safety net.

Conclusion

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 children will be jeopardized. We encourage CMS to delay the implementation of the rule 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 Dr. Mary Braddock, Director of Child Health Policy (612-813-6027 or mary.braddock@childrensmn.org.). Thank you for your consideration.

Sincerely,

Alan L. Goldbloom, MD
President and Chief Executive Officer

ALG:rs

cc: Mary Braddock, MD

Submitter : **Date: 03/13/2007**

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#91

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 : Gene Wright **Date:** 03/13/2007

Organization : Upson Regional Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-92-Attach-1.DOC

#92

UPSON REGIONAL MEDICAL CENTER

801 West Gordon Street • P.O. Box 1059

Thomaston, Georgia 30286 • 706-647-8111

March 8, 2007

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

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

Dear Ms. Norwalk:

Upson Regional Medical Center is located in Thomaston, Georgia. Our county has lost almost 9,000 jobs in the last six (6) years as a result of the demise of the American Textile industry. Upson Regional employees approximately 700 people, provides almost $1,000,000 in care to our indigent population, has assumed responsibility for the counties ambulance and rescue service, and is the only emergency room within 30 miles, and then by mostly 2 lane county roads.

Upson Regional is in trouble. If CMS-2258-P is allowed to go forward and becomes policy, we will not cut back heart surgery nor need surgery - we will cut back fast track emergency services, pediatrics, and made drastic cut backs in the way we staff the ambulance service just to mention a few of the changes I would recommend to the Board as a means of keeping our hospital's call services open.

I appreciate this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rules. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospitals and the patients we serve.

The rules represent 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. An, 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 stat 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 rules, 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 the, 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 education and physician on-call services or clinic services would not be recognized and therefore would no longer be reimbursed.

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

New Definition of "Unit of Government"

The proposed rule puts forward a new and restrictive definition of "unit of government," such as 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 taxiing 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 statue that support this proposed change in definition.

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

The proposed rules impose 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 statue 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 EMS has inappropriately interpreted the federal statue.

CPE's 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. 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,

Gene B. Wright
CEO
Upson Regional Medical Center

Submitter : Ms. Lillian Shirley **Date:** 03/13/2007

Organization : Multnomah County Health Department

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

attached

#93

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. Philippe Largent **Date:** 03/13/2007

Organization : Illinois Primary Health Care Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-94-Attach-1.DOC

#94

IPHCA
Illinois Primary Health Care Association

Memo

To: Centers for Medicare and Medicaid Services (CMS)

From: Philippe J. Largent, Vice President of Governmental Affairs, IPHCA

CC: Bruce A. Johnson, President and CEO, IPHCA

Date: March 20, 2007

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

The Illinois Primary Health Care Association (IPHCA) is Illinois' sole trade association representing the network of Community/Migrant Health Centers (CHC), Federally Qualified Health Centers (FQHC) and FQHC Look-Alike providers in Illinois. In 2006, our member organizations provided care to over 990,000 patients. Nearly 50% of those patients were beneficiaries of Medicaid, the State Child Health Insurance Program (SCHIP) or Medicare programs and another 34% had no form of public or private health insurance.

The IPHCA is grateful for the opportunity to comment on above cited proposed rule. For purposes of these comments FQHCs and Community Health Center federal grantees under section 330 of the Public Health Service Act will both be referred to as "CHC". The proposed rule does not differentiate between the two and therefore our comments will not either.

Comment on Proposed Rule

Section 433.50 Defining a Unit of Government and 433.51 Funds from Units of Government as State Share of Financial Participation

Proposed definition of "Unit of Government" and proposed restrictions on the sources of Non-Federal Share funding may jeopardize current CHC/State Medicaid agency Certified Public Expenditure (CPE) arrangements.

Illinois, as well as other states, contain what are known as "Public Entity" (PE) model community health centers. These kinds of CHCs, which are specifically provided for within the Public Health Service Act, are spun off from either an entity within state government such as a public university or a county government. They must adhere to all of the prescribed program expectations and rules set forth by the Health Resources and Services Administration (HRSA) and the Bureau of Primary Health Care including the CHC governance requirements. CHC governance requirements mandate that a community health center have a Board of Directors comprised of at least 51% users of the health center. This mandate ensures community control over the health center and the resources used by the center to provide primary health care services to its patients.

