



N • A • C • H

March 12, 2007

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

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

Dear Centers for Medicare and Medicaid Services:

The National Association of Children's Hospitals (N.A.C.H.) 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 hospitals and the children they serve. We ask that you stop implementation of this regulation until the significant direct and indirect effects of the proposed changes can be closely examined and addressed.

The regulation as proposed would cut Medicaid funding by \$3.8 billion, which would significantly limit the funding available for state Medicaid programs. If this regulation were to go into effect as planned in September 2007, most states could face significant Medicaid funding shortfalls 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.

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

The annual growth in federal Medicaid spending has declined significantly due to both improvements in the economy and cost containment policies adopted by states in

recent years. Federal spending on Medicaid is not out of control and does not warrant changes such as those proposed, which would have a negative impact on the health care safety net.

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. Because children are the majority of Medicaid enrollees any changes made to the program, such as those in the proposed regulation, would have a disproportionate impact on them.

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

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

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

Not only does the proposed regulation threaten the financial viability of public safety net providers, it would also threaten reimbursement for children's hospitals. Children insured by Medicaid account for over half of all inpatient days of care provided at free-standing acute care children's hospitals. Children's hospitals, on average, are reimbursed 78 percent of the cost of care provided even when disproportionate share hospital payments are included in the calculation of total payment. Because Medicaid is such a large payer and existing Medicaid payments do not cover costs, any changes to Medicaid can have a profound impact on children's hospitals and their ability to serve all children.

States faced with budget shortfalls would likely institute reimbursement cuts, which could include disproportionate share hospital payment decreases, to make up for the loss of federal funds. Because a large percentage of our patients rely on Medicaid for their health insurance coverage, any decreases in reimbursement impact our ability to provide care to all children.

When faced with payment decreases, our hospital faces tough decisions about the potential for service cutbacks. These cutbacks affect all children, not just children on Medicaid. Any efforts to address these financing mechanisms should consider the

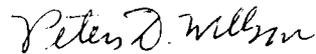
significant impact changes would have on children's hospitals' ability to receive adequate funding and continue to provide health care services to all children.

Conclusion

As you can see from our comments, we are extremely concerned about this proposed regulation and the impact it would have on children enrolled in Medicaid and on children's hospitals. We encourage CMS to delay the implementation of the regulation to allow time for a thorough review of the proposed regulation's impact on children enrolled in Medicaid and the providers who serve them.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Aimee Ossman at 703-797-6023 or aossman@nachri.org. Thank you for your consideration.

Sincerely,



Peters D. Willson
Vice President, Public Policy
National Association of Children's Hospitals



March 8, 2007

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

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

Dear Sir/Madam:

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

The regulation as proposed would cut Medicaid funding by \$3.8 billion, which would significantly limit the funding available for state Medicaid programs. If this regulation were to go into effect as planned in September 2007, our state could face a significant Medicaid funding shortfall that could result in cuts to the program. Texas would lose nearly \$300M and Bexar County would lose nearly \$37 M to our Medicaid 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.

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 our state, 1.9 million children have Medicaid coverage and these children make up 70 percent of the state Medicaid population. Because children are the majority of Medicaid enrollees any changes made to the program, such as those in the proposed regulation, would have a disproportionate impact on them.

At CSRCH in FY06 79% of our inpatient days were Medicaid and our total Medicaid days were 33,000. We have the only Level 3c NICU in our area serving mainly Medicaid newborns. The children we treat rely on Medicaid and the coverage it provides for all medically necessary care. With insufficient financing for their share of Medicaid, states would be forced to find new funding sources or make cuts to the program, which could directly affect children's eligibility and the benefits and services provided. These types of cuts would have a significant impact on our patients and threaten our ability to provide quality health care to all children.

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

Additional Changes Unnecessary

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

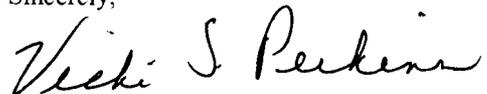
The annual growth in federal Medicaid spending has declined significantly due to both improvements in the economy and cost containment policies adopted by states in recent years. Federal spending on Medicaid is not out of control and does not warrant changes such as those proposed, which would have a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

Conclusion

As you can see from our comments, we are extremely concerned about this proposed regulation and the impact it would have on children enrolled in Medicaid and on children's hospitals. We encourage CMS to delay the implementation of the regulation to allow time for a thorough review of the proposed regulation's impact on children enrolled in Medicaid and the providers who serve them.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Ms. Vicki Perkins at (210)313-2386 or vicki.perkins@christushealth.org. Thank you for your consideration.

Sincerely,

A handwritten signature in cursive script that reads "Vicki S. Perkins".

Vicki S. Perkins, Director of Advocacy and Public Policy



March 14, 2007

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

1215 K STREET
 SUITE 1930
 SACRAMENTO, CA 95814

916.552.7119
 FAX: 916.552.7119

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 (Vol. 72, No. 11, January 18, 2007)

Dear Ms. Norwalk:

On behalf of California's Children's hospitals, I write to provide comments to the Centers for Medicare and Medicaid Services (CMS) on its Medicaid administrative rule published in the January 18th *Federal Register*. We oppose this rule as written, and ask that you withdraw it. If implemented, this proposed rule will have a devastating impact on California's safety net hospitals and the patients served.

This 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, especially children. If this regulation were to go into effect as planned in September 2007, California could face a significant Medicaid funding shortfall that could result in cuts to the program. It is estimated that California's safety net hospitals could lose approximately \$550 million per year for the next three years, and potentially millions more beyond that period.

Medicaid funding to California's safety net providers is based on a waiver that was negotiated between the state and the Center for Medicare and Medicaid Services (CMS) in June 2005. Because this rule explicitly states that its provisions will apply to state waivers, I am concerned that it will limit the availability of funds, already negotiated in the waiver, to California for safety net providers.

Ms. Leslie Norwalk

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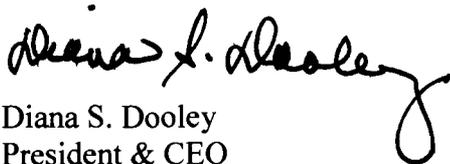
March 14, 2007

The magnitude of the anticipated losses could result in hospital closures in California and the diminished ability to provide services to vulnerable populations such as children. In addition, entire communities could be negatively impacted by the loss or reduction of emergency, trauma, burn, and other essential life saving services that safety net hospitals provide. While the rule could directly and immediately impact public safety net hospitals, I believe that this rule could create a domino effect that would be damaging to California's entire health care system, including children's hospitals.

Many of the children we treat rely on Medicaid and the coverage it provides for all medically necessary care. With insufficient financing for their share of Medicaid, states like California could be forced to find new funding sources or make cuts to the program, which could directly affect children's eligibility and the benefits and services provided.

We urge CMS to permanently withdraw this rule. 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. Please contact me at 916-552-7111 should you need additional information. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Diana S. Dooley". The signature is fluid and cursive, with a large loop at the end of the last name.

Diana S. Dooley
President & CEO



Carolinus Rehabilitation

March 15, 2007

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

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

Dear Ms. Norwalk:

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

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

Leslie Norwalk
March 15, 2007
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Although there are many troublesome aspects of the proposed regulation, the provision that will have the most detrimental effect to the Carolinas Rehabilitation hospital is the proposed definition of "unit of government." and Non-Public hospitals. Over 40 of North Carolina public hospitals have been participating in Medicaid programs as public hospitals for over a decade with the full knowledge and approval of CMS. Yet, under the proposed new definition requiring all units of government to have generally applicable taxing authority or to be an integral part of an entity that has generally applicable taxing authority, virtually none of these truly public hospitals will be able to certify their expenditures. Imposing a definition that is so radically different and has the effect wiping out entire valuable programs that are otherwise fully consistent with all of the Medicaid statutes is unreasonable and objectionable. Carolinas Rehabilitation hospital respectfully requests that CMS reconsider its position on the definition of unit of government and defer to applicable State law. This narrow definition basically eliminates all public hospitals in the country as so few have taxing authority since most public hospital boards are to be elected by the electorate.

