

Submitter : Mr. Bill Bedsole
Organization : Beaufort County Hospital
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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

Submitter :

Date: 03/19/2007

Organization :

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-194-Attach-1.DOC

CMS-2258-P-194-Attach-2.DOC

CMS-2258-P-194-Attach-3.DOC

CMS-2258-P-194-Attach-4.DOC

CMS-2258-P-194-Attach-5.DOC

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

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

Dear Ms. Norwalk:

On behalf of Archbold Medical Center, the safety net healthcare provider for a wide area of southwest Georgia, I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The rule, as proposed puts at risk some \$8.8 million in critical Medicaid payments for Archbold, funding that has been essential to our ability to provide healthcare services to all who need them.

Archbold Medical Center is a not-for-profit healthcare system comprised of five hospitals, four nursing homes, two home health agencies and a network of clinics and facilities that reaches across a wide area of southwest Georgia and north Florida. Our system hospitals are operated pursuant to long-term lease agreements with their respective hospital authorities. Archbold operates the only designated trauma center in southwest Georgia (the next closest is some 150 miles away), as well as a number of rural health clinics, and we serve a high percentage of Medicaid patients and a large number of uninsured citizens.

As a key safety net provider in our region of Georgia and as a member of the Georgia Coalition of Safety Net Hospitals, we strongly oppose the proposed rule, and respectfully request you to withdraw it immediately. This letter details the negative aspects of the rule and its negative impact on our health system and the patients who depend on us for their care.

As proposed, this rule would impose on states a new definition of a "unit of government" that would require generally applicable taxing authority in order to be considered governmental. Entities that are not units of government (or providers operated by units of government) would be prohibited from contributing funding to the non-federal share of Medicaid expenditures through intergovernmental transfers ("IGTs"). We oppose this

restrictive new definition and urge the CMS to allow states to determine which entities are units of government pursuant to state law.

For years, Georgia Medicaid has recognized our role as a safety net provider and has provided crucial financial support through Georgia's Indigent Care Trust Fund (ICTF) and through supplemental "upper payment limit" ("UPL") payments, totaling \$3.7 million in FY 2006. Georgia hospitals and health systems have long provided the non-federal share of these support payments through IGTs, and it is our understanding that CMS approved the transfers to help fund the Medicaid program. At the same time, Georgia restructured its IGT program in response to CMS concerns so that now none of the transfers exceed the non-federal share of the supplemental payments they support.

As a result of this proposed change, Georgia hospitals and health systems would no longer be able to support Medicaid payments through IGTs, and we stand to lose the very payments that have allowed us to so successfully serve as the safety net provider in our community. Our Indigent Care Trust Fund and UPL payments provide the financial backbone for so many of the services we provide that are unreimbursed or under-reimbursed. For example, in during FY 2006 we provided \$19.3 million in care to the uninsured, providing access to those who often have nowhere else to turn.

The impact to our facilities of the loss of these payments is unthinkable. More importantly, however, our patients – especially those on Medicaid or who are uninsured – are most likely to suffer from the loss of access to care that will result from this new policy. Georgia's IGTs are not abusive and have been approved by CMS. There is no justification for adopting a restrictive definition of "unit of government" that will simply deprive Georgia Medicaid of an important and legitimate source of local public funding. We urge you to defer to state law in the determination of "units of government."

We are equally opposed to the proposed rule's new cost limit on Medicaid payments to governmental providers. This limit puts hospitals in a box – either they are considered to be a private entity and, as such, are unable to provide IGTs to fund our supplemental payments, or they are considered to be governmental but subject to a limit to cost. This is an untenable "Catch-22" that again is unwarranted by the existence of any inappropriate financing mechanisms in Georgia – Georgia's IGTs have been deemed by CMS to be appropriate. Instead, the limit would impose an \$8.1 million cut to our Medicaid payments (which currently are based on Medicare rates). This cut, while not as substantial as the loss of all of the supplemental payments funded by IGTs that would result from a determination that the Hospital Authority is no longer governmental, would nevertheless be substantial. This aspect of the rule should be withdrawn as well.

Georgia recently established Georgia Healthy Families, a program to enroll Medicaid recipients into private care management organizations ("CMOs"). As CMO enrollment grows, it directly impacts our supplemental UPL payments, as CMS regulations prohibit states from providing supplemental payments for Medicaid patients who are enrolled in private plans. Based on preliminary projections of FY 2007 UPL payments, we expect to lose approximately \$1.7 million because of the loss of UPL payments associated with

CMO enrollees. One way to temper the cut that is being imposed by the Proposed Rule is to relax your regulatory prohibition on direct payments to providers for managed care enrollees (42 C.F.R. §438.6; 438.60). We urge you to consider this refinement to the regulation.

In summary, we are deeply concerned about the impact that the proposed rule will have on our institution and the essential services we provide to our community. The negative impact on our patients will be severe. We urge you to withdraw the regulation immediately.

Sincerely,

J. William Sellers, Jr.
Senior Vice President & CFO

CC: Congressman Bishop
Senator Chambliss
Senator Isakson

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

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

Dear Ms. Norwalk:

As administrator of Brooks County Hospital, I am writing to oppose the proposed Medicaid regulation published on January 18, 2007, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes significant Medicaid support payments for our hospital, funding that is key to our continued financial viability.

Brooks County Hospital is owned by the Brooks County Hospital Authority and is operated pursuant to a long-term lease management agreement with John D. Archbold Memorial Hospital. We also operate several rural health centers that provide key healthcare services to our community, and, last year, we provided more than \$781,000 in healthcare services to the uninsured, providing access to those who often have nowhere else to turn.

Overall, we estimate the Proposed Rule would result in a net loss of \$584,000 to Brooks County Hospital and our related healthcare entities.

Because of the drastic negative impact to our facilities and the patients who depend on us for their care, we strongly oppose the Proposed Rule and ask that CMS withdraw this proposed rule change.

Sincerely,

LaDon Toole
Administrator

CC: Congressman Bishop
Senator Chambliss
Senator Isakson

#194-3

**EARLY MEMORIAL HOSPITAL
EARLY MEMORIAL NURSING HOME**

11740 Columbia Street – Blakely, Georgia 39823

Phone (229) 723-4241

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

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

Dear Ms. Norwalk:

As administrator of Early Memorial Hospital, I am writing to oppose the proposed Medicaid regulation published on January 18, 2007, CMS-2258-P (“the Proposed Rule”). The Proposed Rule jeopardizes significant Medicaid support payments for our hospital, funding that is key to our continued financial viability.

Early Memorial Hospital is owned by the Early Memorial Hospital Authority and is operated pursuant to a long-term lease management agreement with John D. Archbold Memorial Hospital. We also operate a nursing home and several rural health centers that provide key healthcare services to our community, and, last year, we provided more than \$700,000 in healthcare services to the uninsured, providing access to those who often have nowhere else to turn.

Overall, we estimate the Proposed Rule would result in a net loss of \$1.5 million to Early Memorial Hospital and our related healthcare entities.

Because of the drastic negative impact to our facilities and the patients who depend on us for their care, we strongly oppose the Proposed Rule and ask that CMS withdraw this proposed rule change.

Sincerely,

Robin Rau
Administrator

CC: Senator Chambliss
Senator Isakson
Congressman Bishop

#194-4

GRADY GENERAL HOSPITAL

1155 5TH Street S.E. - P.O. Box 360 - Cairo, Georgia 39828-0360

Phone (229) 377-1150

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

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

Dear Ms. Norwalk:

As administrator of Grady General Hospital, I am writing to oppose the proposed Medicaid regulation published on January 18, 2007, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes significant Medicaid support payments for our hospital, funding that is key to our continued financial viability.

Grady General Hospital is owned by the Grady General Hospital Authority and is operated pursuant to a long-term lease management agreement with John D. Archbold Memorial Hospital. We also operate several rural health centers that provide key healthcare services to our community, and, last year, we provided more than \$2.4 million in healthcare services to the uninsured, providing access to those who often have nowhere else to turn.

Overall, we estimate the Proposed Rule would result in a net loss of \$1.4 million to Grady General Hospital and our related healthcare entities.

Because of the drastic negative impact to our facilities and the patients who depend on us for their care, we strongly oppose the Proposed Rule and ask that CMS withdraw this proposed rule change.

Sincerely,

Floyd Bounds
Administrator

CC: Senator Chambliss
Senator Isakson
Congressman Bishop

#194-5~

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

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

Dear Ms. Norwalk:

As administrator of Mitchell County Hospital, I am writing to oppose the proposed Medicaid regulation published on January 18, 2007, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes significant Medicaid support payments for our hospital, funding that is key to our continued financial viability.

Mitchell County Hospital is owned by the Mitchell County Hospital Authority and is operated pursuant to a long-term lease management agreement with John D. Archbold Memorial Hospital. We also operate a nursing home and several rural health centers that provide key healthcare services to our community, and, last year, we provided more than \$2.3 million in healthcare services to the uninsured, providing access to those who often have nowhere else to turn.

Overall, we estimate the Proposed Rule would result in a net loss of \$1.5 million to Mitchell County Hospital and our related healthcare entities.

Because of the drastic negative impact to our facilities and the patients who depend on us for their care, we strongly oppose the Proposed Rule and ask that CMS withdraw this proposed rule change.

Sincerely,

Mark Kimball
Administrator

CC: Senator Chambliss
Senator Isakson
Congressman Bishop

Submitter : Kenneth Robbins
Organization : Illinois Hospital Association
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-195-Attach-1.PDF



March 14, 2007

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

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

Dear Ms. Norwalk:

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

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

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

For Illinois, the impact of the proposed rules would represent a serious financial impact to hospitals and nursing homes providing healthcare for thousands of low-income, elderly, and disabled people throughout the state. Illinois' Governor has stated that this action would mean "a serious financial blow of \$623 million" to certain public hospitals in Illinois and to the State. The total negative impact to Illinois' Medicaid program could be even greater.

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

Limiting Payments to Government Providers

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

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

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

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

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

Insufficient Data Supporting CMS's Estimate of Spending Cuts

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

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

Sincerely,



Kenneth C. Robbins
President
Illinois Hospital Association

Submitter : Mr. Bryan Kindred
Organization : DCH Health System
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-196-Attach-1.DOC

#196

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW, Room 445-G
Washington, D.C. 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 deeply concerned about the recently proposed CMS rules (CMS-2258-P) that would severely impact Alabama's ability to fund its Medicaid program and am asking for your help to permanently withdraw this proposed rule.

If the rule is implemented as proposed, Alabama could stand to lose about one-fourth of our annual budget, a total of \$1 billion. This would occur because of the restrictions placed on funding from providers, approximately \$300 million, and the resulting loss of \$700 million in matching funds. The state certainly does not have the means to make up a loss of \$1 billion. Such a deficit would result in cuts in services to those in our state who can least afford to go without health care. In fact, since the vast majority of Alabama's Medicaid program is federally mandated, losing such a significant amount of the total funding could literally shut down the Medicaid program. In our area of West Alabama, the DCH Health System estimates a loss of funding of \$7.8 million.

The proposed changes restrict our state in terms of the way we can use funds to support the Medicaid program. Our most significant concerns include: (1) the limitation on reimbursement of governmentally operated providers; (2) the narrowing of the definition of public hospital; and, (3) the restrictions on intergovernmental transfers and certified public expenditures.

I believe the proposed rule is a significant change from long-standing Medicaid policy, and that CMS has not provided any data to support the need for the proposed restrictions. Alabama has received permission from CMS for 12 years to operate our Medicaid program as we currently are doing, and it would be devastating for CMS to retreat from its prior agreement with these new rules.

The Medicaid program has a long-standing history of being a partnership between the state government, the federal government and providers. These proposed rules would dramatically affect that partnership and have a significant impact on our state.

I oppose the rule and strongly urge CMS to permanently withdraw it. If the proposed rule is implemented, there will be drastic cuts in healthcare benefits for many of our citizens in Alabama.

Sincerely,

Bryan N. Kindred
President/CEO
DCH Health System

Submitter : Mr. Ray Whitmore
Organization : McCurtain Memorial Hospital
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attached Letter

CMS-2258-P-197-Attach-1.PDF



McCurtain Memorial Hospital

Working for a Healthier Community

March 16, 2007

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

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

Dear Ms. Norwalk:

On behalf of McCurtain Memorial Hospital, we appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals. The McCurtain Memorial Hospital opposes this proposed rule and would like to highlight the harm it would cause to hospitals and the patients we serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid programs. The rule further restricts how states reimburse safety-net hospitals. In addition, CMS fails to provide data justifying the need or basis for these restrictions. This unauthorized and unwarranted shift in policy will have a detrimental impact on providers of Medicaid services, particularly safety-net hospitals, and on patient access to care.

