

Submitter : Ms. Karah Herdman

Date: 03/19/2007

Organization : Allergan, Inc.

Category : Drug Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-220-Attach-1.PDF

ALLERGAN

2525 Dupont Drive, P.O. Box 19534, Irvine, CA 92623-9534 • (714) 246-4500

March 19, 2007

VIA Electronic Submission at www.cms.hhs.gov/eRulemaking

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, D.C. 20201

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

Dear Ms. Norwalk:

Allergan, Inc. (Allergan) welcomes the opportunity to respond to the above-captioned Proposed Rule. Allergan is the manufacturer of BOTOX[®] (Botulinum Toxin Type A) Purified Neurotoxin Complex and BOTOX[®] Cosmetic and other specialty pharmaceuticals and medical devices. Allergan participates in the Medicaid Rebate Program and has a rebate agreement with the Secretary of the Department of Health and Human Services. Allergan is pleased to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the Proposed Rule focusing on the implications on the Medicaid Rebate Program of the proposal to limit reimbursement for health care providers that are operated by units of government to amounts that do not exceed the providers' costs. If CMS finalizes this proposal, we request that CMS instruct states that outpatient drugs provided by health care providers that are operated by units of government are excluded from Medicaid rebates pursuant to Soc. Sec. Act § 1927(j)(2) (42 U.S.C. § 1396r-8(j)(2)). Our rationale for this request is provided below.

The Proposed Rule would add new section 447.206 to Title 42 of the Code of Federal Regulations adopting the following cost limit for providers operated by units of government:

“(c)General rules. (1) 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.”¹

Allergan offers no opinion on the appropriateness of the Proposed Rule for determining reimbursement limits to providers operated by units of government. However, we believe that the Proposed Rule, if finalized as drafted, will exclude outpatient drug utilization by providers from the Medicaid Rebate Program because the government will get the full benefit of any price reductions these providers obtain.

Under the Medicaid Rebate Law,² hospitals that bill the Medicaid Program no more than the hospitals' purchasing costs for covered outpatient drugs are not subject to the Medicaid Rebate Program.³ Under

¹ 72 Fed Reg. 2236, 2246 (Jan. 18, 2007).

² Section 1927 of the Social Security Act (42 U.S.C. 1396r-8).

³ Under Section 1927(j)(2): “The State Plan shall provide that a hospital (providing medical assistance under such plan) that dispenses covered outpatient drugs using drug formulary systems, and bills the plan no more than the hospital's purchasing costs for covered outpatient drugs (as determined under the State plan) shall not be subject to the requirements of [Section 1927].” (42 U.S.C. 1396r-8(j)(2).) All hospitals typically have drug formulary systems so this first criterion for exclusion from the Medicaid

CMS-2258-P

Leslie V. Norwalk, Esq.

March 19, 2007

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the Proposed Rule, Medicaid reimbursement to hospitals operated by units of government would be limited to the hospitals' costs as determined by their Medicare Cost Reports.⁴ Under the Proposed Rule, any interim payments in excess of costs will be reconciled to the finalized cost report, and any overpayment amounts received will be credited to the federal government.⁵ Therefore, under the Proposed Rule, if finalized, hospitals operated by units of government will receive no more than the hospitals' purchasing costs for covered outpatient drugs, and therefore, must be excluded from the Medicaid Rebate Program under § 1927(j)(2).⁶

Exclusion from the Medicaid Rebate Program of hospitals operated by units of government when these providers are reimbursed at their costs is consistent with the goals and objectives of the Medicaid Rebate Program—i.e., that the Medicaid Program receive the benefit of price reductions offered by manufacturers. Insofar as hospitals operated by government units are reimbursed at their costs, the Medicaid Program will enjoy the benefit of whatever price reductions the hospitals negotiate with manufacturers.

Therefore, if the Proposed Rule is finalized to limit Medicaid reimbursement to hospitals operated by units of government to the hospitals' costs, we request that CMS expressly instruct states that outpatient drug utilization billed to the Medicaid Program by such providers is not subject to the Medicaid Rebate Program.