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

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

Respectfully Submitted,



Dennis Phillips, President
Carolinas Medical Centers-Charlotte

DP:sd

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



Carolinan Medical Center
Carolinan HealthCare System

March 15, 2007

Suzanne H. Freeman
President

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

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

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

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

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

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

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

Respectfully submitted,



Greg A. Gombar
Executive Vice President
Administrative Services-CFO

GAG:sd

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



NEW YORK STATE CONFERENCE OF LOCAL MENTAL HYGIENE DIRECTORS, INC.

99 Pine St., Suite C100 ▲ Albany, NY 12207 ▲ (518) 462-9422 ▲ FAX (518) 465-2695
E-MAIL: clmhd@clmhd.org ▲ www.clmhd.org

Chair

Nicole Bryant, LMSW
Essex County

March 9, 2007

First Vice Chair

Larry Tingley, LMSW
Jefferson County

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

Second Vice Chair

Philip Endress, LCSW, ACSW
Erie County

Secretary

John J. Cadalso, ACSW
Schenectady County

Re: Code # CMS-2258-P:
Medicaid Program: Cost Limit for
Providers Operated by Units of
Government and Provisions to
Ensure the Integrity of Federal-
State Financial Partnership (42
CFR Part 433, 447 and 457)

Treasurer

Michael O'Leary, DSW
Columbia County

Committee Chairs

Chemical Dependency

Robert Anderson, Ph.D.
Allegany/Steuben Counties

On behalf of the New York State Conference of Local Mental Hygiene Directors (NYSCLMHD), I am commenting on the above-referenced proposed rule published in the Federal Register of January 18, 2007 on pages 2236 to 2248.

Developmental Disabilities

Susan Delehanty, LCSW
Franklin County

The NYSCLMHD is created in state statute and is a membership association comprised of the Commissioners and Directors of Mental Hygiene in each of the 57 counties and the City of New York.

Mental Health

Arthur R. Johnson, LMSW
Broome County

Our members, representing consumers, providers and their respective county governments are concerned that the proposed rule would seriously undermine mental hygiene services in two primary ways. First, new limitations proposed in the regulatory definition of allowable costs for providers which are units of government would be particularly harmful to the continuing viability of the range of services available to seriously mentally ill adults and children living in our communities.

Children and Families

Katherine Maciol, LCSW
Rensselaer County

Executive Director

Duane Spilde, LCSWR, ACSW

Deputy Executive Director

Kathleen P. Mayo

Counsel

Peter R. Freed

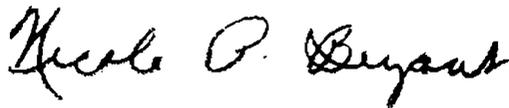
Also, new limitations on allowable services under the rehabilitation option would be particularly harmful to persons with mental retardation and currently receiving health-related specialty services which allow them to participate meaningfully and in a more mainstreamed manner in the public education system.

Centers for Medicare & Medicaid Services
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Additionally, more rural counties appear to be disproportionately disadvantaged/singled out by the proposed rule because (i) there are few if any alternative providers not subject to the costs limitation (not-for-profit agencies which are more available in more populous jurisdictions) which could substitute services previously provided by a rural county-operated clinic, and (ii) a county is particularly dependent on Medicaid transportation funding because of large travel distances for poor clients, so that proposed new limitations on Medicaid transportation could be disproportionately disadvantageous by isolating seriously mentally disabled clients living in the community.

We urge you to reconsider the potential harm to some of our most disenfranchised and disabled citizens that will result from promulgation of this rule, and withdraw it from further consideration.

Very truly yours,



Nicole Bryant, LMSW
Chair

cc: Honorable Charles Schumer, Member, U.S. Senate
Honorable Hillary Clinton, Member, U.S. Senate
Honorable Gary Ackerman, Member, U.S. House of Representatives
Honorable Michael Arcuri, Member, U.S. House of Representatives
Honorable Timothy Bishop, Member, U.S. House of Representatives
Honorable Yvette D. Clarke, Member, U.S. House of Representatives
Honorable Joseph Crowley, Member, U.S. House of Representatives
Honorable Eliot Engel, Member, U.S. House of Representatives
Honorable Vito Fossella, Member, U.S. House of Representatives
Honorable Kirsten E. Gillibrand, Member, U.S. House of Representatives
Honorable John J. Hall, Member, U.S. House of Representatives
Honorable Brian Higgins, Member, U.S. House of Representatives
Honorable Maurice Hinchey, Member, U.S. House of Representatives
Honorable Steve Israel, Member, U.S. House of Representatives
Honorable Pete King, Member, U.S. House of Representatives
Honorable Randy Kuhl, Member, U.S. House of Representatives
Honorable Nita Lowey, Member, U.S. House of Representatives
Honorable Carolyn McCarthy, Member, U.S. House of Representatives
Honorable John M. McHugh, Member, U.S. House of Representatives
Honorable Michael R. McNulty, Member, U.S. House of Representatives
Honorable Carolyn Maloney Member, U.S. House of Representatives
Honorable Gregory W. Meeks, Member, U.S. House of Representatives

Centers for Medicare & Medicaid Services
Page Three

Honorable Jerrold Nadler, Member, U.S. House of Representatives
Honorable Charles B. Rangel, Member, U.S. House of Representatives
Honorable Thomas M. Reynolds, Member, U.S. House of Representatives
Honorable Jose E. Serrano, Member, U.S. House of Representatives
Honorable Louise Slaughter, Member, U.S. House of Representatives
Honorable Edolphus Towns, Member, U.S. House of Representatives
Honorable Nydia M. Velazquez, Member, U.S. House of Representatives
Honorable Jim Walsh, Member, U.S. House of Representatives
Honorable Anthony D. Weiner, Member, U.S. House of Representatives



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

MAR 12 2007

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,

Larry S. Gage
President



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

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.

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 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.

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

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 Colleges²⁴) 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.

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.

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 1991⁴³ 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.



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North Carolina Hospital Association

March 15, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and 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), Jan. 18, 2007

Dear Ms. Norwalk:

On behalf of the 100 North Carolina acute care hospitals, both public and non-public, participating in the State's Hospital DSH and Medicaid Supplemental Payment Program, we appreciate this opportunity to comment on the Centers for Medicare and Medicaid Services' proposed rule. We strongly oppose this rule because of the significant harm these proposed policy changes would cause to these hospitals and the patients and communities they serve.

The rule represents a departure from long-standing Medicaid policy by imposing 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 North Carolina program is based upon the certified public expenditures of 43 public hospitals, used to draw down matching federal funds to make enhanced Medicaid and Disproportionate Share Hospital payments to both public and non-public hospitals that provide essential hospital services to all patients, including Medicaid and uninsured. Approximately \$340 million goes to these safety net hospitals to provide quality health care to our state's most vulnerable residents. Hospitals in our state are facing numerous challenges with the growing level of the uninsured and continued threats to reimbursement from government payers and others. In North Carolina, about one-third of our hospitals operate with negative operating margins, while another third have problematic financial results with operating margins of less than five percent, much less than the expected level needed to adequately fund ongoing operations.