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

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

made by legislation, not by regulation. The Administration recognized this in its fiscal year 2006 budget submissions to Congress--it proposed that Congress pass legislation to implement the policy changes contained in this rule. We believe CMS is acting outside of its authority.

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

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

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

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

Since more than 26% of the patient revenue of McCurtain Memorial Hospital is from serving Medicaid patients, any reduction in reimbursement will significantly impair our ability to continue to provide needed services and invest in new technologies such as electronic medical records and digital radiology.

We urge CMS to permanently withdraw its proposed rule.

If you have any questions, please feel free to contact me at (580) 208-3104 or by email at cfo@mmhok.com.

Sincerely,



Ray B. Whitmore, Jr.
Chief Financial Officer
McCurtain Memorial Hospital

Submitter : Mr. William Cassels
Organization : DCH Regional Medical Center
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-198-Attach-1.DOC

#198

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW, Room 445-G
Washington, D.C. 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 deeply concerned about the recently proposed CMS rules (CMS-2258-P) that would severely impact Alabama's ability to fund its Medicaid program and am asking for your help to permanently withdraw this proposed rule.

If the rule is implemented as proposed, Alabama could stand to lose about one-fourth of our annual budget, a total of \$1 billion. This would occur because of the restrictions placed on funding from providers, approximately \$300 million, and the resulting loss of \$700 million in matching funds. The state certainly does not have the means to make up a loss of \$1 billion. Such a deficit would result in cuts in services to those in our state who can least afford to go without health care. In fact, since the vast majority of Alabama's Medicaid program is federally mandated, losing such a significant amount of the total funding could literally shut down the Medicaid program. In our area of West Alabama, the DCH Health System estimates a loss of funding of \$7.8 million. DCH Regional Medical Center alone will lose approximately \$5 million in Medicaid funds.

The proposed changes restrict our state in terms of the way we can use funds to support the Medicaid program. Our most significant concerns include: (1) the limitation on reimbursement of governmentally operated providers; (2) the narrowing of the definition of public hospital; and, (3) the restrictions on intergovernmental transfers and certified public expenditures.

I believe the proposed rule is a significant change from long-standing Medicaid policy, and that CMS has not provided any data to support the need for the proposed restrictions. Alabama has received permission from CMS for 12 years to operate our Medicaid program as we currently are doing, and it would be devastating for CMS to retreat from its prior agreement with these new rules.

The Medicaid program has a long-standing history of being a partnership between the state government, the federal government and providers. These proposed rules would dramatically affect that partnership and have a significant impact on our state.

I oppose the rule and strongly urge CMS to permanently withdraw it. If the proposed rule is implemented, there will be drastic cuts in healthcare benefits for many of our citizens in Alabama.

Sincerely,

William H. Cassels
Administrator
DCH Regional Medical Center

Submitter : Mr. Timothy Goldfarb

Date: 03/19/2007

Organization : Shands HealthCare

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-199-Attach-1.DOC

#199

March 17, 2007

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

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

Dear Ms. Norwalk:

On behalf of Shands HealthCare ("Shands"), I am writing to oppose the proposed Medicaid regulation published on January 18, 2007, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes over \$100 million annually in critical Medicaid support payments for Shands' hospitals, funding that has been essential to our ability to serve as a major safety net health care system in Florida.

The Shands HealthCare system includes two of Florida's six statutory teaching hospitals, a children's hospital, two specialty hospitals (psychiatric care and comprehensive rehabilitation), and four community hospitals. These hospitals serve patients from every county in Florida. Annually, Shands has more than 211,000 emergency room visits, 84,000 inpatient admissions, and more than 900,000 outpatient hospital visits. Shands' teaching hospitals in Gainesville and Jacksonville provide the primary sites for the University of Florida's clinical training programs. These facilities together with our community hospitals, are key components of Florida's health care "safety-net," providing high quality care for people who have little or no medical coverage. Indeed, Shands spends approximately \$150 million annually to provide charity and uncompensated care for Florida's needy residents. Shands cares for nearly one out of every two of the

Medicaid-eligible and uninsured patients in north Florida, assuming responsibility for more needy patients than any other health system in our area. The Shands HealthCare system is the only not-for-profit system in the Southeast that operates two Level I Trauma Centers. In addition to specialized trauma care, Shands operates a specialty burn care unit, representing a critical element for our national public health emergency preparedness. Only 125 such units exist nationally. Shands also offers comprehensive pediatric care, including a pediatric intensive care unit as well as Level II and III neonatal intensive care units. If this Proposed Rule becomes final as drafted, the resulting loss of funds for the Shands system would jeopardize our ability to provide these crucial services to residents of our state.

As the major safety net provider in north Florida, we strongly oppose the Proposed Rule, and respectfully request you to withdraw it immediately. Moreover, we endorse the comments on the Proposed Rule submitted to the Centers for Medicare and Medicaid Services (CMS) by the National Association of Public Hospitals and Health Systems on March 8, 2007 and those submitted by the Safety Net Hospital Alliance of Florida on March 13, 2007. Below we provide more detailed comments on specific aspects of the rule, along with a description of how we believe each of these provisions would impact our hospitals, our patients, and our community.

Defining a Unit of Government (§ 433.50)

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

Shands operates three formerly public hospitals – Shands at the University of Florida (in Gainesville), Shands Jacksonville, and Shands Lake Shore (in Lake City). All of these facilities are owned by public entities and leased to Shands. The public owners of the facilities (the University of Florida Board of Governors, the Lake Shore Hospital Authority, and the city of Jacksonville) chose to enter these leases to ensure the efficient operation of the hospitals and to enable these hospitals to better compete with the private hospitals in the area. Each of these hospitals provides critically needed high cost services regardless of a patient's ability to pay. As a result, if the hospital is unable to attract paying patients, as well as indigent patients, the hospital will be unable to afford to keep up with technology and maintain or expand the services it provides. Each of the public lessors required that Shands through these hospitals continue to provide care to the indigent residents of the counties that they serve.

The Proposed Rule threatens to undermine all of the good that we have accomplished through the reorganization of these hospitals. Medicaid has always recognized our

funding as public, and, in accordance with the statutory scheme established by Congress in Title XIX of the Social Security Act, has allowed our funds to be used as the non-federal share of Medicaid expenditures. The matching of our funds is a *critical* element of our operation, and the \$107 million in supplemental payments that we receive in connection with this match is essential to our ability to carry out the safety net role described above. Moreover, CMS has recently reviewed the IGTs we provide and has determined them to be an appropriate source of non-federal share funding. Given that we, like many of our counterparts across the country, are contributing to Medicaid expenditures through mechanisms that are not in any way abusive, it is unclear why CMS feels the need to adopt a restrictive definition of a unit of government.

Indeed, CMS has scrutinized and approved all sources of the non-federal share of Medicaid funding in Florida in the course of approving Florida's recently adopted Section 1115 waiver, which resulted in the creation of Florida's Low Income Pool program ("LIP") and significant Medicaid reform. The implementation of Medicaid reform in Florida is ongoing, and reliant upon the terms and conditions negotiated with CMS, which included the establishment of a CMS-approved alternative Upper Payment Limit ("UPL") program, the non-federal share of which is funded entirely by IGTs and CPEs that the Proposed Rule has placed in jeopardy.

If the funding contributed on behalf of Shands is deemed to no longer be public under this regulation, and if we are no longer able to support our Medicaid payments through our IGTs, we would stand to lose the very payments that have allowed us to so successfully serve as the backbone of the safety net in our community. Our Disproportionate Share Hospital ("DSH") payments and LIP payments provide crucial financial support for so many of the services we provide that are unreimbursed or under-reimbursed. For example, these supplemental payments enabled Shands to establish a Level I Trauma Center in north central Florida in 2005, a region of the state that had no trauma services at that time. Without these supplemental payments, Shands would not have been able to establish this costly new service.

The impact to our facility of the potential loss of these payments would be catastrophic. More importantly, however, our patients – especially those who are eligible for Medicaid or who are uninsured – are most likely to suffer from the loss of access to care that would result from this new policy. If our supplemental payments are reduced by more than \$100 million annually, as they would be under the Proposed Rule, Shands will likely need to reduce or eliminate services in order to maintain the overall quality of the services it provides.

Our funding mechanisms are not abusive and have been approved by CMS. There is no justification for adopting a restrictive definition of "unit of government" that will simply deprive the Florida Medicaid Program of an important and legitimate source of local public funding. We urge you to defer to state law in the determination of "units of government."

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

The preamble to the Proposed Rule asserts that health care providers making intergovernmental transfers of funds to the Medicaid agency “must be able to demonstrate . . . [t]hat the source of the transferred funds is State or local tax revenue” in order for the funds to receive federal match. This requirement that IGTs be derived from tax revenues is not repeated in the text of the regulation itself. We urge CMS to rescind this preamble statement.

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

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

The cost limit contained in the Proposed Rule does not specify whether it applies only to institutional providers or also to professional providers. The University physicians who practice in our teaching hospitals are public employees. If the cost limit applies to professional providers, it is unclear how to determine whether such providers are an “integral part” of a unit of government or are “operated by” a unit of government. Given the difficulties of calculating costs for professional services, a cost limit would be particularly inappropriate for professional providers. The additional administrative burden on the states and the affected professionals would exceed the value of the cost limit. We request that CMS clarify that the provisions of the Proposed Rule apply only to institutional providers, and not to professionals.

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

The preamble to the Proposed Rule states that “all Medicaid payments ... made under ... Medicaid waiver and demonstration authorities are subject to all provisions of this regulation.” (72 Fed. Reg. 2240). In 2005, our state negotiated an extremely complex Section 1115 demonstration program with CMS that we have been working hard to implement. The underpinning of this demonstration project is the establishment of the Low Income Pool and the phased implementation of Provider Service Networks, funding for which CMS authorized through its authority under Section 1115(a)(2) of the Social Security Act to provide federal financial participation. Florida’s demonstration waiver relies heavily on funds made available through elimination of certain above-cost payments to providers – specifically the elimination of certain supplemental UPL payments. Despite CMS’s recent review and approval of Florida’s program, the Proposed Rule would undermine Florida’s LIP program, cut payment rates to safety net providers, and eliminate approved sources of funding for the non-federal share of Florida’s Medicaid program. The Proposed Rule will thus compromise the ability of Florida’s safety net providers to serve Medicaid and uninsured patients. Florida’s Medicaid program will suffer substantial budget shortfalls with no apparent gain in fiscal

integrity, as CMS has repeatedly reviewed in detail the financing of Florida's program and found it to be legitimate.

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

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

CMS proposes to implement the Proposed Rule as of September 1, 2007 – an unreasonable schedule given the sweeping nature of the changes proposed. Assuming that a final regulation is not issued until this summer, states will have very little time to adopt the changes necessary to come into compliance. In Florida, for example, the Legislature is only in session during the months of March and April. Even if the Legislature convened a special session, it would have very little time to make all of the necessary appropriations and statutory changes for Florida's program to comply with the new regulatory requirements. Moreover, the Florida Medicaid agency would not have time to develop and obtain approval for any state plan amendments that may be required, nor to adopt changes to state rules and provider manuals.

Given the longstanding payment policies and financing arrangements that the Proposed Rule would disrupt, CMS should provide a generous transition period for states and providers to adjust to these enormous changes. We recommend a ten-year transition period.

* * *

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

If you have any questions about this letter, please feel free to contact Paul Rosenberg, Senior Vice President and General Counsel of Shands HealthCare at (352) 265-6995.

Very truly yours,

Timothy M. Goldfarb
Chief Executive Officer

Submitter : Ms. Maeghan Gilmore
Organization : National Association of County Behavioral Health a
Category : Other Health Care Professional

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-2258-P-200-Attach-1.DOC

#200

March 19, 2007

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



NACBHDD
National Association of County
Behavioral Health and
Developmental Disability
Directors

Dear Acting Administrator Norwalk:

The National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) urges the Centers for Medicare and Medicaid Services (CMS) to withdraw its proposed rule CMS-2258-P published on January 18, 2007 in the Federal Register. The proposed rule would restrict severely the ability of states and counties to finance health systems serving their most vulnerable populations.