* * * *

We thank you for the opportunity to comment on the Proposed Rule. Please feel free to contact us if you have any questions about these comments at 714-246-5621 (or by e-mail at herdman_karah@allergan.com).

Sincerely,

/s/

Karah S. Herdman, Esq.,
Senior Compliance Counsel
Allergan, Inc.

Rebate Program should be met easily. The Proposed Rule, if finalized, would make clear that the second criterion would be met as well.

⁴ Proposed 42 C.F.R. § 447.206(c)(3), 72 Fed. Reg., at 2246.

⁵ Proposed 42 C.F.R. § 447.206(d)(3), (f). *Ibid*, at 2247.

⁶ Allergan does not address in these comments whether hospital outpatient clinics not operated by government units should also be excluded from the Medicaid Rebate Program where reimbursement under the state Medicaid Program is set at estimated acquisition cost. Our point here is that if CMS finalizes the reimbursement limit rule as proposed, it should be clear that hospitals operated by government units would be excluded from the Medicaid Rebate Program.

Submitter : Mr. Mark Newton
Organization : Swedish Covenant Hospital
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-221-Attach-1.DOC



#221

Swedish Covenant Hospital

TECHNOLOGY CHANGES. COMPASSION DOES NOT.

March 19, 2007

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

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

Dear Ms. Norwalk:

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

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

Mark Newton
President/CEO
Swedish Covenant Hospital

Submitter : Ms. Marianne Wiesen
Organization : Knox County Nursing Home
Category : Long-term Care

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

County homes have served the needs of those in need of LTC, long before the industry developed for-profit centers. The few of us remaining are dedicated to the residents of our counties and are concerned that we are being treated with a double standard of reimbursement between government and non-government providers under the proposed rule to limit certain payments to costs. To insure sufficient funding during times of emergencies or low census one needs a cushion of funds to support the home. The county homes have focused their total existence to the highest quality of care for their residents versus the owners' ideals for self.

Submitter : Mr. Mitchell Anderson
Organization : Benton County Health Department
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

CMS-2258-P-223-Attach-1.DOC

#223



Benton County Health Department

530 NW 27th Street • P.O. Box 579

Corvallis, OR 97339-0579

www.co.benton.or.us/health

Main switchboard
(541) 766-6835

Environmental Health
Direct line: (541) 766-6841
Drinking Water
Food Safety
Septic Systems
Solid Waste
FAX (541) 766-6248

Health Management Services
Accounting
Business Services
Client Support Services
Contracts
Purchasing
FAX (541) 766-6142

Mental Health
Administration
Adult Mental Health Service
Chemical Dependency Program
Child Mental Health/ACIST
FAX (541) 766-6175

Developmental Disabilities
Direct line: (541) 766-6847
FAX (541) 766-6186

New Beginnings
Direct line: (541) 766-3540
FAX (541) 766-3543

Public Health
Health Promotion
Immunizations
Maternal & Child Health
Women, Infants, and Children (WIC)
FAX (541) 766-6142

Communicable Disease
Direct line: (541) 766-6654
FAX (CD Only) (541) 766-6197

Public Health Preparedness
Direct line: (541) 766-6623

Telecommunications Relay Service
TTY 1-800-735-2900

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

To Whom It May Concern:

My name is Mitchell Anderson and I represent Benton County Health Department, a County operated community mental health organization in the State of Oregon. I am writing to comment on the impact that proposed regulation CMS 2258-P will have on the Medicaid system in Oregon, with specific emphasis on the Medicaid Mental Health System.

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

In most of the 22 counties served by government providers, the Medicaid Prepaid Inpatient Health Plans (PIHP) use risk-bearing payment mechanisms where counties are sub-capitated for all or a portion of the Medicaid enrollees. Under these financial arrangements the counties are responsible for meeting the mental health needs of enrollees regardless of whether sufficient sub-capitation revenue is available in a given year.