We have several concerns with the CMS proposed rule, including the limitation on reimbursement of governmentally operated providers, restrictions on certified public expenditures, the absence of factual data to support the "savings" to the government projected by CMS, and the narrowing of the definition of public hospital.

Of these concerns, the provision that will have the most detrimental impact on North Carolina is the last one noted above, a new and restrictive definition of "unit of government," such as a public hospital. 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. All 43 of North Carolina's public hospitals are considered public under applicable State law. There is no basis in federal statute that supports the proposed change in definition.

Existing federal Medicaid regulations allow North Carolina hospitals to receive payments under our State's program 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 this vital 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, possibly further exacerbating the increasing numbers of the uninsured who cannot afford such high premiums. The second would eliminate needed services, not only 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.

If this devastating rule is not withdrawn, North Carolina hospitals will lose approximately \$340 million immediately, or almost \$2 Billion over five years. It appears that the rule's estimated losses under such programs or "savings" to the federal government of \$3.87 Billion is significantly understated.

The North Carolina Hospital Association opposes the rule and urges CMS to immediately and 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.

If you have questions about these comments, please contact Millie Harding (919/677-4217) or Hugh Tilson (919/677-4229) at NCHA.

Sincerely,

NORTH CAROLINA HOSPITAL ASSOCIATION



William A. Pully
President

cc: Members of North Carolina's Congressional Delegation

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March 16, 2007

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

Children's Memorial Foundation

Children's Memorial
Research Center

*Affiliated with
Northwestern University's
Feinberg School of Medicine*

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

Dear Ms. Norwalk:

On behalf of the children in our community served by Medicaid, Children's Memorial Hospital is pleased to provide comments to the Centers for Medicare and Medicaid Services (CMS) on its Medicaid administrative rule published in the January 18th *Federal Register*. Both the National Association of Children's Hospitals and the Illinois Hospital Association have asked Children's Memorial to submit comments on the proposed rule.

CMS estimates that the rule will cut \$3.8 billion in federal funding over five years. Rod Blagojevich, Governor of Illinois, has stated that Illinois will lose \$623 million per year if the proposed rule is promulgated. Children's Memorial does not have the technical ability to comment on the total cost to the State or many of the legal technicalities raised by the rule; however we would like to share our view on the importance of this issue for our hospital and the children of Illinois. The funding mechanisms impacted by the rule have been used in Illinois for over a decade with the knowledge and approval of the Health Care Finance Administration and the Centers for Medicare and Medicaid Services. We commend CMS for assisting states; however, we are sensitive to the need to maintain the integrity of the Medicaid program.

After two turbulent decades, the Illinois Medicaid program began work with advocates and providers to achieve fiscal and programmatic order. Coincidentally with the inception of SCHIP, Illinois has taken many steps to both expand coverage for children and enhance payments to providers. CMS has been instrumental in helping Illinois and providers who serve children insured by Medicaid. Both the leadership of CMS and its technical staff have provided indispensable support in helping Illinois work through complex and controversial issues such as the Family Care waiver, Senior Care waiver and, most recently, the desperately needed provider assessment.

The proposed rule would create a significant financial disruption to Illinois at a time when it is on the verge of completing a stable foundation for meeting the health care needs of children who rely upon Medicaid.

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 Illinois, 1.2 million children have Medicaid coverage which translates to approximately 1 in 3 children in the state who rely upon the program for health care. Because children represent the majority of Medicaid enrollees, any changes made to the program, such as those in the proposed regulation, would have a disproportionate impact on them.

Children's Memorial is the State's largest provider of pediatric Medicaid care, representing 57% of our gross patient revenues. In total, Children's Memorial provides 30% more inpatient, outpatient and physician pediatric Medicaid services than the next highest provider in Illinois.

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

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

In the past, states faced with budget shortfalls instituted reimbursement cuts, which included safety net hospital payment decreases, to make up for the loss of federal funds. Because a large percentage of our patients rely on Medicaid for their health insurance coverage, any decreases in reimbursement impact our ability to provide care to all children.

In FY 2006, Children's Memorial Medicaid losses were a staggering \$16.7 million. When faced with payment decreases, our hospital faces tough decisions about the potential for service cutbacks. These cutbacks affect all children, not just children on Medicaid. Any efforts to address these financing mechanisms should consider the significant impact changes would have on children's hospitals' ability to receive adequate funding 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 upper payment limits are still being phased in. The need for additional restrictions on state financing is unsubstantiated. Not only would additional changes have a negative impact on children and children's providers, but they are unnecessary.

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

Conclusion

We are extremely concerned about this proposed regulation and the impact it would have on children enrolled in Medicaid and on children's hospitals.

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

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Jill Fraggos, Director, Government Relations or jfraggos@childrensmemorial.org . Thank you very much for your consideration.

Sincerely,



Patrick M. Magoon
President and CEO



CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

March 16, 2007

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

**Re: Comments 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**

Dear Ms. Norwalk:

On behalf of the California Association of Public Hospitals and Health Systems (“CAPH”), I am writing to express strong opposition to the proposed Medicaid rule regarding cost limits on Medicaid payments to public health care providers. (CMS-2258-P) We appreciate the opportunity to advise the agency of the far-reaching, damaging effects that the rule would have on California’s public health care safety net. The proposed limits on Medicaid payments to public health care providers and the proposed restrictions on the states’ ability to use local public funds to finance Medicaid services will lead to devastating results for safety net providers and the communities they serve across the country. CAPH urges you to withdraw this proposed rule.

CAPH represents 21 public hospitals, health care systems and academic medical centers, located in 16 counties in California. Our hospitals are a cornerstone of the State’s health care system. Public hospitals operate nearly 60% of California’s top-level trauma centers, which are state-of-the-art emergency medical units that treat the most catastrophic, life-threatening injuries. We also operate almost 45% of the State’s burn centers and provide more than 60% of California’s emergency psychiatric care. Our members also operate other types of providers that participate in the Medicaid program, including clinics, Federally Qualified Health Centers (“FQHC”), and managed care organizations, all of which would be adversely affected by this rule. This rule will likely result in the reduction of critical health care services that public hospitals are uniquely qualified to provide, thereby limiting services and health care access—a result directly contrary to the purpose of the Medicaid program.

The rule will limit Medicaid payments to the cost of Medicaid services to Medicaid recipients. This will eliminate funding for indigent non-Medicaid patients whose costs

are currently covered under the Safety Net Care Pool, which is an integral part of California's Hospital/Uninsured Care Demonstration Project, approved under Section 1115 of the Social Security Act, ("Hospital Waiver"). As CMS clearly states in the preamble that the rule applies to all waivers, CAPH is concerned this critical funding for the uninsured will be eliminated. Based on the impact on the Hospital Waiver, we estimate that California's public hospitals will lose \$500 million per year for the next three years, and additional funds beyond that period.

The Centers for Medicare and Medicaid Services ("CMS") claims that the rule is necessary to address state financing abuses, while at the same time the agency touts its success in eliminating these abuses on a state-by-state basis. While we acknowledge and support CMS' efforts in this regard, it is clear that the agency already has the legal tools needed to address these problems and that the proposed limits on state flexibility through this overreaching rule are unnecessary. Any solution to issues of funding integrity should be narrowly tailored to result in the least harmful effects to public providers and their patients. The sweeping restrictions set forward in the rule exceed this basic principle to the extent that its implementation will negatively affect legitimate funding practices, like those used in California.