Each of the PE models in our state utilizes a different governance structure. Each one is an approved variation on the CHC governance model mandated by federal law. For example, one model may use a standard governing board model where the board has the power to hire and fire senior leadership and approve operating budgets. Another model may include a governing board which works in conjunction with another entity within the county or state government to operate the CHC. None of the PE model governance structures are exactly alike.

In our State, all of our public entity health centers have contractual arrangement with the state Medicaid agency to certify expenditures above reimbursement f or purposes of securing additional f ederal match. The federal share is then given back to the provider.

None of the PE model CHC's in our state have taxing authority and so would not meet the definition of a unit of government under sec. 433.50 (ii) (A). However, 433.50 (ii) (B) seems to provide a ray of hope to these centers as along as they can demonstrate that they are an integral part of the unit of the government with taxing authority and that the unit of government is obligated to support the providers expenses, liabilities and deficits. Yet despite this language, it is uncertain whether our PE model members would meet the definition and remain eligible to certify expenditures to Sate Medicaid. These CHCs would lose hundreds of thousands of dollars in federal share resources. Those resources have been used to further the mission of the health center which is generally recognized to be squarely in the public's interest, specifically the provision of quality, affordable health care to an indigent, hard to reach population which other providers cannot or will not serve.

Finally, the proposed rule restricts the source of Non-Federal share dollars which may be used to secure federal match. Restricting these funds to those derived from tax revenue is unduly onerous. Local governments have become expert at creatively using funds from a variety of sources to pay for services to the Medicaid population. Some of those revenues are in fact

derived from taxes other may come from other sources such as grants or gifts b ut u ltimately the funds are used t o p rovide services to Medicaid beneficiaries based upon the CMS approved state plan. Restrictions like this and others proposed in this rule will impact local communities and states after the fact, i.e. after these arrangements have already been approved by CMS. The result will be a significant scaling back of services and/or limiting eligibility in order to conform to the rule.

Recommendation: IPHCA is fearful that the change in definition of what constitutes a unit of government may jeopardize previously approved CPE arrangements between Illinois Medicaid and our members and the loss of those federal matching dollars will result in the loss of capacity to treat low income/indigent populations. Additionally, IPHCA believes CMS should in encourage the use of various funding sources to pay the Non-Federal share of Medicaid financing as opposed to restricting them. The experimentation happening in the states and local communities around financing of health care to low income/uninsured and Medicaid populations is why there are not millions more people who lack access to health care. Additionally, IPHCA recommends that CMS defer the question of what is a unit of government to the states.

Section 447.206 Cost Limit for Providers Operated by units of Government

Cost limits on providers undermine important public policy goals, punishes low income, uninsured populations and reward high cost providers.

The proposed rule seeks to establish a new payment ceiling based solely upon the provider's costs instead of utilizing the Medicare payment principles which has served CMS well for years. Although CHC's are not directly impacted by the cost limit proposed in the rule, CHCs will be impacted by the loss of federal matching support to the State of Illinois which is estimated at $623 million if the rule is implemented in its current form.

The Medicare rates and the ability to calculate payments in aggregate for each category of Hospital provider are reasonable because Medicare rates are reasonable or at least are not excessive and the flexibility afforded the state under Medicare payment principles allows them to target resources to needy areas. Basing payments on a providers cost simply rewards high cost providers and/or provides an incentive to increase cost in order to take advantage of the new opportunity this ill advised rule creates.

In general, the rule seems to be a repudiation of the state's role in administering the Medicaid program. CMS proposes to strip the state's ability to define units of government; it proposes to limit the source of financing of the non-federal share of Medicaid and under this section of the proposed rule

CMS proposes to limit the states flexibility to target resources to where they are needed the most by abandoning Medicare payment principles.