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

As currently written, it appears that the drafters of CMS 2258-P did not envision these types of payment arrangements between the MCO and the provider organization. By limiting allowable Medicaid payments to cost, using a cost reporting mechanism that doesn't take into account a risk reserve, it appears that CMS has assumed that all risk is being held by the MCOs/PIHPs. This is not the case in Oregon or a significant number of other states that have 1115 or 1915(b) waivers for their Medicaid Mental Health Systems.

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

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

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

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

Sincerely,

Mitchell Anderson, M.A.
Deputy Administrator – Mental Health Division

Submitter : Mr. John Berta
Organization : Texas Hospital Association
Category : Other Association

Date: 03/19/2007

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

In addition to the comments provided in the text of our attached letter, our association agrees with other comments related to clarifying provisions of the rule allowing as much flexibility to the IGT process as possible. Provisions of the proposed retention of payment rule should be clarified to explicitly state that a multiple number of hospitals be allowed to retain an IGT made by a single hospital. Clarification is consistent with CMS' overall objective that IGT's are used to reimburse hospitals for the care of Medicaid patients and are not "retained" by local governments.

GENERAL

GENERAL

In addition to the comments provided in the text of our attached letter, our association agrees with other comments related to clarifying provisions of the rule allowing as much flexibility to the IGT process as possible. Provisions of the proposed retention of payment rule should be clarified to explicitly state that a multiple number of hospitals be allowed to retain an IGT made by a single hospital. Clarification is consistent with CMS' overall objective that IGT's are used to reimburse hospitals for the care of Medicaid patients and are not "retained" by local governments.

CMS-2258-P-224-Attach-1.DOC

CMS-2258-P-224-Attach-2.DOC

221



TEXAS HOSPITAL ASSOCIATION

March 13, 2007

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

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

Dear Ms. Norwalk:

On behalf of its more than 500 member hospitals, the Texas Hospital Association appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule restricting how Texas currently funds the state's Medicaid program and reimburses its public hospitals. **The THA respectfully opposes this proposed rule and is very concerned by the harm the proposed rule will have to low-income Texans and the hospital safety-net infrastructure now in place.**

As proposed, the rule severely limits how Texas may reimburse its safety-net hospitals. The rule will dramatically jeopardize the long-standing Medicaid financing mechanisms that have operated in Texas for nearly two decades and THA estimates that Texas safety-net hospitals will lose approximately \$400 million annually in federal Medicaid funds if these proposals are implemented. In addition to directly harming the state's state-owned and public hospitals, the rule has peripheral cascading implications extending beyond public hospitals and will ultimately harm privately-owned hospitals and the low-income Texans they provide much-needed care for.

It's our organization's understanding that the American Hospital Association, the National Association of Public Hospitals and Health Systems and other national organizations have submitted well detailed comments on the proposed rule. Therefore, our association will limit our discussion to three major topics included in the proposed rule:

- Limiting reimbursement to governmentally-operated providers;
- Narrowing the definition of to a "unit of government" standard for Medicaid payment and transfer purposes; and
- Restricting the use of intergovernmental transfers.

Limiting reimbursement to governmentally-operated providers

The proposed rule limits reimbursement for government hospitals to the cost of providing services to Medicaid patients, and therefore severely restricts Texas from making supplemental payments to these safety net hospitals through our Medicaid Upper Payment Limit (UPL) programs.

Almost three decades ago, Congress abandoned 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. Texas' Medicaid program has adopted a similar prospective payment model, and CMS is proposing to resurrect a cost-based limit that Congress long ago declared less efficient.

As referred to in the rule, section 1902(a)(30)(A) of the Social Security Act states, in part, that a state Medicaid plan must:

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

There is no explanation provided in the proposed rule as to why the 100 percent aggregate upper payment limit for governmentally operated hospitals is now insufficient to meet the efficiency and economy requirements of this section, and must be replaced with a limit based on each individual provider's costs and a cost-based reimbursement limit.