Since the rule was published, a bipartisan letter lead by Congresswoman Eshoo and Congressman King, which expressed strong opposition to the implementation of the rule, was signed by 226 members of Congress. A similar bipartisan letter circulated by Senators Dole and Durbin received 43 signatures. In addition, the National Governors Association, the National Association of Counties, and others have formally registered their opposition to the rule. The provisions of this rule are clearly contrary to the will of Congress and many organizations with the expertise to predict its potential impact. CMS must respond to this overwhelming resistance and withdraw the proposed rule.

I. Key Concerns.

A. The proposed rule inappropriately limits states' ability to fund the nonfederal share of Medicaid expenditures by narrowing the types of public entities that can participate in that funding and by restricting the states' ability to use local public funding for the Medicaid program. These restrictions are not authorized by statute and are inconsistent with Congressional intent.

B. The cost limit rule would contravene the rate-setting flexibility granted to the states by Congress. CMS is not authorized to impose the proposed cost limit on public providers. Such a limit will result in inadequate payment and will ultimately restrict access to services for Medicaid recipients and the community as a whole.

C. The proposed retention requirement is too broad and serves no legitimate purpose. Congress has never granted CMS the authority to regulate how providers use the Medicaid revenues they receive for Medicaid services they have already rendered.

II. Specific Comments on proposed rule.

CAPH is concerned with the rulemaking approach reflected in this publication. In places, the preamble discussion mischaracterizes current law and at times it is inconsistent with the language of the proposed rule itself. CMS' rationale for this rule--to protect against states' financing abuses--does not support the draconian measures proposed. Taken as a whole, the notice of proposed rulemaking does not fairly present the issues for public consideration and comment as required by the Administrative Procedures Act ("APA").¹

The proposed rule is inconsistent with express statutory provisions and with Congressional intent to protect states' flexibility under the Medicaid program, both in terms of funding sources and payment rates. The rule will dramatically reduce funds available to care for the most vulnerable populations—those who are in need of medical care, but who lack financial resources. CAPH urges CMS to withdraw the proposed regulation in its entirety. In the event that CMS goes forward with a final regulation, we urge you to make the extensive revisions necessary to protect public safety net hospitals and the people they serve.

A. The proposed rule inappropriately limits states' ability to fund the nonfederal share of Medicaid expenditures.

1. Definition of Unit of Government

The proposed amendments to Sections 433.50 and 433.51 would inappropriately limit those entities qualified to provide the nonfederal share of Medicaid expenditures to units of government with generally applicable taxing authority. CMS relies on Sections 1902(a)(2)² and 1903(w)(6) and (7)³ of the Social Security Act ("Act") in support of these changes. For a number of reasons, however, the legal analysis presented in support of the proposed rule is flawed.

First, there is nothing in Section 1902(a)(2) that supports restrictions on the types of units of government that can make Medicaid certified public expenditures ("CPEs") or intergovernmental transfers ("IGTs"). That section of the Medicaid statute recognizes the states' authority to use public funds, in addition to state funds, to finance Medicaid expenditures. The provision, which has been in place in its current form since 1967, has never been interpreted by CMS in any regulation or formal policy statement to support such narrow restrictions on the categories of public entities that can participate in Medicaid financing. The current regulation reflects the longstanding policy that allows a broad range of public agencies to make CPEs or

¹ 5 U.S.C. § 533.

² 42 U.S.C. § 1396a(a)(2).

³ 42 U.S.C. § 1396b(w)(6) and (7).

IGTs. Section 1902(a)(2) remains unchanged and, as discussed below, the 1991 legislation adding Section 1903(w) was not intended to change this result.⁴

Second, the proposed regulatory definition is inconsistent with the plain language of the statutory definition of unit of government on which CMS relies.⁵ The proposed rule conspicuously adds the requirement of “generally applicable taxing authority” to the statutory definition. If Congress had intended to impose this additional requirement, it would have done so. Instead, Congress adopted a broad definition with the intent of maintaining then existing policy allowing any public agency to fund Medicaid.

Third, the rule would apply the term “unit of government” well beyond its stated applicability. Section 1903(w)(7) expressly limits the scope of the terms defined therein to be used only “for purposes of this subsection.” CMS goes far beyond this limitation and would use the term to change the interpretation of Section 1902(a)(2) of the Act to limit the use of local funds under a completely different section of the Medicaid law.

Fourth, the proposed rule is directly inconsistent with the reason that Congress included these provisions in the 1991 Medicaid Amendments. While Section 1903(w) generally was designed to limit certain types of Medicaid financing methods, paragraphs (6) and (7)(G) of 1903(w) were intended to protect the states’ ability to use local public funds to finance the nonfederal share of Medicaid expenditures. The purpose of these provisions was to make it clear that IGTs were not to be restricted like provider-related taxes and donations, which were considered abusive. The Conference Committee stated:

The conferees note that current transfers from county or other local teaching hospitals continue to be permissible if not derived from sources of revenue prohibited under this act. The conferees intend the provision of section 1903(w)(6)(A) to prohibit the Secretary from denying Federal financial participation for expenditures resulting from State use of funds referenced in that provision.⁶

By limiting the definition of unit of government, the proposed rule is directly contrary to this Congressional directive. In California, the requirement that the unit of government providing the nonfederal share of Medicaid expenditures itself have generally applicable taxing authority would result in eliminating the use of University of California teaching appropriations for Medicaid funding purposes. Moreover, it would eliminate the use of Alameda County Medical Center funds as the nonfederal share of Medicaid expenditures.

⁴ See Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Pub. Law No. 102-234) (“1991 Medicaid Amendments”).

⁵ See § 1903(w)(7)(a); 42 U.S.C. § 1396b(w)(7)(a).

⁶ H.R. Conf. Rep. No. 102-409, at 1444 (1991).

The University hospitals are owned and operated by the Regents of the University of California, a constitutionally created unit of State government. The Regents do not have independent taxing authority and the University hospitals are not an integral part of those units of state government that do have such authority. Therefore, as currently drafted, the proposed rule would restrict the use of “funds appropriated to State university teaching hospitals” in direct violation of the plain language of Section 1903(w)(6) of the Act.

Similarly, Alameda County Medical Center (“ACMC”), a public entity that expends public funds in the provision of hospital services to Medi-Cal beneficiaries, is protected under Section 1903(w)(6) from the restrictions the proposed rule would impose. However, ACMC is operated by a hospital authority which is separate from Alameda County. It is the County, and not the separate authority, that has the generally applicable taxing authority. Under the proposed regulation, California could not rely on the IGTs or CPEs generated at ACMC as a source of Medicaid funding. CMS has set forth no rationale for, or valid federal interest in, limiting ACMC’s ability to participate in Medicaid financing.

There is no legitimate federal interest in imposing these restrictions on California’s ability to fund its Medi-Cal program. While the proposed rule would result in federal savings, those saving would be accomplished in violation of the State’s right to use local funds as the nonfederal share of Medicaid expenditures under Section 1902(a)(2) of the Act.

2. Preamble statements on restricting sources of funds cause confusion and raise concerns.

In the preamble, CMS states that tax revenue is the only valid source of IGTs.⁷ While neither current law nor the proposed regulations expressly impose such a requirement, the preamble statements suggest that CMS intends to adopt an interpretation that would limit local Medicaid funding to those funds derived directly from taxes. Any such limitation on the use of public funds would be directly inconsistent with the long-standing implementation of the Medicaid statute and with the protections intended by Congress in Section 1903(w)(6) of the Act.