NACBHDD members depend upon Medicaid to assist them in serving their communities. County and city governments and other local authorities are charged with assuring that essential mental health, developmental disability, and substance abuse services are provided to vulnerable and often disabled residents. County/city governments and local authorities contribute well over \$15 billion to behavioral health and developmental disability services. County/city governments and other local authorities in 22 states either directly or indirectly provide a range of behavioral health services (e.g. mental health, addictions, mental retardation and developmental disability services) to 70% of the U.S. population. In 18 states, county-sponsored behavioral health authorities ensure delivery of substance abuse services to 60% of the US population. County-sponsored local authorities are also responsible in 15 states for the delivery of developmental disability services that reach over 50% of the US population.

Given these service responsibilities and local financial contributions to the safety net, any reduction in federal support will shift costs to states and localities and place further stress on our systems of care.

Within recent years, through federal legislation and increased CMS audit activity, state Medicaid programs have been subjected to increased oversight. Individual state negotiations with CMS on state plan amendments and waivers have improved program integrity and eliminated questionable financing mechanisms and payment methods. The inability or unwillingness of CMS to identify publicly those states who are 'at-risk' or, alternatively, have Medicaid programs that will not be affected by the rule, has created tremendous programmatic uncertainty among many of our members. Long-standing Medicaid financing arrangements between the federal, state and local governments would be disrupted or eliminated under the proposal and the September 1, 2007 implementation date compounds the concern.

Vulnerable populations, including groups served by our members, often rely on local authorities for their health care. The proposed rule will weaken this safety net through a variety of mechanisms that have, to date, been approved by CMS.

Our specific comments follow.

Section 433.50: Basis, Scope and Applicability

Comment: The proposed rule would re-define a “unit of government”. NACBHDD believes that CMS does not have the authority to do so and should leave to states the authority to define such entities. Congress has given states the ability to determine which entities serve a governmental purpose and the flexibility at the state and local level to craft health systems and the methods used to finance them. The Medicaid statute gives Congress the explicit power to restrict or broaden the state and local sources of funding for use as the non-federal share for Medicaid. The use of the term ‘generally applicable taxing authority’ as a key determinant in qualifying payments as match disregards and undermines those long-standing arrangements.

Recommendation: CMS should withdraw its proposed definition of “unit of government.”

Section 433.51: Funds from Units of Government as the State Share of Financial Participation

Comment: The proposed rule would restrict the ability of state and local governments to raise funds for the non-federal share of Medicaid by further restricting the use of Intergovernmental Transfers (IGTs) to tax revenues and Certified Public Expenditures (CPEs) only for services documented and reimbursed under a Medicaid cost-based reimbursement method.

NACBHDD believes that CMS is again exceeding its authority granted by Congress. The statute (Section 1902(a)(2) of the Social Security Act) allows states to rely on “local sources” for up to 60 percent of the non-federal share of Medicaid expenditures. Only Congress may place limits on the types of local sources used.

Recommendation: CMS should continue to allow states and localities to determine the sources of public funding, within Congressionally-proscribed parameters enacted into law.

Section 447.206 Cost Limit for Providers Operated by Units of Government

Comment: The proposed rule 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.”

NACBHDD believes that this provision would have the effect of only covering the cost of the service provided, with no margin for enabling safety net providers to use funds to supplement coverage of the uninsured. The provision appears to target long-standing Disproportionate Share Hospital (DSH) payment mechanisms approved by CMS. A strict interpretation of the provision would appear to prohibit public providers from receiving

any Medicaid reimbursement for the uninsured or for costs associated with developing and maintaining the infrastructure necessary to serve them and not otherwise covered under the state plan. If more broadly interpreted, this provision appears to apply to all "payments made to health care providers that are operated by units of government" (Section 447.206(a)). In either case this provision would take much needed resources away from safety net providers, thus placing even further stress on state and local financing systems. If state and local governments are forced to redesign and refinance their DSH mechanisms, there will be fewer resources available to fund behavioral health and developmental disability services.

Recommendation: NACBHDD urges CMS to clarify that current demonstration waiver agreements providing payments for individuals or services not covered under a state's Medicaid plan are not pre-empted by this provision. NACBHDD further urges CMS to clarify that calculations of Medicaid "costs" includes all costs necessary to operate a governmental facility, including costs associated with the uninsured.

Section 447.206(g): Compliance Dates

Comment: The proposed rule on cost limits would become effective September 1, 2007. Other effective dates are not specified in the proposed rule.

Recommendation: NACBHDD assumes that the entire proposed rule would become effective September 1, 2007. If that is not the case, some of the 'clarifying' provisions related to the definition of units of government and others could be construed as having an immediate, and perhaps, retroactive effect. In any event, if CMS insists on proceeding with a final rule, NACBHDD urges that the implementation date be delayed or phased-in to allow states and localities sufficient time to make the necessary statutory and administrative changes necessary to comply.

On behalf of our membership, thank you for considering the views of NACBHDD.

Sincerely,

Margaret E. Hanna
Chair
National Association of County Behavioral Health and
Developmental Disability Directors
Executive Director
Bucks County, PA Drug & Alcohol Commission, Inc

Submitter : Mr. Barry Maram

Date: 03/19/2007

Organization : Department of Healthcare and Family Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2258-P-201-Attach-1.DOC



#201

Rod R. Blagojevich, Governor
Barry S. Maram, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

19 March 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services

[VIA ELECTRONIC MAIL]

Attention: CMS-2258-P
Mail Stop C4-26-05
P. O. Box 8017
Baltimore, Maryland 21244-8017

Dear Sirs:

The Medicaid program is a federal-State partnership intended to provide the neediest of our fellow citizens—low-income families, the elderly, and individuals with disabilities—with a medical safety net. This successful partnership facilitates access to affordable, quality healthcare for over two million Illinoisans. It is imperative that this partnership continue and flourish.

Enclosed please find Illinois' comments in response to your agency's notice of proposed rule making, published in the *Federal Register* on January 18, 2007. The proposed changes in regulation governing this critical federal-State partnership, if adopted, would severely impair the program in Illinois. I believe that these comments, and the Joint Comments submitted on behalf of a group of states, in opposition to the proposed changes in regulation provide compelling reasons for the Centers for Medicare and Medicaid Services to abandon the proposal.

I ask that these comments, and the Joint Comments submitted on behalf of a group of states, be given full and serious consideration.

Respectfully,

Barry S. Maram

cc: Governor Rod Blagojevich
Illinois Congressional delegation

**BEFORE THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES**

In the Matter of)
)
Proposed Medicaid Program Rules on)
)
COST LIMIT FOR PROVIDERS)
OPERATED BY UNITS OF)
GOVERNMENT AND PROVISIONS)
TO ENSURE THE INTEGRITY OF)
FEDERAL-STATE FINANCIAL)
PARTNERSHIP)
)

CMS-2258-P

COMMENTS OF THE STATE OF ILLINOIS

The State of Illinois submits these comments in response to the notice of proposed rule making, published in the *Federal Register* on January 18, 2007. The proposed regulations would severely impact the Illinois Medicaid program. Illinois has joined in Joint Comments submitted on behalf of a group of states in opposition to the proposed rules, and believes that those comments set forth compelling reasons for the Centers for Medicare and Medicaid Services (CMS) to abandon the proposal, which is without redeeming merit. Illinois submits these individual comments to identify areas in which the proposed regulations more specifically imperil the Medicaid program in Illinois.

I. The Illinois hospital reimbursement program

A. Public hospitals other than those operated by Cook County

The status of public hospitals in Illinois is determined under State law (*Illinois Compiled Statutes [ILCS]*)—in particular 55 *ILCS* 5/5-37001 *et seq.* (*County Hospitals Law*); 70 *ILCS*

910/1 *et seq.* (*Hospital District Law*); 50 *ILCS* 1/170 (*Township Code*, Township Hospitals); and 65 *ILCS* 5/11-23 *et seq.* (*Illinois Municipal Code*, Hospitals in Cities of Less Than 100,000).

Hospitals in counties with a population of over one million inhabitants are governed by the County Board of Commissioners (55 *ILCS* 5/5-37003). Under the *Hospital District Law*, voters in counties with one million or fewer inhabitants may petition for the creation of districts (70 *ILCS* 910/10). The hospital district is deemed a municipal corporation and has the power to collect a general tax on property in the district (70 *ILCS* 910/20). Townships with fewer than 500,000 inhabitants may, by referendum, establish a hospital (50 *ILCS* 1/170-10). City hospitals are established by petition of the voters of cities with populations of less than 100,000 (65 *ILCS* 5/11-23-1). There are currently 23 non-State public hospitals in Illinois (other than those operated by Cook County) that are organized under these statutory provisions.

The State compensates public hospitals established under the statutes cited above using a prospective payment system—either a *per diem* payment methodology or a diagnosis-related group (DRG) methodology that is based on the Medicare hospital prospective payment system. State law does not require the hospitals to conduct a Medicaid cost reconciliation. The State designed this payment methodology to provide public hospitals with an incentive to operate efficiently. These hospitals also receive disproportionate share hospital (DSH) adjustment payments to help defray their costs incurred in serving the uninsured. Limiting these hospitals to Medicaid cost would undermine the incentives inherent in a prospective payment system to operate efficiently and, thereby, to make the most economical use of their resources to fulfill their mission as safety net providers for their communities—given the limited funding available for DSH payments due to the allocation available to Illinois as a “low-DSH” state. DSH payments do not add significantly to assisting these providers to continue services to the

Medicaid and uninsured population. Neither intergovernmental transfers (IGTs) nor certification of expenditures (CPEs) are used in the financing of reimbursement to these hospitals.

The Board of Trustees of the University of Illinois is responsible for management, control, and operation of its hospitals, established under *University of Illinois Hospital Act* (110 ILCS 330/0.01 *et seq.*). Illinois compensates the University of Illinois Hospital for serving Medicaid patients, and for its costs of providing otherwise uncompensated care, on a cost basis. It utilizes CPEs as the basis for claiming federal funds for these payments.

The proposed regulation at 42 *CFR* 447.206, which would limit Medicaid reimbursement for public hospitals to the provider's actual cost of providing covered Medicaid services, could seriously impact the public hospitals throughout Illinois, and particularly those in the less populated areas of the state. Other than the University of Illinois Hospital and the three hospitals operated by Cook County, most of the public hospitals in Illinois are relatively small and are frequently the only source of inpatient care for Medicaid-enrolled and uninsured patients in their areas. The current payment methods not only encourage efficiency in the operation of these hospitals, but also provide an opportunity to acquire critical resources needed for them to remain viable. To limit payments to their cost (as determined under Medicare cost principles) could, in many cases, deprive these hospitals of revenues that could not be replaced.

There is no reason to impose such a risk on these hospitals. Their current reimbursement (prospective *per diem* or DRG) is based on methods that have been developed in both the Medicare and Medicaid programs over long periods of time and continue to be used for payments to private (non-government) hospitals. To deny to these public hospitals the opportunity for the same revenue stream that their private counterparts continue to receive is

counter-productive and bad public policy. Illinois strongly urges that the proposal to limit payments to public providers to cost be withdrawn.

The highly restrictive proposed rules relating to source of funds should not be adopted. Public, government-operated, hospitals in Illinois receive funding from multiple sources—taxes being but one such source—all of which legitimately contribute to the overall hospital operation. There is no legitimate federal interest in attempting to limit expenditures made by hospitals in support of the Medicaid patients, the uninsured, or charity care to those funded by tax dollars.

B. Cook County hospitals

Reimbursement for the hospitals operated by the Cook County Bureau of Health Services has historically differed from the manner of reimbursement of other hospitals, and reflects the sharing arrangement between Cook County and the State of Illinois for the non-federal portion of all Medicaid services provided to citizens of Cook County. That arrangement is carried out in agreements between the State and the County in which, through IGTs, Cook County resources are committed to the support of Medicaid services throughout the county.

Two elements of federal law, both enacted in the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)* (Pub. L. 106-554; 114 Stat. 2763 [2000]), contribute to the federal statutory authorization for this arrangement. The first is section 705, which required issuance by CMS of final regulations modifying the upper payment limit regulations applicable to hospital services, but established an eight-year transition period for the phasing out of arrangements then in place in certain states that would not have been permitted under the revised regulation. Pursuant to that provision, Illinois continues to make supplemental payments, albeit at a decreasing level of payments, to the hospitals operated by Cook County and Illinois continues to receive IGTs from Cook County. These funds are a local contribution to the

non-federal share of payments for Medicaid services provided to residents of Cook County. This transition will terminate as of September 30, 2008.