The impact to the state of Illinois and specifically providers who treat both Medicaid beneficiaries as well as the uninsured will be dramatic. As sated earlier the rule will cost Illinois an estimated $623 million in federal match. That kind of loss in revenue will force Illinois to make hard choices about program eligibility, benefits, and optional services. Ironically, Illinois, in recent years, has bucked the national trend among states and has invested hundreds of millions of state dollars into expanded coverage under Medicaid as well as our state's SCHIP program, KidCare. CMS should value states like Illinois as partners instead of imposing overly restrictive rules which may force Illinois and other states to take significant steps backward relative to access to care and insurance coverage.

Recommendation: IPHCA recommends maintaining the aggregate upper payment limits based upon Medicare payment principles for all categories of providers.

Conclusion:

IPHCA notes that in the pre-amble to the rule, CMS touts its prowess in denying state plan amendments which do not conform to the intent of the Medicaid statute. Curiously we wonder if the existing method of denying plans which do not conform to the statute is working, what necessitates the proposed rule? A cynic might argue that the intent of the proposed rule is less about strengthening accountability and more about limiting federal funding liability.

IPHCA strongly supports CMS' efforts to make Medicaid more accountable and to ensure that all governments finance Medicaid in accordance with the statute. However, we find the proposed rule too proscriptive and in some instances, for example, defining a unit of government for purposes of financing the non-federal share of Medicaid, arguably outside of CMS' authority.

CMS should encourage more innovation in financing the program instead of restricting innovative approaches to state and local financing of Medicaid. CMS should, for example, make sure that funds generated through Intergovernmental Transfers and Certified Public Expenditures be used to facilitate the public interest in providing increased access to either health insurance coverage and/or health care services rather than for some other non-health care related purpose. In that way the program and its dollars can always be traced back to the original mission of providing a quality, affordable health care product to vulnerable populations.

Submitter : Mr. David Wills **Date:** 03/13/2007

Organization : Bose McKinney & Evans LLP

Category : Attorney/Law Firm

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See attached letter.

GENERAL

GENERAL

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See attached letter.

#95

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 : Mr. Jim Lewis **Date:** 03/13/2007

Organization : Rogue Valley Council of Governments

Category : Other Government

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-2258-P-96-Attach-1.RTF

#96

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
Mailstop C4-26-05
Baltimore, MD 21244-1850

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

Dear Mr. Leavitt:

This letter is in response to the above-proposed rule changes. While no responsible party would argue with the need to ensure that Medicaid match is appropriately derived and applied, the fifteen member jurisdictions of the Rogue Valley Council of Governments, representing Southern Oregon's major population center, cannot agree with the proposed strategies. The draft rule changes appear to be nothing more than a mechanism for dramatically reducing Medicaid funding for some of the most vulnerable populations in the United States, something we cannot countenance.

Although we have issues with practically every aspect of the proposed changes, there are two major pieces we wish to highlight here – the questions of what is an appropriate source of match and what is a suitable definition of a unit of government.

The first, the proposed restriction of Medicaid match to only monies directly derived from state and local tax revenue, is incomprehensible. There are a variety of clean sources of matching funds that are neither tax-based nor recycled Federal funds that should continue to be allowed as local match for Medicaid, including fees and local grants. Until now, these funds have been considered legitimate sources of match, and have been instrumental in allowing for much needed, and entirely appropriate, expansions of Medicaid services to vulnerable citizens. If accountability is the real issue behind the proposed match restrictions, we are certainly open to increased reporting requirements on the presently acceptable sources of match, as long as we can all agree on a system that does not unduly increase administrative costs.

The second major issue we have is the proposal for a severely restricted definition of a unit of government. From the wording of the rule changes, and in using the questionnaire, it is obvious that the nation's vast array of Regional Councils of Governments would not be considered governmental providers, and thus would not be eligible to provide matching funds. For almost 50 years, Councils of Governments across the nation have been partners in every major

federal program in which effective and efficient regional implementation has been a priority. Never before has there been a serious challenge to the governmental status of a Council of Governments; that such a challenge would come from an agency of the federal government, which created Councils of Governments in the first place to assist in the implementation of programs such as Medicaid, makes no sense to us. The decision of where to place the operational responsibility for the Medicaid program has always been, and should remain, the prerogative of state and local governments. These proposed rules damage that right to local decision-making by compromising the ability of Councils of Governments to function as they were originally intended.