Section 1902(a)(2) is the statutory provision that has long been interpreted as granting states authority to use public funds, other than state funds, to finance Medicaid expenditures. Beyond a broad reference to the adequacy of “local sources” of funds, the provision, which has been in place in its current form since 1967, imposes no restriction on the sources of local funds that may be used by the states. Until 1991, when Congress imposed strict limitations on federal financial participation (“FFP”) designed to preclude the use of provider-related taxes and donations to finance Medicaid expenditures, there were no statutes or regulations in place that imposed any such restrictions. The Health Care Financing Administration’s attempt to impose such restrictions through regulations was rejected by

⁷ See 72 Fed. Reg. 2238.

Congress.⁸ As discussed above, at the same time, Congress chose to protect, rather than restrict, the use of public funds to finance Medicaid expenditures.

CMS has no authority to look behind public Medicaid expenditures to determine their source. If it had that authority, the 1991 Medicaid Amendments would not have been necessary.⁹ Once funds are in the hands of a public entity, they are public dollars that can be used for any appropriate public purpose, including the provision of covered Medicaid services. If public expenditures are made for this purpose under an approved state plan or under an approved waiver program, CMS is obligated under Section 1903(a) of the Act to provide FFP.¹⁰

CMS has expressed no rationale for limiting local Medicaid funding to tax revenues. Public entities obtain funds from a number of sources. For example, California counties receive tobacco settlement funds, earn interest on amounts deposited in financial institutions, experience gains on the sale or lease of property, obtain donations from individuals, and earn revenues from various operations, including the operation of their health care providers. CMS has identified no valid policy reason to preclude counties from using these funds to support the Medicaid program.

In any event, it would be virtually impossible for a public entity to demonstrate compliance with such a requirement. Even the suggestion of such an ability reflects a lack of understanding of governmental accounting practices. Generally, tax revenues are not held in separate accounts, but are intermingled with various revenues in a “general fund.” Any attempt on the part of CMS to impose a requirement to segregate and track tax revenue in order to support Medicaid expenditures is unworkable. This is particularly true in multi-hospital systems where tax dollars may be co-mingled with patient care revenue and other available public funds in system-wide accounts.

CAPH urges CMS to withdraw the proposed changes to Sections 433.50 and 433.51. If CMS goes forward with a final rule, the definition of unit of government must be broadened to allow recognition of the legitimate use of all public funds by entities such as the University of California hospitals and ACMC to finance the nonfederal share of Medicaid services. CMS should clarify that sources of the nonfederal share will not be limited to tax revenue.

⁸ Section 2(c)(3) of the 1991 Medicaid Amendments.

⁹ Even the 1991 Medicaid Amendments do not provide such authority. FFP is denied for provider-related taxes or donations regardless of whether they are used for Medicaid.

¹⁰ 42 U.S.C. § 1396b(a).

B. The proposed cost limit on public providers is inconsistent with the Medicaid statute and Congressional intent, will result in inadequate payment and will restrict access to services for Medicaid beneficiaries.

1. The proposed rule is inconsistent with Section 1902(a)(13)(A) of the Act,¹¹ which provides for state flexibility in setting rates.

Since 1980, Congress unequivocally has provided for state flexibility in establishing payment methodologies for inpatient services. Prior to 1980, Medicaid law imposed a reasonable cost limit on all inpatient services. Under legislation collectively referred to as the Boren Amendment,¹² Congress expressly eliminated this requirement, allowing states to set rates without reference to Medicare cost principles. In 1997, Congress repealed the Boren Amendment in favor of granting states even more flexibility to develop innovative payment systems.¹³

Both before and after passage of the BBA, CMS consistently has acknowledged that the BBA was intended to increase state flexibility in rate-setting for inpatient facilities. Former HCFA Administrator Bruce Vladeck, setting forth the agency's support of the BBA provision, stated that the repeal of the Boren Amendment would provide states "with much greater flexibility to develop innovative and more efficient health care delivery and payment systems."¹⁴ CMS guidance regarding the implementation of the BBA also states: "we recognize that the intent in repealing the Boren Amendment was to reduce [CMS'] role in the institutional payment rate setting process and to increase state latitude in this area."¹⁵

Given Congress' clear mandate, it is surprising for CMS now to assert that it has authority to reinstate a facility-specific payment restriction that Congress eliminated more than 25 years ago. When Congress intends for a facility-specific limit to apply, it has specifically enacted one, such as the restriction on payment for inpatient hospital services (exclusive of disproportionate share hospital ("DSH") payments) in excess of a hospital's customary charges (*see* § 1903(i)(3) of the Act¹⁶), and the hospital-specific limit on DSH payments (*see* § 1923(g)

¹¹ 42 U.S.C. § 1396a(a)(13)(A)(1).

¹² Omnibus Reconciliation Act of 1980 § 962 (Pub. Law No. 96-499) and Omnibus Budget Reconciliation Act of 1981 § 2173 (Pub. Law No. 97-35).

¹³ Balanced Budget Act of 1997 ("BBA") § 4711.

¹⁴ Statement of Bruce C. Vladeck, Ph.D Administrator Health Care Financing Administration on the President's Budget Proposal FY 1998 Before the House Committee on Commerce Subcommittee on Health, Feb. 12, 1997.

¹⁵ Letter from Sally K. Richardson, Director, CMS Center for Medicaid and State Operations, to State Medicaid Directors, December 10, 1997.

¹⁶ 42 U.S.C. § 1396b(i)(3).

of the Act¹⁷). Congress also authorized CMS to establish *aggregate* upper payment limits (“UPLs”) that are based on what Medicare would pay.¹⁸ The existing statutory structure can only be interpreted to reinforce the maximum flexibility of states to establish provider rates. The proposed cost limit would have precisely the opposite effect for a significant group of providers.

CMS’ prior regulatory actions have never before been so dismissive of state flexibility in regard to rates. For example, in establishing the current aggregate UPLs, CMS recognized states’ flexibility to “make a reasonable estimate” of the limits based on Medicare payment principles, noting that “[t]here are many factors and elements that States may consider to support their estimates.”¹⁹ At no time was it suggested that the estimates would be reconciled to actual data. Moreover, CMS expressly rejected the approach of imposing facility-specific limits “when balanced against the additional administrative requirements on States and [CMS], *coupled with Congressional intent for States to have flexibility in rate setting . . .*”²⁰

The proposed regulation at Section 447.206 essentially dictates one payment method for public providers. Under this rule, states would not be able to exercise the flexibility afforded by the BBA to develop payment methodologies, such as prospective payment systems, that deviate from the retrospective Medicare cost principles. This is because *any* payment to public providers will be considered “interim,” subject to settlement based on Medicare cost reporting.

Importantly, very few services are reimbursed by Medicare on a cost basis. Congress has over time rejected this inefficient payment method in favor of prospective rate setting. As a result, Medicare cost principles are outdated and have failed to keep up with industry and technological changes. Additionally, as more fully discussed below, the proposed rule would eliminate the aggregate UPLs for public providers, thereby eliminating the ability of states to target rate differentials for particular types of providers in order to address standards relating to quality of care and access.

2. The proposed cost limit is inconsistent with the statutory standard that states establish payments adequate to ensure access.

The preamble to the proposed rule refers to “statutory principles of economy and efficiency as required by Section 1902(a)(30)(A) of the Act” in support of imposing individual cost-based payment limits upon public providers. However, the complete statutory principle is that:

¹⁷ 42 U.S.C. § 1396r-4(g).

¹⁸ Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (“BIPA”) § 705.

¹⁹ 66 Fed. Reg. 3148, 3153 (January 12, 2001).

²⁰ *Id.* at 3175 (emphases added).