The second *BIPA* provision is section 701(d) (codified as a note to 42 *U.S.C.* 1396r-4), that authorizes additional DSH payments to a specified class of hospitals at a level of payment that increased over time and has now reached the permanent level of \$375 million in federal funds annually. These payments are without regard to the limits established in section 1923(f) and (g) of the *Social Security Act*, relating to DSH allotments and to payments not in excess of uncompensated cost, respectively.¹ Illinois is the only state that qualifies for the additional DSH payments authorized by this section. In connection with the payments made under this provision to the hospitals operated by Cook County, the county makes IGTs to the State measured by a percentage of the payment amounts.

The arrangements described above, between the State and Cook County, are authorized by federal statute and, thus, can not be altered by unilateral regulatory action. Illinois presumes that CMS does not intend, by its proposed regulations, to interfere with extant federal statutorily authorized arrangements between the State and Cook County. The proposed change to the inpatient hospital upper payment regulations (447.272) contains the qualification that the limitation of payments to cost does not apply to DSH payments and references the general statutory limits applicable to DSH payments. But it does not reference *BIPA* section 701(d), authorizing payments in excess of these limits. Nor does the proposed rule acknowledge the remainder of the transition period for non-qualifying payments pursuant to section 705 of *BIPA*

¹The statute expressly states that these additional payments are without regard to the DSH allotments otherwise established in statute. The non-applicability of the provision limiting DSH payments to uncompensated cost is implicit in the amount of funds authorized, and has been recognized by CMS as part of the approval of the Illinois State plan amendment implementing section 701(d).

(which is set forth in the current regulation at 447.272). While Illinois strongly urges CMS to withdraw the proposed regulations in their entirety, if they are adopted in any form they (or the preamble) must contain express reservations for the payments authorized by sections 701(d) and 705 of *BIPA*. Similarly, proposed section 447.207, if adopted, should contain exceptions for the *BIPA*-authorized arrangements that involve IGTs related to payments authorized by those provisions.

The proposed rule that providers must receive and retain the full amount of a payment is without justification, for the reasons set forth in the Joint Comments, and would cause enormous confusion and disruption in the financing and delivery of medical services by safety net providers in Illinois. In the context of Cook County and the State of Illinois, application of the proposed rule would interfere with the long standing and successful arrangement between the State and the County for the joint funding of Medicaid services throughout the county. For this reason, we believe is not in concert with section 1902(a)(2) of the *Social Security Act*, which recognizes that the non-federal share of Medicaid expenditures can be derived from county, as well as other public, sources.

The IGT arrangements in place between Cook County and the State allow Illinois to support safety net hospitals statewide, while still advancing the interests of Cook County. (See 146 *Cong. Rec.* E2124 [daily ed. Dec. 5, 2000] floor statement of Rep. Bobby Rush in introducing the predecessor to *BIPA* section 701[d], noting that Illinois and Cook County have “diligently and constructively used the IGT funding,” and urging passage of the provision to “allow Illinois, and all of the states, to continue to make inroads towards ensuring that an extensive safety net of hospitals and health care providers exist to provide care to the most vulnerable groups of society”). By sharing in the cost of providing Medicaid services to its

residents (through the IGTs covered by its agreements with the State), Cook County allows the State to direct more of its resources to the private providers in the county and the remaining parts of the state, thereby contributing to the safety net for needy citizens in the less populated areas as well as in Cook County itself.

II. Public nursing facilities

The same considerations that militate against adopting the proposed rules for hospital services apply in the case of other categories of Medicaid services. Currently, Illinois counties that operate nursing facilities contribute, through IGTs, to the non-federal share of payments made to those facilities. This contribution allows the State to make more efficient use of its own resources to support a more robust safety net for needy citizens throughout the State.

County-operated nursing facilities in Illinois receive payments based upon the Medicare reimbursement rates to those same facilities.² As in the case of Medicare providers (public as well as private), those facilities that are efficiently run may earn a profit (reimbursement in excess of cost) under a rate tied to the Medicare reimbursement methodology. Reimbursement in excess of cost is not a reason to withhold the full payment earned. Yet the proposed rule would overlay a cost limit on payments to these facilities, thereby removing incentives for efficiency and cost effectiveness.

CMS has recently approved an Illinois State plan amendment authorizing payments to county-operated nursing facilities at 94% of the Medicare payment rate with the understanding that the counties would be contributing, through IGTs, to the State a portion of the payment in an amount not to exceed the non-federal share. This amendment addressed all of the concerns

²Rates are set at 94% of the facility's Medicare reimbursement rate, to reflect that Medicare rates cover some services that Medicaid reimburses separately.

raised by CMS. This stands as a prime example of the federal-State partnership at work—as intended by the Congress through the Medicaid provisions of the *Social Security Act*. The ability of CMS to deal through the State plan process with what it perceived to be a financing problem, and to work with the State to craft a solution that met the fiscal concerns of both CMS and Illinois, demonstrates why there is no need for any regulation in this area, let alone the highly restrictive and inflexible regulation that CMS has proposed.

Conclusion

For the foregoing reasons, as well as those set forth in the Joint Comments, Illinois urges CMS in the strongest possible terms to withdraw its proposed regulations.

Respectfully submitted,

Barry S. Maram
Director of Healthcare and Family Services
State of Illinois

CMS-2258-P-202

Submitter :

Date: 03/19/2007

Organization : State of NJ, DMAHS

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-2258-P-202-Attach-1.DOC



#202

JON S. CORZINE
Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712
Telephone 1-800-356-1561

JENNIFER VELEZ
Acting Commissioner

ANN CLEMENCY KOHLER
Director

March 15, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention CMS-2258-P
Post Office Box 8017
Baltimore, Maryland 21244-8017

Re: File Code CMS-2258-P

This letter is intended to provide comments on the proposed rule "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of the Federal-State Financial Partnership" published in the Federal Register on January 18, 2007 beginning at page 2236.

The Centers for Medicare and Medicaid Services (CMS) believes the proposed rule "... strengthens accountability to ensure that statutory requirements within the Medicaid program are met in accordance with Section 1902, 1903 and 1905 of the Act." Unfortunately, the CMS proposal provides only minimal evidence of perceived necessity and no explanation of program benefit. The proposal attempts to accomplish the vague objective by assuming questionable authority and creating extensive additional burdens on the Medicaid program. Even assuming a sufficient need for the proposed regulations, the CMS approach only transfers the agency's responsibility to the States. Enactment of the proposed regulations will needlessly reduce State resources available for the provision of medical assistance to needed individuals.

Comments on the proposed regulations are provided below:

I. Background:

At page 2238, in regards to intergovernmental transfers (IGT), CMS states that

- claimed expenditures must be net of any redirection or assignment from a health care provider to any State or local governmental entity that makes IGTs to the Medicaid agency;
- the source of transferred funds from a governmentally operated health care provider must be from tax revenue; and

- the provider retains the full Medicaid payment and is not required to repay any portion of the Medicaid payment to the tax revenue account.

Without additional clarification or modification, these provisions appear contradictory and will restrict appropriate funding for governmental providers. For example, this language appears to preclude transfers from governmental providers, but later lists specifications for allowable transfers. Additionally, all providers receive Medicaid reimbursement only after incurring the cost for the provision of medical services. Consequently, governmental providers routinely return Medicaid payments to the entity that provided the initial funding. Further, governmental health care providers are expected to minimize the use of tax revenues and will generate revenue from many sources such as health insurance coverage, the sale of unneeded assets, waste products or services or private donations and fund raising activities. Once received, these revenues become public resources available to support the providers' operations exactly like tax revenues. The need to differentiate between the sources of funds available to a governmental provider is unclear and appears to be an unnecessary administrative burden.

CMS reaches the conclusion that requirement that a governmentally-operated health care provider transfer to the State more than the non-federal share of a Medicaid payment creates an arrangement in which the net payment to the provider is necessarily reduced; the provider can not retain the full Medicaid payment claimed by the State. Without additional clarifying information or specific examples of the application of the proposed requirements this conclusion can not be supported.

The principles explained in this section of the proposed rules are not reflected in the specific amendments to the existing regulations beginning at page 2246 of the applicable federal register. The proposed criteria applicable to intergovernmental transfers should be specifically included in the appropriate sections of the regulations.

At page 2239, related to certified public expenditures (CPE), CMS indicates that a claimable expenditure must involve a shift of funds (either by an actual transfer or a debit in the accounting records of the contributing unit of government and a credit in the records of a provider of medical care or services) and can not merely be a refund or reduction in accounts receivable. This restriction is unclear and does not appear necessary for the purpose stated. The premise of a CPE generally excludes the actual transfer of funds between the Medicaid agency and a governmental provider. Likewise, there appears to be no necessity for the specific processing of accounting transactions as indicated. For example, it is common practice for governmental providers to be directly funded by legislative appropriations and/or recurring revenues. These providers certify allowable Medicaid expenditures through the submission of claims for covered services. These claims are valued at the prevailing Medicaid reimbursement rate in accordance with the approved Medicaid State Plan and support the State's claim for FFP. There should be no need for further accounting transactions by the provider or

any other governmental entity. To the extent this requirement is intended for a different purpose, the proposal should include additional explanations or examples.

The proposal states that a CPE equals 100 percent of a total computable Medicaid expenditure. This is not accurate. A certifying governmental unit may fund all or part of the cost of the applicable component of the Medicaid program. For example, a governmental provider or entity may be responsible for funding the cost of prospective rate increases while the State Medicaid agency continues payments at the base period rate. This governmental provider or entity could appropriately certify or fund a portion of the total computable amount of the Medicaid expenditure.

The proposal allows a governmental provider to certify costs only if the State Plan contains an actual cost reimbursement methodology. This is an unnecessary restriction that is not reasonably supported in the proposal. It is common for Medicaid reimbursement to be based on prospective payment systems or a fixed fee-for-service. These reimbursement rates have long been acceptable methods to reimburse efficient and effective providers for the cost of providing specific service units regardless of the provider's actual costs. In the case of such reimbursement rates established in accordance with the approved State Plan, it is appropriate for a governmental provider to certify that the allowable Medicaid costs for purpose of claiming FFP equals the total services provided at the approved rate. A common approach is for a governmental provider to submit claims for specific services to be processed through the Medicaid reimbursement systems and valued at the reimbursement rate allowed in the Medicaid State Plan. These processed claims subsequently support the State's claim for FFP. The requirement to utilize an actual cost reimbursement process in these cases would increase the cost to the Medicaid program if the existing prospective or fixed rates are less than actual costs. The administrative burden needed to convert existing reimbursement processes is surely an additional cost that appears unnecessary in this case.

At page 2239, State and Local Tax Revenue, the proposal indicates in order for State and/or local tax dollars to be eligible as the non-Federal share of Medicaid expenditures that tax revenue can not be committed or earmarked for non-Medicaid activities. This provision requires further clarification. Since Medicaid activities are most specifically defined in federal statute or regulation, it is likely that State or local appropriations are not precisely related to Medicaid activities. Instead, the applicable allotments of tax revenues are committed for State or locally defined purposes such as public assistance programs that include Medicaid and other activities or Medicaid and other needy individuals. For example, appropriations to governmental providers will reflect the funds available for salaries, utilities, food, etc. Departmental Appeals Board decisions recognize the distinction between expenditures for these items and the accounting entries that determine Medicaid expenditures available for FFP. Governmental appropriations are routinely committed or earmarked for the former while FFP is applicable only to the latter.

This part of the regulation also specifies that tax revenue that is contractually obligated between a governmental entity and health care providers to provide indigent care is not considered a permissible source of non-Federal share of funding for purposes of Medicaid payments. Since many allowable Medicaid payments could appropriately be traced to contractual obligations between governmental entities and providers for the care of indigent patients, this restriction should be clarified or changed. It is likely that many governmental entities contract with providers for indigent care and subsequently identify the Medicaid eligible patients and submit claims for reimbursement or appropriately certify expenditures for claiming FFP. The preclusion of this use of tax revenue as the non-Federal share of Medicaid funding appears unreasonable.

II. Provisions of the Proposed Rule

The beginning of this portion of the proposal indicates the preceding background section conveys critical information about the statutory and regulatory context of this proposal. This statement appears to indicate that portions of the background section include information necessary for an appropriate understanding of the proposed regulations. Since the background section is not clear in many respects, this statement should not be included under this heading. Likewise, this statement appears to indicate that the language of the proposed regulations could not be understood in the absence of the information contained in the background section. Since the information from the background section of this proposal will not be readily available after publication of the regulations, this statement should not be included with provisions of the proposed rule. Likewise, critical information in other sections of the proposal should be included in the regulatory revisions.