After much local discussion and analysis, we have come to the inescapable conclusion that the proposed rules are inherently flawed, and that they would create major hardships to the economically disadvantaged and elderly in our region and across the United States. We urge you to cancel these rule changes, and instead request that you address the issue of Medicaid match by tasking your partners across the nation – entities like the Rogue Valley Council of Governments - with providing real recommendations for better control and oversight. We feel that to continue as you are suggesting would constitute nothing less than a fundamental breach of trust with the American public, and an abrogation of the Centers for Medicare and Medicaid Services' institutional mission and vision.

Sincerely,

Jim Lewis, Board Chair
Rogue Valley Council of Governments

cc: Congressman Greg Walden
2nd Congressional District
1210 Longworth House Building
Washington, DC 20515

Senator Gordon Smith
U.S. Senate
404 Russell Building
Washington, DC 20510

Senator Ron Wyden
U.S. Senate
230 Dirken Senate Office Building

Washington, DC 20510-3703

Forms Response:
Attn: Kathryn P. Astrich
Office of Information and Regulatory Affairs
Office of Management and Budget
Room 1023 New Executive Office Building
Washington, DC 20503

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

Submitter : **Date: 03/14/2007**

Organization : **Tulane University Hospital & Clinic**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Letter attached.

CMS-2258-P-97-Attach-1.DOC

Tulane
UNIVERSITY
HOSPITAL & CLINIC

#97

March 12, 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:

We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospital(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 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 House members 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. Limitation on reimbursement of governmentally operated providers;
2. Narrowing of the definition of public hospital;
3. Restrictions on intergovernmental transfers and certified public expenditures; and;
4. Absence of data or other factual support for CMS's estimate of savings.

Limiting Payments to Government Providers

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

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. We are very concerned that, in CMS' 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 no longer be reimbursed.

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

New Definition of "Unit of Government"

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

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

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

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

Insufficient Data Supporting CMS' 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,

James T. Montgomery
President and Chief Executive Officer

Submitter : Mr. Jeff Dye **Date:** 03/14/2007

Organization : New Mexico Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-98-Attach-1.PDF

#98

NMHHSA
New Mexico Hospitals & Health Systems Association

P. O. Box 92200
Albuquerque, NM 87199-2200
2121 Osuna Road NE. 87113
(505) 343-0010
Facsimile (505) 343-0012

March 14, 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 New Mexico Hospital Association represents the 41 acute, non-federal hospitals in our state. We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospitals and the patients they serve.

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

The Sole Community Provider Fund in New Mexico utilizes county-generated taxpayer revenue to fund the state share of an expanded indigent care program. The proposed rule imposes a restriction that state and local tax revenue being federally matched for health care services to the indigent would no longer be allowable. The rule would place the entire Sole Community Provider Fund in jeopardy ($159,495,624 for FY07 and estimated to grow in FY08). Such a reduction essentially represents the operating margins for all of our 28 participating hospitals. This program was established in 1993 specifically to assist with indigent care. It has been well-structured and has made appropriate use of federal funding. The elimination of this program would be especially devastating to the rural hospitals that depend on it and to the communities they serve.

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.

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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,

Jeff Dye
President and CEO

Submitter : Ms. Diane Seyl **Date:** 03/14/2007

Organization : Jefferson County Public Health

Category : Nurse

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

Please include the ability for Counties to use other non governmental funds as matching. We need funding from many sources and have multiple health challenges to deal with. Don't put a roadblock in our ability to protect the public.

GENERAL

GENERAL

See Attachment

#99

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 : **Date: 03/14/2007**

Organization : **Grant County Commissioners**

Category : **Local Government**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

#100

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

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