*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...*²¹

As Congress has recognized, this standard is not best met with a generic, one-size-fits-all approach, but the proposed rule attempts to do just that. The rule assumes that, in every geographic area in each of the states, access to Medicaid services provided by public providers can be assured with payments that are at or below Medicare costs, even though Medicare has abandoned that payment method with respect to most services. The rule ignores the fact that many actual expenditures of public providers essential to maintaining access for Medicaid patients would not be reflected as Medicare costs. For example, CAPH members maintain emergency rooms and trauma centers that are required to provide care to anyone in need of emergency care.²² While the costs for the uninsured must be incurred by the hospitals, the cost limit would not recognize such costs. If enough hospitals close their emergency rooms because of these losses, it will be impossible for the state to maintain access for its Medicaid population. The result is loss of access to critical care, not just for Medicaid beneficiaries, but for the entire community. Clearly, this is not good public policy.

As noted above, states have not been restricted to Medicare cost reimbursement for over 25 years. Congress allowed states to pay providers on a different basis to satisfy the statutory quality and access standard. The states, rather than CMS, are better able to determine the quality and access standard in particular geographic areas within the state and how best to meet the standard, which may include prospective payments and rate differentials that may be based on performance or other factors. Congress did place some limitation on state flexibility when it directed CMS to establish aggregate payment limits based on what Medicare would pay. The proposed cost-based limit on individual providers would virtually handcuff states in their ability to comply with the quality and access standard, and usurp clear Congressional intent as reflected in the existing Medicaid statutory structure.

3. The proposed rule violates the statute as applied to FQHCs.

The proposed rule at Section 447.206 would impose a cost limit on payments for all publicly operated providers. This rule directly contravenes the statutorily imposed prospective payments for FQHCs at Section 1902(bb) of the Act.²³ Under Section 1902(bb), FQHCs are paid per visit amounts based on their average costs incurred during 1999 and 2000, increased by the percentage increases in the applicable Medicare Economic Index. Importantly, the statute permits states to establish alternative payment methodologies that pay in excess of the

²¹ § 1902(a)(30)(A) of the Act (emphasis added); 42 U.S.C. § 1396a(a)(30)(A).

²² § 1867 of the Act; 42 U.S.C. § 1395dd.

²³ 42 U.S.C. § 1396a(bb).

statutory prospective payments system. Under the proposed rule, however, the prospective payments to publicly operated FQHCs would be interim, subject to reconciliation to actual costs. This consequence vividly demonstrates why the proposed rule does not fit within the statutory structure of state flexibility that Congress has methodically set forth.

4. CMS' analysis of Congressional intent to cover only Medicaid recipients does not support the cost limit.

CMS cites the statutory restrictions on matching only Medicaid expenditures as the basis of limiting payments to cost for public providers. This rationale is flawed, however, because the statutory restrictions apply to *states'* expenditures. When a state makes a payment to a provider for Medicaid covered services rendered to a beneficiary, it is that payment by the state which is recognized as the medical assistance expenditure for which federal matching is made and not the provider's expenditures in rendering the services. Contrary to the suggestion in the preamble, Congress has never attempted to legislate what a provider can do with its Medicaid payments once they have been earned for services rendered.

Congress never has precluded providers from using their Medicaid revenues to care for the uninsured. In fact, the mission and purpose of public and private non-profit providers is to provide health care to those in need. It is entirely appropriate for revenues to be used for this purpose. The fact that there is specific legislation that permits federal payments to providers for services to the uninsured does not mean, as CMS implies, that Congress intended these to be the exclusive sources of funding that providers can use for these services.

As CMS has acknowledged, there is no federal restriction on what a provider can do with the revenue it earns.²⁴ This is the case regardless of whether the provider is public or private. CMS' attempt to impose a payment limit on only public providers assumes that there is no operational expense or other use of revenue by private providers that is unrelated to Medicaid. This assumption is without merit. Support for uninsured services is not necessarily unique to public providers, and there are a variety of different purposes for which public and private providers may apply their revenues. There is no rational basis for limiting payments for public providers to costs, while allowing payments to private providers to exceed costs. In fact, CMS has recognized the importance of payment equity across provider types.²⁵

5. The proposed restriction will severely under fund California's safety net providers, jeopardizing access to care for Medicaid beneficiaries.

As discussed above, Medicaid rates must be sufficient to ensure quality of care and access to care and services for beneficiaries. CMS assumes that reimbursement of individual providers' costs at or below that determined under Medicare cost-finding principles is sufficient. This assumption is incorrect, because Medicare cost principles do *not* recognize all of a

²⁴ See 67 Fed. Reg. 2602, 2605 (Jan. 18, 2002).

²⁵ See 67 Fed. Reg. 2602, 2603 *passim* (Jan. 18, 2002).

provider's expenditures. In the case of public providers, these unrecognized costs are substantial.

For example, because of the requirements of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), as well as similar state laws, hospitals that operate trauma centers must provide certain trauma and emergency services, and screening services, without regard to the patient's ability to pay. Given the high cost of trauma services, and the increasing numbers of uninsured seen by public hospitals, trauma hospitals incur substantial losses in complying with these requirements. While not all of these losses are directly tied to Medicaid beneficiaries, if the losses reach such a level that the hospital is forced to close its trauma center, access to trauma services for Medicaid beneficiaries, as well as others in the community, will be impaired.

Even with DSH funding, essential costs of operating public providers to ensure access to care remain unfunded. First, DSH funding in the aggregate is capped, and this cap is imposed without regard to costs incurred. Second, in recent years CMS has shifted its policies regarding the computation of the hospital-specific DSH limits to exclude the costs of physicians and other professional services. Public providers typically incur significant costs for recruiting and retaining physicians and other health professionals to treat their uninsured patients. These costs are not taken into account under DSH.

All of these costs are necessary and legitimate to consider in establishing rates that assure quality of care and access pursuant to Section 1902(a)(30)(A), yet under the proposed limit such costs would be disregarded. If states lose their flexibility to establish adequate rates, access to care and services for Medicaid beneficiaries will be substantially curtailed, as increasingly more providers become unable and unwilling to treat them.

6. Implementing the proposed cost limit poses numerous practical problems.

The proposed rule at Section 447.206 does not set forth the specific methodology for identifying and allocating individual provider costs, but instead provides that, at some point, the Secretary will determine the appropriate procedures. The preamble suggests use of the Medicare cost reports for hospital and nursing facility services, with "exceptions" to be addressed on a case-by-case basis.²⁶ The proposed regulatory language, however, provides differently, stating that costs for such services "must" be supported using Medicare cost report information.

As previously discussed, Medicare currently reimburses for almost all services on a prospective payment basis and not on the basis of reasonable costs. Thus, the reliability of Medicare cost principles for widespread use today is suspect because these cost principles were developed 30 years ago, and they were designed to address a different program structure and

²⁶ See 72 Fed. Reg. 2241.

scope of services. What this means is that the use of Medicare cost reports without substantial changes would not be appropriate.

For example, the Medicare cost report provides for the removal of the salaries and benefits for interns and residents as well as related overhead costs, from Medicare allowable costs. The reason Medicare removes these is not because such costs were not incurred or were not allowable, but because Medicare reimburses hospitals for medical education activities through a separate graduate medical education (“GME”) payment mechanism. The GME payment amount is based on the application of a historical per resident rate to a capped and reduced number of residents. If adopted in final, the rule should recognize the full costs of GME.

Another example is with respect to physician services. Medicare separates out the professional services component that is covered under Part B, leaving only the cost of physician services to the hospital (“provider component”) on the hospital cost report. While this distinction was required under Medicare rules, it has no similar rationale under Medicaid, particularly for public hospitals in California, which typically directly employ or contract for physicians to serve their patients.