The proposal subjects all Medicaid payments (including disproportionate share hospital payments) to all provisions of the regulations. Since disproportionate share hospital (DSH) payments are subject to additional specific requirements, it is not appropriate to subject these payments to every provision of these regulations. For example, DSH payments are subject to separate hospital specific limits that apply equally to private and governmental providers. As reflected in section 447.272 of the regulations, not all of the proposed regulations will apply to DSH payments. As mentioned in comments on previously regulations in this regard, the hospital specific DSH limit must be determined on a prospective basis. Any requirement to apply retrospective limits on DSH payments will adversely impact States' ability to appropriately access available funds. Since DSH funding is limited on an annual basis, States must determine an appropriate DHS allocation at the beginning of the year with respect to the applicable limits.

The proposal at page 2240 indicates that providers that assert status to make IGTs or CPEs must demonstrate they are a governmental entity through a showing of access to taxing authority or tax revenues. However, the regulations greatly exceed this proposal by requiring a similar demonstration by all governmental providers regardless of any assertion to make IGTs or CPEs. Consequently, the regulations will impose significant burdens beyond the intended purpose or need in this regard.

The regulatory impact analysis that accompanies this proposal indicates that CMS has access to information that details the governmental status of health care providers. Since the proposed regulatory requirements duplicate information currently available, CMS should withdraw this unnecessary and wasteful requirement.

Beginning on page 2240, the proposal explains provisions related to Sources of State Share and Documentation of Certified Public Expenditures. This section indicates the 'plain meaning of the Act' precludes not-for-profit entities from financing the Medicaid program. This appears to be a crucial concern prompting this proposal. However, there is no support provided for this opinion in this section of the proposal. Assuming the statutory intent is so clear in this regard, CMS should include the relevant statutory provisions supporting this conclusion here to avoid potential misunderstandings.

Appropriate documentation to support CPEs is mentioned in the proposal. However, the proposal does not specify what is considered appropriate documentation and indicates that required forms will be issued in the future. Consequently, it is not possible to fully respond to this portion of the proposal. CMS should withdraw this requirement until the specific requirements and/or forms can be developed. Otherwise, States, other government agencies and/or providers may develop and implement procedures that will have to be abandoned or extensively modified in the future. This situation would add unnecessary and wasteful costs to the program.

This section of the proposal appears to indicate that four additional, specific requirements will be implemented to support CPEs. CMS should consider how other requirements and regulations impact this issue and avoid duplicative requirements and regulations. For example, other portions of this proposal require specific documentation of the governmental status of providers. If this documentation supports the governmental status of the provider, an additional need to separately demonstrate that the provider is beyond the scope of the limitations on provider taxes and donations appears duplicative and wasteful. Likewise, governmental entities are routinely audited for various purposes, this additional auditing requirement appears unnecessary. CMS should withdraw this requirement until a thorough analysis of existing requirements is completed.

The proposal seeks to specify the costs that may be included or must be excluded from a CPE. However, these prescriptions may impact legitimate processes used for the reimbursement of medical services. For example, some governmental providers currently account for Medicaid costs through the submission and processing of individual claims for medical services. These claims are routinely valued at rates that may not strictly comply with these requirements. It is reasonable to calculate Medicaid reimbursement rates based on allocations of some costs from surveys of providers or overall averages of the costs of providing services inclusive of non-Medicaid populations. CMS should withdraw these requirements until the impact on legitimate reimbursement processes is determined.

This section reiterates that a CPE for less than 100% of the total computable cost is unacceptable. As explained previously, this provision will exclude otherwise allowable CPEs and should be deleted.

The section, Cost Limit for Providers Operated by Units of Government beginning on page 2241 specifies the limit on Medicaid payments to individual governmental providers. The stated purpose of this change is compliance with the requirements of the Act. Since the overall limit for the applicable service should not be materially impacted by this proposal, it is not possible to understand how this change affects better compliance with the Act. Likewise, the change appears arbitrary since other provider groups subject to the same statutory provisions are not impacted or considered. CMS should withdraw this proposal or provide additional explanation to support the opinion this regulatory change is required.

The proposal indicates the applicable cost limits will need to be supported by standard, auditable, nationally recognized cost reports such as the Medicare cost report, where available. However, due to the application of prospective payment and other reimbursement methods, it appears these cost reports are becoming increasingly irrelevant to the amount of individual provider reimbursement and may not be reliable for this purpose. It is not clear that there is a consistent use, review or audit of these reports even by the Medicare program. Consequently, there is an increasing probability for these reports to contain errors and/or omissions. CMS should allow for other means to document provider costs in the event alternative sources prove more accurate and reliable.

The regulations will require the development and submission of annual Medicaid specific cost reports to the Medicaid State Agency by each, individual governmental provider. This requirement appears unnecessary and wasteful in situations where governmental providers are reimbursed through prospective payment systems or by a fee-for-service. Assuming a reasonable rate setting methodology in these cases, the development, preparation, submission, review, etc. of individual cost reports does not appear necessary. The proposal should provide reasonable alternatives to support provider costs or additional support of the burdensome approach specified.

The proposal requires an annual reconciliation of governmental provider costs and Medicaid reimbursement. As indicate above, this is an unnecessary and wasteful requirement in many instances. The proposal should provide reasonable alternatives to support provider costs or additional support of the burdensome approach specified.

At page 2242, the proposal describes the requirement that providers receive and retain the full amount of the total computable payment. This provision is confusing. This provision appears to preclude CPEs by a governmental provider. Specifically, a governmental health care provider that expends funds for salaries, utilities, food, etc. in the provision of medical services and certifies an expenditure eligible for FFP will not receive a payment. Consequently, this provision should be withdrawn or modified.

The proposal intends to eliminate section 447.271(b) of the regulations. The proposal indicates that the regulation becomes irrelevant due to the new cost limits included in the rule. However, the existing regulation is related to limitations based on provider charges and not provider costs. This regulation allows Medicaid payments in excess of a provider's charges if those charges are nominal or do not exist. Eliminating this provision would restrict Medicaid reimbursement to nominal charge providers or require them to implement unnecessary or artificial charge structures. The proposal to eliminate this regulation should be withdrawn.

Page 2242 of the proposal includes a new tool to evaluate the governmental status of providers. This tool is a separate questionnaire that will need to be completed for each governmental provider initially and with each State Plan Amendment. As indicated above, it appears CMS currently collects information concerning the governmental status of health care providers. Since the proposed regulatory requirements duplicate information currently available, CMS should withdraw this unnecessary and wasteful requirement.

III. Collection Information Requirements

This section of the proposal seeks comments related to the proposed information collections requirements related to CPEs, cost limitations for governmental providers and the tool to evaluate the status of governmental providers. Since many of the specific requirements for these information collection activities are yet to be determined, it is not possible to determine the reasonableness of the projections provided by CMS. It is likely the workload projections are significantly understated. For example, CMS projects a provider will take 10 to 60 hours to submit an annual cost report to the Medicaid agency. However, providers currently spend hundreds of hours preparing and submitting the Medicare cost reports. This is the only report specified in the current proposal. In addition, CMS does not include the effort that will be required to develop and implement new cost reporting procedures beyond the Medicare cost reports.

CMS indicates that States will require 1 to 10 hours to review provider cost reports. This estimate is likely understated and does not include recognition of the audit requirements imposed under the regulation. CMS should expand their analysis of this subject including review of current Medicare cost report preparation, review and audit activities and modify the proposal to reflect more accurate information.

V. Regulatory Impact Analysis

The regulatory impact analysis (RIA) prepared for this proposal indicates CMS projects reductions in Medicaid program expenditures. However, there are no details of this calculation and no indication of the additional administrative burdens placed on States, other governmental entities and/or providers. Consequently, it is not possible to determine the reasonableness of the estimates and therefore, the necessity for the

proposed regulations. Likewise, any serious analysis of alternatives is hampered by this lack of information.

The impact of the proposed regulations in the State of New Jersey will be a significant increase in Medicaid program costs. CMS has not indicated there are any areas of concern in New Jersey related to the issues raised in the proposed regulation. Likewise, state staff has not identified any areas that would be directly impacted outside of the onerous administrative requirements proposed. However, based on a cursory review of the number of governmental providers enrolled in the Medicaid program and the understated workload estimates in the proposal, more than 20,000 man hours will be required in New Jersey to initially comply with this regulation. This additional burden will be detrimental to the citizens of New Jersey and should be afforded additional consideration.

Based on the concerns mentioned above, it is not possible to support the conclusion of the proposed regulation. The need and purpose for the proposed regulations is not adequately explained. Therefore, the proposed regulatory changes can not be appropriately evaluated and it is difficult to identify appropriate, less onerous and costly alternatives. Additionally, the regulations include related administrative burdens that may be unnecessary if existing methods and operations are considered. As a result, the proposed regulations should be withdrawn until additional information is compiled and adequate analysis conducted.

Sincerely,
Ann Clemency Kohler
Director

Submitter : Mr. Douglas Florkowski
Organization : Lawrence County Memorial Hospital
Category : Critical Access Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk,

As the CEO of a small, rural hospital, I am writing you to express my opposition to the proposed Medicaid cuts.

Our hospital is required to provide services to the medicaid population and is reimbursed significantly less than the cost to provide the care. This gap should be so alarming to the point that additional cuts to this program would not only be absurd but considered insane. Currently, my hospital receives 20 cents on the dollar for every Medicaid patient we see and we receive payment 6-7 months after the care was provided!

What other businesses are required to operate in such an environment let alone one as important as healthcare? Considering this, CMS wants to reduce funding?

This proposed rule is terrible for hospitals and patients. How many hospitals will it take to close before CMS wakes up and recognizes the consequences for their actions?

Lawrence County Memorial Hospital opposes the rule and strongly urge that CMS permanently withdraw it.

Respectfully,
Douglas Florkowski
Chief Executive Officer
Lawrence County Memorial Hospital

Submitter : John Erwin
Organization : Conference of Boston Teaching Hospitals
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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

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

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

Submitter : Mr. Lester Robertson

Date: 03/19/2007

Organization : Sunny Acres Home

Category : Long-term Care

Issue Areas/Comments

**Collection of Information
Requirements**

Collection of Information Requirements

The proposed rule to limit certain payments to costs creates a double standard of reimbursement between government and non-government providers. Non-governmental providers could be paid above costs, while government providers could not.

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

Relating the reimbursement to cost only and not allowing for a profit would be devastating to facilities in states that do not adjust each year for the real costs to provide services to the frail and elderly. Illinois is the lowest reimbursement state in the union and at times does not even use the latest cost from the latest available cost reports.

Submitter : Mrs. Karen Clark

Date: 03/19/2007

Organization : St. Mary's Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please oppose CMS-2258-P. This legislation will seriously impact hospitals and nursing homes in providing care to thousands of low-income, elderly and disabled people. The current program is totally inadequate in the State of Illinois and this legislation will cut \$3.97 billion over 5 years. Totally unheard of. You might as well not pay us anything to take care of these people. Now we only get 42 cents on a dollar of cost! This legislation will be a serious financial blow to the State of Illinois. We are supposed to be expanding health care coverage for the uninsured. How can we do that with no funding. Please do not support this legislation. Thank you.

Submitter : Ladon Homer
Organization : Texas Medical Association
Category : Health Care Provider/Association

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2258-P-207-Attach-1.PDF



Physicians Caring for Texans

March 19, 2007

The Honorable Michael O. Leavitt, Secretary
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear Secretary Leavitt:

On behalf of the 42,000 physician and medical student members of the Texas Medical Association, I am writing to convey our opposition to two initiatives recently proposed by the Administration. At issue are the proposed rules to limit federal payments to safety-net providers -- CMS-2258-P: *Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership* (published in the *Federal Register* on January 18, 2007) -- and the President's budget proposal to eliminate administratively the federal Medicaid payments for Graduate Medical Education (GME).

Medicaid insures nearly 3 million Texans. Unfortunately, Medicaid payments are inadequate to cover the costs of caring for the population. Without supplemental federal payments to offset these losses, it would not be possible for hospitals to continue to invest in resources that communities depend upon to care for the least and sickest among us.