Limiting reimbursement to each specific hospital's cost is severely more restrictive than implementing an overall, aggregate upper limit. Furthermore, there is no explanation in the proposed rule why the agency is disregarding without explanation its previous decisions that allows Texas greater flexibility and adaptability in addressing the special needs of specific hospitals in establishing the upper payment limit.

Redefining "Unit of Government"

As proposed, the rule puts forth a new and restrictive definition of organizations that may assist in financing the state share of Medicaid. CMS has proposed narrowly redefining these facilities as a "unit of government," such as a public hospital. Public hospitals that meet this new definition must demonstrate they are operated by a unit of government or are an integral part of a unit of government that has taxing authority.

The THA is concerned that hospitals that do not meet this new definition will not be allowed to make intergovernmental transfers to the Texas Medicaid program. It's our association's position that the statutory definition of "unit of government" does not require "generally applicable taxing authority."

Texas hospitals are concerned that this new, more restrictive definition could possibly limit some of our public hospitals that operate as public taxing entities or as local taxing districts from helping in financing the state share of Texas Medicaid funding. Furthermore, the THA is unable to find any basis in federal statute supporting the proposed change in definition.

Restricting the use of intergovernmental transfers

The proposed rule imposes new restrictions on a state's ability to fund the non-federal share of Medicaid payments through IGTs and CPEs, including limiting the source of IGTs to funds generated from tax revenue. **While THA acknowledges that the discussion does not apply to public hospital intergovernmental transfers operating in Texas,** our association encourages CMS to adopt broad based principles in certifying and permitting the state share of Medicaid funds.

Our association is concerned that restrictions on IGTs may adversely impact Texas Medicaid funding in the future, especially as public and privately-owned hospitals consolidate their operations to achieve higher quality while increasing efficiency and lowering their costs of treatment.

Finally, a table included in the rule illustrates that CMS estimates the proposed rule will save approximately \$3.9 billion in federal funds over five years. This reduction is, in fact, a budget cut for Texas safety-net hospitals, and will have devastating effects on the Texas health care safety net. Respectfully, THA opposes the rule and strongly urge that CMS permanently withdraw the rule from future consideration. If you have any questions, or need additional information, please e-mail jberta@tha.org, or contact me at 512-465-1556.

Sincerely,



John Berta
Director, Policy Analysis

Submitter : Mrs. Andrea Dolan
Organization : Sunny Hill Nursing Home of Will County
Category : Long-term Care

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2258-P-225-Attach-1.DOC

CMS-2258-P

**FROM: Andrea Dolan
Sunny Hill Nursing Home of Will County**

The following lists the concerns I have with this proposal:

- 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.
- 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.

Submitter : Mr. Jerry Friedman
Organization : American Public Human Services Association
Category : State Government

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-226-Attach-1.DOC



American Public Human Services Association

NASMD

National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

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March 19, 2007

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

Attention: CMS-2258-P

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

Dear Ms. Norwalk:

The American Public Human Services Association (APHSA) and its affiliate, the National Association of State Medicaid Directors (NASMD), respectfully submit this comment letter on the provider cost limit regulation published in the January 18, 2007 Federal Register (72 FR 2236) for the Centers for Medicare and Medicaid Services (CMS).

Please be assured that the state Medicaid agencies share the federal government's strong commitment to protecting the fiscal integrity of the Medicaid program and are prepared to do so through federal-state initiatives and state-specific efforts. However, we respectfully submit that the agency's proposed rule is a fundamentally flawed approach to achieve this stated goal.

The analysis that states have conducted thus far indicates that the proposed regulation could reverse much of the progress that they have made to strengthen the efficiency and accuracy of their reimbursement and financing systems. State initiatives have helped to ensure the sustainability of their evolving Medicaid programs and the health care system more broadly. Such changes were pursued in accordance with statutory requirements, and, in many cases, through the explicit guidance and approval of CMS. They also reflect CMS' and federal policymakers' philosophy for facilitating cost-effective market principles into federally funded health care programs and are likely to impede ongoing efforts to move towards so-called "pay-for-performance" payment models that align

Leslie V. Norwalk, Esq.