Medicare historically did not reimburse physician services on a cost basis, except with respect to the provider component. Limits on such physician services costs, known as the reasonable compensation equivalents (“RCE”), were established in 1983 and derived from limited physician salary data from 1979. The extremely narrow application of the RCEs in the Medicare context has not warranted much administrative or analytical attention by CMS and is inappropriate to apply in the Medicaid context.

Apart from institutional settings, there is no Medicare cost-reporting precedent and no other “standardized” mechanism to collect cost information. Such publicly-operated settings include medical offices and clinics, including public health clinics. In California, the development of an appropriate methodology has been challenging, with no approved form to date.

Implementation of the proposed limit with respect to all public providers would be immensely burdensome, not only because of the administrative hardships it would impose on already stressed public resources, but because it will create financial uncertainties for many years. This is because the limit essentially makes all payments received by public providers interim, subject to retrospective reconciliation to costs. Even under Medicare, it typically took years before cost and reimbursement settlements were finalized. The proposed cost limit will wreak havoc upon the currently precarious finances of public providers, since Medicaid constitutes a substantial proportion of their revenues. Furthermore, many states do not have the substantial administrative procedures and mechanisms in place to conduct the audits and appeals necessary to implement the proposed limit. The “efficiencies” of the proposed rule are simply not evident.

Finally, we note that the proposed cost limit appears to apply to payments made by Medicaid participating managed care organizations to public providers. If this is CMS’ intent, we do not understand its rationale. The application of a retrospective cost limit to

managed care services will preclude providers from negotiating for and receiving capitation payments, and would seem to contradict the principles of managed care. CMS should clarify that these payments are excluded from the limit.

7. As drafted, the application of the proposed cost limit to DSH payments would contradict the Medicaid DSH requirements.

Proposed Section 447.206 does not exclude DSH payments from the restriction on payments in excess of the individual provider's cost of providing covered services to eligible Medicaid recipients. DSH payments are, however, payments for inpatient hospital services rendered to Medicaid recipients; they are payment adjustments that provide additional compensation to take into account the situation of hospitals which serve disproportionate volumes of low-income patients. Even though the hospital-specific DSH limits (Section 1923(g) of the Act) include the uncompensated costs of uninsured patients, a DSH payment is *not* reimbursement for a non-Medicaid patient, that is, it does not convert a service rendered to a non-Medicaid patient into a Medicaid covered service to a Medicaid recipient.

If the proposed cost limit is applicable to DSH payments, then DSH payments to a public hospital could not exceed the cost of services to Medicaid recipients. As a result, DSH payments could not reflect a hospital's uncompensated costs of care rendered to uninsured patients. Such a result is in direct conflict with the provisions of Sections 1902(a)(13)(A) and 1923(g) of the Act. Therefore, DSH payments must be expressly excluded from the proposed limit.

8. The impact of the proposed cost limit on the UPL transition provisions is unclear.

The proposed rule modifies somewhat the existing aggregate UPLs for non-state government operated facilities under Sections 477.272 and 477.321. However, there remain a number of inconsistencies in how the proposed cost limit will interrelate with these UPLs. For example, the UPLs as modified by the proposed rule would be individual limits, as opposed to aggregate, yet the amount that is in excess of the UPLs that are to be phased out over the transition period appears to still be an aggregate amount. Even if the excess amount to be phased out is supposed to be an individual provider-specific amount, it is unclear as to how that should be calculated. Finally, we note that, notwithstanding the modifications to the UPL transition rules, the proposed cost limit at Section 447.206 appears to be in conflict because there is no exception to reflect transition payments.

C. CMS has no authority to require providers to retain payments received for services already rendered.

As currently drafted, proposed Section 447.207 is too broad. Although the preamble suggests that this requirement would only apply to IGT funded Medicaid payments, the language of the regulation is much broader, applying to all Medicaid payments to all types of providers.

The proposed rule lacks the specificity necessary to make it enforceable. It is unclear how a provider can "retain the full amount of" its total Medicaid payments. Would

providers be required to place all Medicaid revenues in a separate account and never use them, even to pay employees or to purchase supplies? This would be a problem, particularly for managed care organizations that would be precluded from using their capitation payments to obtain services for their enrollees. Clearly, CMS did not intend this absurd result, but the language of the rule does not provide guidance as to how a provider is to comply with the rule. Although the regulation appears to base compliance with the retention requirement on an “examination” of the underlying Medicaid expenditures, this language does not add clarity to the regulation because it fails to state the standards that will be applied in such an examination. As a result, the regulation is impermissibly vague.

Through this regulation, CMS is apparently attempting to regulate providers’ use of the Medicaid revenues that they have earned for the Medicaid services they have already provided. As discussed above, nothing in the Medicaid statute grants CMS the authority to impose such restrictions. CMS simply has no statutory authority to tell providers, public or private, what to do with their Medicaid revenues. This proposal is particularly egregious when applied to public providers that will never receive more than reimbursement of costs already incurred under this proposed rule. If the provider has already spent the full amount on services, what is left to be “retained”?

The preamble suggests that this rule is necessary to protect against abuses. However, the rule is neither a necessary nor effective means of addressing state funding abuses. If CMS is concerned that state Medicaid expenditures are not consistent with legal requirements, then CMS should impose regulations on the calculation of those expenditures. CMS is attempting to regulate states’ behavior by imposing unwarranted restrictions on providers. Moreover, if, as the preamble states, current law requires offsets to ensure appropriate net expenditures, then this proposed regulation is unnecessary.²⁷

Proposed Section 447.207 should be withdrawn.

D. If, as the preamble states, all payments under Medicaid waivers are subject to all provisions of this rule, the impact on the California safety net would be devastating.

California’s Medi-Cal program operates under a number of waiver programs. The Hospital Waiver provides Medicaid funding for inpatient hospital services to Medi-Cal recipients and for services to the uninsured. Under the Hospital Waiver and related State plan amendments, private safety net hospitals receive negotiated contract rates for Medi-Cal inpatient hospital services and additional Medi-Cal payments in lieu of DSH funding. The State’s 23 designated public DSH hospitals are paid based on their CPEs for inpatient hospital services rendered to Medi-Cal recipients. These CPEs are made with local public funds and, based on the current federal medical assistance percentage, the public hospitals receive 50 cents on each dollar of allowable cost for these services. The public hospitals also receive most of the State’s DSH allotment under Section 1923(f) of the Act,²⁸ based on their CPEs. They can receive 50 cents in

²⁷ See 72 Fed. Reg. 2238.

²⁸ 42 U.S.C. § 1396r-4(f).

DSH funding on each dollar spent on hospital services to the uninsured, subject to hospital-specific DSH limits under Section 1923(g) and up to the to California's DSH allotment.

The Hospital Waiver also includes a Safety Net Care Pool of \$766 million per year of federal funds available to match State, public hospital and other public entities' expenditures on services to the uninsured. Section 1115(a)(2) of the Act²⁹ allows CMS to pay these funds to California, even though expenditures for the uninsured would not normally be eligible for federal matching under Medicaid. CMS has determined that, even taking into account the Safety Net Care Pool dollars, the Hospital Waiver is budget neutral. That is, CMS will pay no more under the Hospital Waiver than it would have paid California in the absence of the waiver. Thus, the amount in the Safety Net Care Pool represents federal Medicaid dollars that currently could be paid to California, such as the amount above allowable costs that public hospitals could earn under the existing federal rules, an amount representing the UPL transition, and other savings resulting from Hospital Waiver.