With respect to the proposed rules, TMA shares the view of Texas public hospitals and medical schools that the initiative threatens the ability of safety net institutions to provide needed services not only to Medicaid patients, but to all Texans who depend on these facilities for critical services such as trauma, burn, and neonatal intensive care. Under the proposed rule, the public hospitals in Texas' ten largest communities will lose a combined \$557.6 million annually in supplemental payments and \$338.4 million annually in federal Medicaid funds.

Additionally, we believe the proposed rule will undermine legislative momentum to reduce the number of uninsured. As you know, Texas is the uninsured capital of the nation. Some 5.6 million Texans -- 12 percent of the national total -- lack health insurance. The Texas legislature is currently debating a variety of mechanisms to increase coverage. The most promising proposals rely on the continued financial partnership between the state and federal governments to use Medicaid dollars as a financing tool to expand coverage -- such as low-income or safety-net pools approved in other states. Should the federal government prevent Texas from availing itself of supplemental funding, Texas taxpayers will not be able to fill the void, thus stifling the mutual goal of expanding affordable coverage to low-income patients.

The rule also would foreclose additional opportunities to use Upper Payment Limit (UPL) dollars to improve reimbursement rates for physicians affiliated with state medical schools. CMS recently approved a state plan amendment to allow UPL funds for physician faculty members affiliated with the University of Texas, University of North Texas and Texas Tech System. Similar state plan amendments are under consideration. With fewer than 40 percent of Texas physicians participating in Medicaid, these dollars are a vital part of the state's efforts to rebuild the physician Medicaid network. Additionally, all physicians, regardless of any formal affiliation with a public medical school or teaching hospital, benefit from having financially secure safety-net institutions as partners in caring for the state's uninsured.

TMA Letter to Secretary Leavitt
March 19, 2007
Page 2

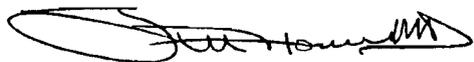
Regarding the President's fiscal year 2008 budget proposal, we urge the Administration to reconsider elimination of matching dollars for Medicaid Graduate Medical Education. Compared to other large states (New York, California, and Pennsylvania), Texas has fewer GME slots, virtually guaranteeing some medical students will be forced to leave the state upon graduation. Given the strong relationship between location of GME training and entrance into practice, those leaving will likely not return to Texas. Without more GME slots, Texas will not be able to meet the health care needs of its booming population, including Medicare and Medicaid enrollees.

TMA is currently working closely with the state lawmakers to improve GME opportunities. Legislators are considering a GME funding package that includes, among other initiatives, restoration of state Medicaid GME dollars eliminated in 2003 as a result of a state budget shortfall. Restoring the state's share of Medicaid GME -- \$81 million -- would result in \$206 million all funds to invest in the GME infrastructure and to support our efforts to ensure a robust physician workforce.

Lastly, we would be remiss if we did not take the opportunity to express our strong support for reauthorization of the State Children's Health Insurance Program. CHIP plays a vital role in insuring low-income children of hard working families. Currently, there are 325,479 Texas CHIP enrollees, though TMA is advocating vigorously in favor of bipartisan state legislation to increase that number. Of the 1.4 million uninsured Texas children, about 700,000 are estimated to be eligible for CHIP or children's Medicaid. Covering them would reduce the number of uninsured Texas children by half. To achieve this goal, CHIP must be sufficiently funded. We urge you to support funding levels that will not only allow states to maintain coverage for current enrollees but to expand coverage to children who are eligible but not yet enrolled.

Thank you for your timely consideration of our concerns. We stand ready to work with you to develop innovative measures that achieve our mutual goals of affordable, timely health care.

Sincerely,



Ladon W. Homer, MD, President
Texas Medical Association

LWH:hkd

cc: Texas Congressional Delegation
The Honorable Rick Perry
Albert Hawkins, Executive Commissioner, Texas Health and Human Services Commission

Submitter : Mr. Farrel Marx
Organization : Central Utah Counseling Center
Category : Local Government

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

see attachment

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

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

Submitter : Mrs. Krista Stone
Organization : Van Matre HealthSouth Rehabilitation Hospital
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-209-Attach-1.DOC

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March 19, 2007

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

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

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

For Illinois, the impact of the proposed rules would represent a serious financial impact to hospitals and nursing homes providing healthcare for thousands of low-income, elderly, and disabled people throughout the state. Illinois' Governor has stated that this action would mean "a serious financial blow of \$623 million" to certain public hospitals in Illinois and to the State. The total negative impact to Illinois' Medicaid program could be even greater.

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950 South Millford Road, Rockford, IL 61108 (815) 381-8500

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

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Limiting Payments to Government Providers

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

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

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

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

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

Insufficient Data Supporting CMS's Estimate of Spending Cuts

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

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

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Sincerely,

Krista Stone
Accounting Manager
Van Matre HealthSouth Rehabilitation Hospital

Deleted: Kenneth C. Robbins
President
Illinois Hospital Association

Submitter : Ms. Karen Hendren
Organization : Stillwater Medical Center
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comment letter from Stillwater Medical Center, Stillwater, OK

CMS-2258-P-210-Attach-1.PDF

CMS-2258-P-210-Attach-2.PDF

March 16, 2007

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

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

Dear Ms. Norwalk:

On behalf of Stillwater Medical Center, we appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals. Stillwater Medical Center opposes this proposed rule and would like to highlight the harm it would cause to hospitals and the patients we serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid programs. The rule further restricts how states reimburse safety-net hospitals. In addition, CMS fails to provide data justifying the need or basis for these restrictions. This unauthorized and unwarranted shift in policy will have a detrimental impact on providers of Medicaid services, particularly safety-net hospitals, and on patient access to care.

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

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

Congress pass legislation to implement the policy changes contained in this rule. We believe CMS is acting outside of its authority.

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

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

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

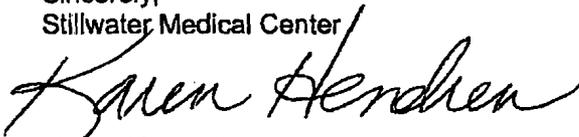
Today, our state—Oklahoma—has one of the lowest health statuses of any state in the United States; we have one of the highest proportions of uninsured in the country; we have already eliminated a very short lived IGT program; we are trying to implement a Medicaid waived program to reduce the number of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

We urge CMS to permanently withdraw its proposed rule.

if you have any questions, please feel free to contact me at 405-742-5729 or by email at

khendren@stillwater-medical.org.

Sincerely,
Stillwater Medical Center



Name Karen Hendren
Title COO
Address PO Box 2408 Stillwater, OK 74076

Submitter : Mr. Patrick Finnerty
Organization : Department of Medical Assistance Services
Category : State Government

Date: 03/19/2007

Issue Areas/Comments

**Collection of Information
Requirements**

Collection of Information Requirements

See attachment.

GENERAL

GENERAL

See attachment.

CMS-2258-P-211-Attach-1.DOC

211



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

PATRICK W. FINNERTY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804-786-7933
800-343-0634 (TDD)
www.dmas.virginia.gov

March 19, 2007

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

Re: CMS-2558-P

Dear Ms. Norwalk:

DMAS is commenting on the proposed rule published January 18, 2007 on the "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership." DMAS is the single state agency responsible for the administration of the Medicaid program in the Commonwealth of Virginia. DMAS opposes the proposed rule and strongly urges CMS to withdraw it.

DMAS does not believe that the proposed rule is necessary in any way to ensure the integrity of the federal-state financial partnership. Over the last several years, CMS has addressed the issues it is concerned about in regards to certain intergovernmental transfers and certified public expenditures. The rule unreasonably interferes with the state determination of public entities and unfairly discriminates against those public entities. The proposed rule unreasonably limits reimbursement to public providers and imposes unnecessary cost reporting requirements on public providers. The proposed rule is far reaching and would have unintended consequences.

Determination of Government Providers

Despite careful efforts to read Sec. 433.50 of the proposed rule, DMAS cannot determine whether some providers will be determined to be "government units." Several traditional "public" providers do not appear to meet the definition. It appears possible

Ms. Leslie Norwalk

March 19, 2007

Page 2

that the rule may also create inconsistent treatment among similar providers. In Virginia, for example, mental health authorities may be organized in three different ways authorized by the Code of Virginia. As a result, DMAS cannot determine whether all, some or none of the mental health authorities in Virginia will be considered government units. In some ways, however, the proposed rule is so broad that it would include even county or city ambulance services that provide emergency transportation.

It appears that CMS will make the final determination if a provider meets the new definition of a government unit, but it is not clear how a provider, or the state, could appeal the determination. Such a determination could have a significant positive or adverse impact on a provider depending on the provider's circumstance and there should be an avenue of appeal.

Limitations on Reimbursement for Government Providers

During the last few years, CMS has asked states five funding questions during every review of a SPA related to reimbursement. The last question asks if any public provider receives payments that in the aggregate exceed their reasonable cost of providing services and, if they do, does the state recoup the excess. DMAS' response indicated that this was not required by Federal law or regulation. While CMS may modify its regulations, it has not demonstrated that payments that exceed reasonable costs are "excess" payments.

The current UPL for government providers of inpatient and outpatient hospital, nursing home, ICF-MR and clinic services is what Medicare would have paid. For other services, CMS has limited reimbursement to what commercial insurers pay based on Sec. 1902(a)(30) of the Social Security Act that payments should be consistent with efficiency and economy. Neither standard is based on costs. CMS does not propose to change the upper payment limit for private providers. The current UPL seems perfectly reasonable to DMAS. We don't understand why what is acceptable for Medicare is too generous for Medicaid. It seems like the existing UPL is a perfectly reasonable upper payment limit for both public and private providers and there is little justification for changing it.

There are certain areas of reimbursement such as physician fees that have little or no history of using costs as a benchmark for reimbursement. A substantial portion of DMAS reimbursement to local health departments is based on the DMAS physician fee schedule. DMAS only pays approximately 70% of what Medicare pays for physician fees.

Many payers, both government and private including Medicare, have invested extensive resources in developing prospective payment systems because they are inherently more efficient and cost effective. Under such systems, efficient providers may earn a "profit." Paying government providers the lower of cost or the prospective rate is unfair and undermines the prospective payment system. In fact, DMAS believes it likely that public providers will insist that they be paid cost if this rule becomes final.

In most cases, the reimbursement methodology makes no distinction between public and private providers. It seems unnecessary to impose additional requirements on government providers who are being treated exactly the same as private providers.

There are circumstances when Medicaid payments, including DSH, are used to cover the uninsured. Limiting Medicaid reimbursement to costs will make it difficult to fund uninsured care provided by the state teaching hospitals. DMAS will not be able to shift costs to DSH because of caps on Virginia's DSH allocation. While Congress placed limits on DSH allocations to States ten years ago, we believe that Congress understood that States have different arrangements for financing uncompensated care and it did not envision additional Medicaid regulatory reductions that would jeopardize the capacity of States to cover uncompensated care costs.

Cost Reporting Requirements

The proposed rule will require many providers who are government units to submit cost reports for the first time. We believe that this will create an unnecessary hardship on these providers for no good purpose since many will not have costs that exceed reimbursement. If the proposed rule is finalized, we would urge CMS to include a basis for exemption to the cost reporting requirements. The exemption could be related to the extent to which public providers are a significant percentage of the total providers using the same reimbursement methodology, a dollar reimbursement threshold or a demonstration that reimbursement in the aggregate does not exceed cost. As one provider indicated to DMAS, it adds insult to injury to require cost reporting when DMAS pays only 70% of what Medicare pays for physician services, for example.

One of the advantages of prospective payments systems is to reduce the level of effort on both the provider and government to prepare and audit cost reports. Over the years, DMAS has reduced the number of providers who must file cost reports and has substantially reduced the resources needed to audit cost reports. The proposed rule will greatly expand the number of providers who must file cost reports. To the extent that certain providers have limited capacity for preparing cost reports, they may decide that furnishing services to Medicaid recipients is not worth it. DMAS is particularly concerned about the burden on small local health departments that often play a key role in providing access in underserved areas. DMAS currently spends less than half a cent on auditing for each dollar of reimbursement. Under the proposed rule the auditing cost per dollar of reimbursement could increase significantly.

Certified Public Expenditures

DMAS contracts with several state agencies for Medicaid administrative services. The state share is appropriated directly to these agencies and DMAS "passes through" the federal share. It is unclear whether this is considered a certified public expenditure.

Ms. Leslie Norwalk

March 19, 2007

Page 4

Retention of Payments

This new section appears particularly unnecessary. To the best of our understanding, CMS has eliminated the "recycling" of funds and the purpose of the regulation is to formalize the current practice, not to accomplish anything new. We, like others, are concerned, however, that the regulation may have unintended consequences by potentially limiting transactions between parties that clearly are not problematic.

Implementation

While DMAS strongly encourages CMS to withdraw the proposed rule, if it is finalized, CMS must address issues related to the implementation of the rule. First, DMAS cannot implement this rule on September 1, 2007 if it does not know in advance who qualifies as a government unit under the rule. It may seem self evident to CMS, but it is not self-evident to DMAS and the public providers DMAS has consulted with. Second, implementing cost reports for some providers may take a considerable time to develop. DMAS has been working with CMS for several years to develop a cost report for school providers. Third, DMAS may need to consider alternative financing for certain providers if the current reimbursement exceeds costs. DMAS does not know whether costs exceed reimbursement for some providers, if they are currently not required to file cost reports.

In conclusion, DMAS appreciates the opportunity to comment on the proposed rule. We do not believe the proposed rule is necessary to ensure the integrity of Federal-State financial partnership. In fact, we believe that it will harm the Medicaid program and the people we serve. We urge CMS to withdraw the proposed rule.

Sincerely,



Patrick W. Finnerty

PWF/wjl

Submitter : Sarina Fogel
Organization : Families USA
Category : Consumer Group

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

March 16, 2007

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

Re: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership
72 Fed. Reg. 2236 (January 18, 2007)

To Whom It May Concern:

The undersigned organizations are writing to comment on Centers for Medicare and Medicaid Services proposed rule entitled Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership. We urge CMS to reconsider this proposal rule and not implement it.

Implementing this proposed rule will have a severe impact on state governments, public providers and the people who receive health care services through Medicaid and safety net providers. The proposed rule will directly impact public providers by drastically reducing their low reimbursement levels. Moreover, implementing the changes in the proposed rule will also restrict states ability to support our health care safety net, and place new pressures on already squeezed state budgets.

Ultimately, individuals with health care needs will pay the price. Cutting public provider reimbursement and squeezing state budgets will lead to substantial reductions or outright elimination of critical services for Medicaid beneficiaries and the uninsured. Many states are currently working to expand health care coverage for the uninsured and the proposed rule works to unravel this progress by weakening our fragile health care safety net and increasing the number of uninsured in the United States.

The Centers for Medicare and Medicaid Services claim that this new rule is necessary in order to protect Medicaid's fiscal integrity, however, the proposed rule goes far beyond what is necessary to achieve it and actually works to undermine the premise of the Medicaid program. If implemented, the proposed rule will weaken our nation's fragile health care safety net and reduce or eliminate access to health care services for the 50 million low-income children, parents, seniors and people with disabilities on Medicaid and the 47 million uninsured Americans who rely on public providers. This is no improvement to our health care system.

We urge CMS to reconsider the proposed rule and refrain from implementing it.

Sincerely,
American Association of Homes and Services for the Aging
American Federation of State, County and Municipal Employees
American Network of Community Options and Resources
American Public Health Association
Association for Community Affiliated Plans
Bazelon Center for Mental Health Law
Catholic Health Association
Child Welfare League of America
Easter Seals
Families USA
First Focus
HIV Medicine Association
Housing Works
Independent Living Resource Center San Francisco
Jewish Federation of Metropolitan Chicago

L.A. Care Health Plan
National Advocacy Center of the Sisters of the Good Shepherd
National Association of County Behavioral Health and Developmental Disability Directors
National Association of County Human Services Administrators
National Association of Social Workers
National Education Association
Premier Advocacy
Premier Inc.
Project Inform
Service Employees International Union
The Arc of the United States
The Children's Health Fund
United Cerebral Palsy

Submitter : Mr. Geoff Heatherington
Organization : Polk County Mental Health
Category : Local Government

Date: 03/19/2007

Issue Areas/Comments

**Collection of Information
Requirements**

Collection of Information Requirements

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

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

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

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

CMS-2258-P-215

Submitter : Ms. Alice Middleton

Date: 03/19/2007

Organization : Maryland Department of Health and Mental Hygiene

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-215-Attach-1.PDF



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor • Anthony G. Brown, Lt. Governor • John M. Colmers, Secretary

March 19, 2007

Leslie V. Norwalk, Esq
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-2258-P

Dear Ms. Norwalk:

The Maryland Department of Health and Mental Hygiene (the Department) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule entitled, "*Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership*" 72 Fed. Reg. 2236 (January 18, 2007). Although the Department understands the need to ensure the financial integrity of the Medicaid Program, we do not believe the regulations as written achieve this purpose. At the same time, we are very concerned that the regulations will greatly increase administrative burdens and costs to Maryland.

The regulations require the development of a cost-based rate for each public provider with cost-settlement after the fact. These two requirements will create a tremendous financial and administrative burden to Maryland. As an example, CMS currently allows states to develop statewide reimbursement methodologies for specific services delivered by public providers. Often states do this through the use of statewide time study methodologies. If the new regulations are approved, each provider will have to develop a cost-based rate for each service which will require individual provider time studies, necessitating much larger sample sizes and much more extensive data analysis.

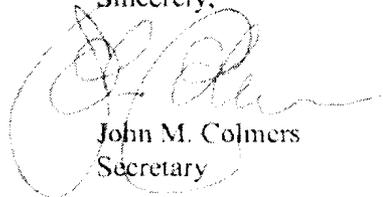
The proposed regulations then require the State Medicaid agency to perform interim and final cost settlements for each governmentally operated provider to verify that actual payments did not exceed the provider's costs. This rule would significantly increase the administrative burdens for both providers and the State. These new administrative costs would be especially devastating for small providers such as local health departments that

Leslie V. Norwalk, Esq
March 19, 2007
Page 2

provide community mental health and substance abuse services and school-based health centers. Unlike hospitals and nursing facilities, these providers have a very limited administrative infrastructure and are not accustomed to cost reporting. In addition, under the regulations, Maryland would be forced with the onerous task of completing annual cost settlements for these providers.

Finally, Maryland Medicaid is very concerned that these regulations have an effective date of September 1, 2007. 72 Fed. Reg. at 2247. This does not provide enough time to make necessary changes, especially since specific allowed cost definitions remain unclear.

Sincerely,

A handwritten signature in cursive script, appearing to read "John M. Colmers", is written over a faint circular stamp or watermark.

John M. Colmers
Secretary

cc: Mr. Charles Lehman
Ms. Audrey Richardson
Ms. Tricia Roddy
Ms. Susan Steinberg
Ms. Susan Tucker

Submitter : Mr. Terry Steczo
Organization : County Nursing Home Association of Illinois
Category : Health Care Provider/Association

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

Re: File Code CMS-2258-P

Date: March 19, 2007

The County Nursing Home Association of Illinois, an organization comprised of local government owned nursing facilities, files its objection to the rulemaking referenced above for the following reasons:

First, the proposed rule to limit certain payments to costs creates a double standard of reimbursement between government and non-government providers. Non-government providers could be paid above costs, while government providers could not.

Second, under these rules, government providers would not be able to make a profit. This undermines the safety net mission of government hospitals and nursing homes that use such profits to fund other health care services.

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

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

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

For the above cited reasons the County Nursing Home Association of Illinois urges that this rule be rejected.

Submitter : Anthony D. Rodgers

Date: 03/19/2007

Organization : AHCCCS

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-217-Attach-1.DOC



AHCCCS

Our first care is your health care

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

217

Janet Napolitano, Governor
Anthony D. Rodgers, Director

801 East Jefferson, Phoenix AZ 85034

PO Box 25520, Phoenix AZ 85002

phone 602 417 4000

www.ahcccs.state.az.us

March 16, 2007

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

RE: File Code CMS-2258-P

Please accept the following questions and comments from the Arizona Health Care Cost Containment System (AHCCCS), the single state agency responsible for administering Arizona's Medicaid program, in response to the portion of the Federal Register Notice of January 18, 2007 (72 FR 2236) applicable to 42 C.F.R. Parts 433, 447, and 457.

For ease of review, AHCCCS has organized its response by general topic, with the proposed Federal requirements initially stated and the correlating question or comment thereunder.

Retention of Payments

42 C.F.R. § 447.207, as proposed, would require all providers "to receive and retain the full amount of the total computable payment provided to them under the approved State plan or approved provisions of a waiver or demonstration if applicable."

- The preamble to the proposed rule at 72 FR 2242 explains that the purpose of this section is to strengthen efforts to remove any potential for abuse involving the re-direction of Medicaid payments by Intergovernmental Transfers ("IGTs") in the future. The section itself, however, makes no reference to IGTs. 42 C.F.R. § 447.207 should be clarified such that the provisions only apply to situations in which an IGT is involved.
- During a phone call with the States on January 25, 2007, CMS indicated that an expenditure must have occurred before a unit of government can certify an expenditure to the Medicaid agency. That expenditure could either be in the form of: 1) a payment by a unit of government to a provider, or 2) a governmental provider incurring expenses associated with the delivery of care. In either case, CMS indicated that once a unit of government certifies a "valid" expense, the provider has been paid. There is concern that the proposed retention requirements make it possible for a governmental provider to assert it is entitled to 100% of the FFP returned to the State on the basis of its expenditure, and the State's retention of any of the FFP constitutes a violation of this proposed rule. 42 C.F.R. § 447.207 should be clarified to clearly state:

- Once a governmental provider certifies an expenditure, the retention of payments as required by the proposed rule has been satisfied.
 - The distribution of FFP from the Medicaid agency to any certifying unit of government is not a relevant factor in measuring compliance with the proposed rule.
 - The State may withhold a portion or the entire amount of FFP resulting from a CPE.
- Health care providers may be subject to taxation, licensing, and other fees that are generally applied to the private sector or to the health care industry at large. There is some concern that the proposed rule would enable providers to assert that they should not be subject to normal operating expenses, which have no direct connection to Medicaid, in as much as they are required to retain the full amount of the total computable payment. 42 C.F.R. § 447.207 should be clarified to:
 - Clearly state that “normal operating expenses including taxes, licensing, other fees associated with the cost of conducting business that are unrelated to Medicaid and in which there is no connection to Medicaid payments” are not affected by the retention requirements of the proposed rule and are not included in the calculation of a State’s net expenditures.
 - The proposed requirement to retain full payments conflicts with the provisions of Section 1903(w) (codified at 42 U.S.C. §1396b) which clearly contemplates that providers can return certain portions of payments as bona fide donations and permits certain qualifying health care taxes. 42 CFR §447.207 should be clarified to:
 - Clearly allow donations and taxes as permitted by Section 1903(w) even if a Medicaid payment is the source of those donations or tax payments.

Managed Care Organizations

At 42 FR 2236, the preamble to the proposed rule states that the provisions related to cost limits do not apply to Medicaid Managed Care Organizations (“MCOs”) or SCHIP providers. At 42 FR 2240, the same cost limit exception for MCOs and SCHIP providers is repeated. However, nowhere else in the proposed rule are MCOs mentioned. There is confusion as to the meaning of the phrase “except that Medicaid managed care organizations ... are not subject to the cost limit provision of this regulation.” The preamble and wherever appropriate in the proposed rule should be clarified to:

- Specifically indicate that MCOs, including prepaid inpatient health plans, are not subject to the proposed rule’s cost limitation requirements with respect to both a State’s payment to a MCO and to a MCO’s payment to governmental providers.

Pursuant to proposed 42 C.F.R. § 447.206(c)(1) and subject to exceptions related to Indian Health Service and tribal facilities, “all health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider’s cost of

CMS

March 16, 2007

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providing covered Medicaid services to eligible Medicaid recipients.” The language does not seem to provide an exception for payments made by MCOs. 42 C.F.R. § 447.206 should be clarified to:

- Specifically state that the section does not apply to payments made by MCOs to health care providers that are operated by units of government.

Pursuant to proposed 42 C.F.R. § 447.272(b)(4) and subject to exceptions related to the Indian Health Service, tribal facilities, and Disproportionate Share Hospitals, Medicaid payments to State government operated facilities and non-State government operated facilities must not exceed the individual provider’s cost. 42 C.F.R. § 447.272(b)(4) should be clarified to:

- Specifically state that the section does not apply to payments made by MCOs to health care providers that are operated by units of government.

Proposed 42 C.F.R. § 447.321(b)(4), which largely mirrors 42 C.F.R. § 447.272(b)(4), limits Medicaid payments for outpatient services to the individual provider’s cost. 42 C.F.R. § 447.321(b)(4) should also be clarified to:

- Specifically state that the section does not apply to payments made by MCOs to health care providers that are operated by units of government.