CAPH is concerned that the proposed rule will dramatically lower payments to its member hospitals under the Hospital Waiver, resulting in reduced access to services for the vulnerable populations served by public hospitals. Our concern is based on the unequivocal statements in the preamble that all Medicaid payments "made under the authority of the State plan and under Medicaid waiver and demonstration authorities are subject to all provision of this regulation."³⁰ Moreover, the Special Terms and Conditions that govern the Hospital Waiver require that the State come into compliance with any regulatory changes, and that CMS must adjust the budget neutrality cap to take into account reduced spending that would be anticipated under new regulations. (See, Section II, paragraphs 2 and 4 of the Special Terms and Conditions.)

If CMS implements its stated intent to apply these rules to the Hospital Waiver without significant changes to the proposed regulatory language, the result is clear: Medicaid funds under the Hospital Waiver will no longer be available for services to the uninsured, the budget neutrality cap will be adjusted accordingly and a substantial portion of the Safety Net Care Pool will be lost.

In response to expressions of these concerns, CAPH has been advised that CMS officials have stated that the proposed rules will have no impact on California's Hospital Waiver. If these statements reflect the intent of CMS, then substantial changes will be necessary in the final regulations to make the rule consistent with that intent. Although CAPH would welcome the changes set forth below, they would protect the Hospital Waiver only in the short term, and would do nothing to address the fundamental policy concerns we have raised in this letter. Even if the Hospital Waiver is protected until it expires in 2010, California's safety net providers will soon have to begin planning the changes that will be necessary to deal with the adverse consequences of these flawed regulations. Therefore, we strongly urge that CMS withdraw this

²⁹ 42 U.S.C. § 1315.

³⁰ 72 Fed. Reg. 2236, 2240.

ill-considered proposal altogether. If the rule goes forward, however, the following changes should be made:

- The preamble language quoted above should be replaced with a clear statement that the new regulations do not apply to waivers and demonstration projects like those in California and that, as a result, no adjustment to the budget neutrality limit will be necessary.
- CMS should either revise Sections 433.50 and 433.51 to address the issues identified above, **or** it should clarify that, notwithstanding these provisions, the University of California hospitals and Alameda County Medical Center can continue to fund the nonfederal share of Medi-Cal through CPEs and IGTs under the terms of the Hospital Waiver.
- CMS should either revise the regulations or otherwise clarify that neither CPEs nor IGTs need be drawn solely from tax revenue, as long as they are not derived from sources prohibited under Section 1903(w) of the Act, **or** it should clarify that the specific terms of the Hospital Waiver to this effect continue to apply in California.
- CMS should eliminate the proposed retention requirement in Section 447.207, **or** CMS should expressly state that the retention rule applies only to IGT funded payments and that it does not restrict the redistribution of federal dollars earned through public hospitals' CPEs as expressly allowed under the Hospital Waiver.
- CMS should eliminate the cost limit proposed in Section 447.206, **or** CMS should expressly state that federal Safety Net Care Pool funds will continue to be available for services to the uninsured under the authority of Section 1115(a)(2) of the Act, notwithstanding the new regulations.

III. Comments on other aspects of Notice of Proposed Rulemaking.

A. Collection of information.

The proposed regulations have three information collection requirements each of which raises issues of CMS' compliance with the requirements of the Paperwork Reduction Act of 1995 ("PRA").

The proposed Section 433.51 would require that CPEs be supported by auditable documentation on forms to be approved by the Secretary and that, at a minimum, the documentation identifies the relevant Medicaid category of expenditures; demonstrates the cost of providing services; and is subject to periodic audit and review by the State. CMS estimates that completion of the forms will require from 10-60 hours, for each provider depending on the size of the provider. CMS asserts it is unable identify the total number of affected providers or the aggregate hours of paperwork burden as it has not identified the number of providers who are governmentally operated.

CMS' assessment of the scope of the information collection burden is not based on a realistic assessment. The experience of public providers with the implementation of the

Hospital Waiver in California suggest that the estimate is unreasonably low. CAPH staff and members have spent hundreds of hours working with the State and attempting to implement the new CPE and cost-finding rules. At present, CMS has not developed the format or the criteria for approval of the form used to maintain the documentation required by its proposal. The PRA implementing regulations define “burden” to include reviewing instructions and training personnel to respond to the collection.³¹ Since the proposed Section 433.51 only sets out the minimum documentation requirements and leaves the development of the form of documentation subject to future approval, it is unlikely that CMS has fully assessed the extent of the paperwork burden associated with the requirement.

In addition to the documentation requirement imposed in the proposed Section 433.51, CMS also is proposing that each governmentally operated health care provider subject to cost reimbursement be required to file a cost report with the State Medicaid agency. The proposed Section 447.206 provides that methods for identifying and allocating costs will be determined by the Secretary. Many providers who are not currently subject to cost-based reimbursement will be required to file cost reports under the proposed rules. Because the cost identification and allocation methods have yet to be determined, the CMS paperwork burden estimates cannot be based on a realistic assessment of the extent of time necessary to comply with the new requirements. Again, the California experience suggests that the estimates set forth in the preamble are unreasonably low.

Finally, the CMS proposal also includes a notice that CMS intends to require each State to complete a questionnaire for each provider it claims is governmentally operated. In its submission to OMB, CMS estimates the paperwork burden associated with completion of the form to be approximately two hours per provider based on the assumption that the States will request that providers supply the information required in the questionnaire. To obtain OMB approval for a collection of information, CMS must show that its proposal is the least burdensome option necessary for the proper performance of the agency’s functions. The CMS OMB submission fails to set out any analysis of alternative approaches to obtaining the information that CMS believes necessary to determine State compliance with the relevant regulations.

CMS also must show that the collection of information has practical utility. Practical utility means the actual usefulness of the information to or for an agency taking into account its accuracy, validity adequacy and reliability.³² The form unsuccessfully attempts to face a complex legal analysis into a Q&A format. CMS has failed to demonstrate the practical utility of the information collected by the form. Moreover, the form itself is deficient in that it fails to provide the necessary context so that the person completing the form will understand the consequences of the answers.

³¹ See 5 C.F.R. § 1320.3(b)(1).

³² See 5 C.F.R. § 1320.3(l).

B. Regulatory impact statement.

CAPH also disagrees with CMS' regulatory impact analysis. The costly and burdensome administrative requirements taken together with the substantial reduction in Medicaid funding will unquestionably have a severe impact on patient care. The regulatory analysis discussed in the preamble fails to recognize the far-reaching consequences of the proposed rule. Because public hospitals represent a significant economic element of their communities, a substantial reduction in funding for the hospitals will likely have a ripple effect on the communities they serve. There is no indication that CMS has taken these adverse consequences into account. Most importantly, the rule is substantially more burdensome than necessary to address the alleged abuses that are the impetus for the rule. The rule is clearly not the least restrictive alternative available to CMS to address its policy goals.

IV. Conclusion

The proposed regulations will adversely affect the ability of CAPH members to continue to provide critically needed health services to the most needy in California. CMS' goal to eliminate state financing abuses, while important, does not support the broad limitations proposed in this rule. The rule would limit the state flexibility guaranteed by the Medicaid statute to set appropriate Medicaid payment rates and to use local funds for Medicaid. The loss of federal funding for the health care safety net in California under this rule will be devastating to the providers, the people they serve, and to the well-being of the State as a whole. CAPH urges you to withdraw this proposed rule.

Sincerely,



Melissa Stafford Jones
President and Chief Executive Officer

cc: Melissa Musotto, CMS
cc: Katherine T. Astrich, OMB