Disproportionate Share Hospitals (DSH)

Pursuant to proposed 42 C.F.R. § 433.51(b)(3), CPEs must at a minimum “demonstrate the actual expenditures incurred by the contributing unit of government in providing services to eligible individuals receiving medical assistance or in administration of the state plan.” With respect to DSH, it is unclear whether DSH payments are *services to eligible individuals receiving medical assistance* or are payments *in administration of the state plan*. 42 C.F.R. § 433.51 should be clarified to:

- Indicate how and where DSH payments fit into proposed rule requirements.

Proposed 42 C.F.R. § 447.206(c)(1) states that “all 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”. One of the purposes for DSH payments is to help ensure that States provide adequate financial support to hospitals that serve a disproportionate number of low-income patients with special needs. Therefore DSH payments are not solely made to *provide covered Medicaid services to eligible Medicaid recipients*. When read literally, this section appears to prohibit DSH payments for low income patients with special needs. 42 C.F.R. § 447.206 should be clarified to:

- Specifically recognize DSH in the cost limit provision of the rule.

CMS

March 16, 2007

Page 4

Proposed 42 C.F.R. § 447.272 and 42 C.F.R. § 447.321 set forth the application of upper payment limits to inpatient services and to outpatient hospital and clinical services respectively. Whereas, 42 C.F.R. § 447.272 contains exceptions for IHS and DSH, 42 C.F.R. § 447.321 contains an exception only for IHS. There is concern that this omission may prohibit or restrict DSH payments for outpatient hospital services. 42 C.F.R. § 447.321 should be clarified to:

- Provide the same exception for DSH as contained in 42 C.F.R. § 447.272.

The preamble to the proposed rule at 72 FR 2239 specifies that tax revenue contractually obligated between a unit of State or local government and health care providers to provide indigent care is not considered a permissible source of non-Federal share funding for purposes of Medicaid payments. The example fails to recognize that a tax levied to support indigent care and is ultimately used to reimburse a hospital for its provision of inpatient services for indigent care, may serve as the basis for that government unit's CPE for DSH purposes. The preamble should be clarified to:

- Indicate that the use of taxes levied to support indigent health care can serve as the basis for CPE for DSH purposes.

Administrative Burden

CMS has indicated its disapproval when States make Medicaid payments in excess of costs to governmentally operated providers as it is considered inconsistent with the principles of economy and efficiency. As such, the proposed rule at 72 FR 2241 seeks to limit reimbursement to actual costs for governmental providers. In order to effectuate cost-limited reimbursement, governmental providers would be required by the proposed 42 C.F.R. § 447.206 to utilize a cost report or other auditable documentation. Additionally, 42 C.F.R. § 433.51(b)(3), 42 C.F.R. § 447.272, and 42 C.F.R. § 447.321 would be changed to conform with cost-limited reimbursement requirements.

The application of the proposed rules to all Medicaid programs and all governmental providers is overly broad and imposes administrative burdens and expenses in situations where abusive practices are unlikely to occur. CMS should consider providing exemptions to the proposed rules in the following circumstances:

- *Exemption for entire Medicaid programs.* In circumstances where fee for service payments to governmental providers constitutes only a small percentage of a State's total medical assistance payments (e.g., less than 5%) due to either the widespread use of managed care or the relative lack of governmental providers, the entire Medicaid program should be exempt from the rules. 42 C.F.R. §§ 433.51(b)(3), 447.206, 447.272, and 447.321 should all be amended to:

- Exempt a State and its governmental providers from their provisions when the percentage of a State's fee for service payments to governmental providers constitutes less than a certain percentage of total medical assistance payments.
- *Exemption for governmental providers paid based on a fee schedule applicable to both governmental and non-governmental providers.* As described at 72 FR 2241, the requirement for cost-limited reimbursement is based, in part, on CMS' concern that payment in excess of cost is flowing to governmental providers and is either being used to subsidize health care operations unrelated to Medicaid or returned to the State as an additional source of revenue. A reimbursement system in which a single rate schedule is applied to governmental and non-governmental providers alike, and no supplemental payment is made to governmental providers except for DSH and GME, would appear to assuage this concern. Additionally, such a reimbursement system would serve to encourage economy and efficiency in governmental providers. As such, in the event the proposed exemption described in the previous bullet is unacceptable as overly broad, 42 C.F.R. §§ 433.51(b)(3), 447.206, 447.272, and 447.321 should alternatively be amended to:
 - Exempt governmental providers from their provisions when the State's reimbursement system applies the same fee schedule to all providers of the service in the State (or in a region) and no supplemental Medicaid payment is made in addition to the fee schedule except for DSH and GME.
- *Exemption for governmental providers receiving only a nominal amount of payments and paid based on a fee schedule applicable to both governmental and non-governmental providers.* The requirement to utilize a cost report or other auditable documentation will cause a hardship on governmental providers that only receive a nominal amount of Medicaid payments. In fact, the costs incurred by a governmental provider associated with establishing and maintaining a cost report could, in certain situations, exceed total Medicaid payments received by the governmental provider. For example, fire districts often provide ambulance services, and ambulances sometimes attend to Medicaid recipients. Associated reimbursement may be on a fee-for-service basis. School districts also provide critical services as part of the State Plan and the administrative burden imposed, on particularly smaller districts, by the proposed regulations, could effectively end their ability to receive Medicaid reimbursement. The blanket application of the rule to all governmental providers, regardless of the total amount of reimbursement received, prohibits a State's compliance with the economy and efficiency provisions of Section 1902 (a)(30)(A) of the Act, which is the very issue CMS seeks to resolve. Furthermore, where the cost of establishing and maintaining a cost report exceeds the Medicaid reimbursement, governmental providers may decline to participate in the program. As such, in the event the proposed exemptions described in the previous bullets are overly broad, revenue thresholds should be included in order for cost reporting requirements to apply. Accordingly, 42 C.F.R. §§ 433.51(b)(3), 447.206, 447.272, and 447.321 should all be amended to:
 - Exempt governmental providers from the provisions of the proposed rules if:

- The governmental provider is reimbursed on a fee schedule that is faced by all providers of the service in the state (or in a region) and no supplemental Medicaid payment is made in addition to the fee schedule except for DSH and GME;

And

- The governmental provider receives Medicaid payments that are less than a fixed amount during a fiscal year (e.g., \$500,000), or less than a fixed percentage amount of the entire operating budget of the governmental provider (e.g., 5% of the total revenue of the government).

As described at 72 FR 2241 and in the proposed 42 C.F.R. § 447.206(d), regardless of whether or not a Medicaid cost reimbursement payment system is funded by CPEs, governmentally-operated providers must file annual cost reports. The definition of provider contained in 42 C.F.R. § 433.50(a)(1), which is referenced by 42 C.F.R. § 447.206(d), does not specifically mention professional services. Therefore, the cost reporting requirements of licensed professionals (e.g., physicians, nurses, therapists) that are employed by, and bill under the provider number of, public entities are not sufficiently clear. In order to protect professional service providers from the administrative burden associated with having to report costs, and the State from the administrative burden associated with having to review the cost reports of professional services providers, 42 C.F.R. § 433.50(a)(1) and 42 C.F.R. § 447.206(d) should be amended to:

- Exempt professional service providers under the employ of, or billing under the provider number of, a unit of government.

Also as described at 72 FR 2241 and in the proposed 42 C.F.R. § 447.206(d), under a Medicaid cost reimbursement payment system funded by CPEs, States may utilize most recently filed cost reports to develop interim Medicaid payment rates and may trend these interim rates by an applicable health care-related index. Interim reconciliations must be performed by reconciling the interim Medicaid payment rates to the filed cost report for the spending year in which interim payment rates were made. Final reconciliation must also be performed by reconciling the interim payments and interim adjustments to the finalized cost report for the spending year in which interim payment rates were made.

- In general, the process described above is administratively burdensome for both the Medicaid agency and the governmental provider. The procedure outlined in the proposed 42 C.F.R. § 447.206(e) is less burdensome in that it only mandates a single "review" when CPEs are not being used to fund payments to governmental providers. 42 C.F.R. § 447.206 should be amended to:
 - Eliminate the methodology for payment currently set forth in 42 C.F.R. § 447.206(d), in favor of having the methodology set forth in 42 C.F.R. § 447.206(e) apply to both CPE and non-CPE scenarios.

Timeframe for Compliance

Currently, States must comply with the proposed rule by September 1, 2007. The date is referenced in proposed 42 C.F.R. § 447.206(g), 42 C.F.R. § 447.272(d)(1), and 42 C.F.R. § 447.321(d)(1). Because State legislative authority is a prerequisite to compliance with many of the provisions set forth therein, either a transition period should be established or the September 1, 2007 deadline should be extended. 42 C.F.R. §§ 447.206(g), 447.272(d)(1), and 447.321(d)(1) should be amended to:

- Permit States up until September 1, 2008 to fully comply with the provisions of the proposed rule.

Thank you for the opportunity to comment on the proposed rule. Should you have any questions, please do not hesitate to contact Tom Betlach at (602) 417-4483.

Sincerely,

A handwritten signature in black ink, appearing to read "Anthony D. Rogers". The signature is written in a cursive, flowing style with a large initial "A".

Anthony D. Rogers
Director

Submitter : Ms. Pat Comstock
Organization : Illinois Health Care Association
Category : Long-term Care

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

my comments are an attachment

CMS-2258-P-218-Attach-1.DOC

March 16, 2007

Ms. Leslie Norwalk
Acting Administrator
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 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, 72 Federal Register 2236 (January 18, 2007)

Dear Ms. Norwalk:

On behalf of the members of the Illinois Health Care Association (IHCA), an organization representing 483 licensed/certified long-term care facilities and programs throughout the State, thank you for the opportunity to submit comments on the proposed rulemaking referenced above. IHCA acknowledges and respects the government's responsibility to enforce the fiscal integrity of all federal programs. We believe that this rulemaking; however, is seriously flawed and could have a disastrous effect on all health care providers by removing considerable funds from the system, an act which can prolong and worsen Medicaid fiscal problems. Some concerns with this rule include:

- The proposed provision to limit certain payments to costs creates a double standard of reimbursement between government and non-government providers. Non-government providers could be paid above costs, while government providers could not.
- Under these rules, government providers would not be able to make a profit. This undermines the safety net mission of government hospitals that use such profits to fund other health care services.
- The proposed rule will actually encourage inefficiency. A fixed reimbursement rate provides a target by which public providers attempt to control spending, and if efficient, spend below. Capping payments to costs encourages inefficient increases in costs.

- CMS has historically allowed states to define their payment methodologies through Medicaid state plans. The proposed rule will constrain the flexibility of states to address critical issues of access.
- The proposed rule inappropriately limits the sources of public funding. Taxes are just one of many sources available to units of local government.

IHCA respectfully requests withdrawal of the proposed rule. CMS should work with state government representatives and nursing home and hospital providers to work out a broad regulatory framework that would help to ultimately provide consistency and stability to the Medicaid program, assure adequate payment for Medicaid providers, provide access to quality health care, and meet the highest standards of fiscal integrity.

Thank you for allowing the Association the opportunity to submit these comments. Please feel free to contact me if you have any questions.

Sincerely,

Pat Comstock
Vice President-Public Policy
Illinois Health Care Association
1029 S. 4th Street
Springfield, IL 62703
217-528-6455

Submitter : Mrs. Norma Jean Morgan

Date: 03/19/2007

Organization : Effingham Hospital

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-219-Attach-1.DOC

#219



**EFFINGHAM
HOSPITAL**
GROWING WITH YOU

March 19, 2007

Leslie Norwalk
Acting Administrator
Center 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)
January 18, 2006.

Dear Ms. Norwalk:

Effingham Hospital appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule. We oppose this rule and would ask that you refer to the compelling information submitted to you by the Georgia Hospital Association and the American Hospital Association on behalf of Georgia hospitals, highlighting the harm the policy changes would cause our hospital and our patients.

We urge CMS to permanently withdraw this rule: (1) limiting reimbursement of government operated providers (2) narrowing the definition of public hospitals (3) restricting intergovernmental transfers and certified public expenditures. We are also concerned regarding the absence of data or other factual support for CMS's estimate of savings.

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

Sincerely,

/s/ **Norma Jean Morgan**

Norma Jean Morgan
Chief Executive Officer

NJM:ctk