March 19, 2007

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payment and desired outcomes. The proposed payment limit on costs is contrary to these federal and state policy decisions.

In addition, AHPA and NASMD believe this rule could cause significant upheaval and have a far-reaching impact on states' Medicaid programs and public health care delivery systems as they were developed without first considering the unique and complex reimbursement processes employed in each state. At a minimum, the agency has failed in its responsibility to communicate the proposed rule's impact on specific policies, systems, and entities throughout the states. For example, states believe CMS has failed to account for the magnitude of effort and new resources that will be required to undertake cost-based reporting and reconciliation.

Although states believe that the proposed rule could have a significant impact on their Medicaid programs, it is difficult to quantify this impact due to the lack of clarity and specificity in the rule itself. AHPA has convened a number of calls with states during which several fundamental questions have arisen. Although we appreciate that CMS has attempted to provide clarification to the extent possible given the constraints of the federal rulemaking process, states believe it is inappropriate for CMS to move forward on the rule without a more comprehensive understanding of the state-by-state impact. Specifically, CMS staff on a number of occasions has indicated that they lack data and other relevant information on the fiscal impact the proposed changes would have.

For these reasons, we ask that CMS not move forward with this new regulation without first obtaining and communicating additional information on the proposed rule's impact on the various state reimbursement practices and providing a more comprehensive regulatory analysis.

AHPA and NASMD also wish to take this opportunity to note that a bipartisan majority of Members of Congress previously have contacted Secretary Leavitt regarding their opposition to the changes contained within this proposed rule. States have significant concerns with CMS' decision to move forward with the rulemaking process without further consideration by Congress.

The six major areas of concern identified by states include:

- Dismantling, or at a minimum significant disruption of, the current financing and reimbursement systems in many states;
- Creating an arbitrary distinction in reimbursement policies for providers based solely on whether they are public or private entities;
- Imposing a state mandate to comply with far reaching audit and review programs merely to demonstrate that they do not employ certain financing mechanisms that CMS now characterizes as inappropriate;
- Arbitrarily overturning principles that grant states the unique authority to define and create standards for entities classified as "units of government;"
- Proposing an unfeasible implementation timeframe; and

- Underestimating the regulatory impact in terms of scope, time, and resources at both the state and federal level.

We appreciate the opportunity to provide you with the following comments.

§ 433.51 Funds from units of government as the state share of financial participation

Defining unit of government

In § 433.50(a)(1)(i), CMS proposes to define “unit of government” as a “city, county, special purpose district, or other governmental unit in the State with generally applicable taxing authority.” States respectfully submit that CMS has exceeded its authority in defining “unit of government” in this proposed regulation.

There are a number of long-standing provisions and discussions regarding the Medicaid program that have sanctioned public entities not funded by state appropriations to contribute to the non-federal share of Medicaid expenditures. Section 1902(a)(2) authorizes a state plan to provide for local participation in as much as 60 percent of the non-Federal share of total Medicaid expenditures, as long as the lack of adequate “funds” from “local sources” does not result in lowering the amount, duration, scope of quality of care and services under the plan. There is no requirement in this section of the law that such “funds” come from tax revenues or that the “sources” be federally determined to be “units of government.” Further, congressional intent regarding permissible sources for the state share is indicated at section 1903(d)(1). This provision makes clear that sources of funds in addition to amounts appropriate by the State or its political subdivisions may supply the non-Federal share.

We are concerned that CMS is newly determining states that it must substitute “units of government” for “public agencies” as the only entities qualified to put up the non-Federal share through transfer or certification in order “to be consistent with” and “to conform the language to” Sections 1903(w)(6)(A), which was added to Title XIX as part of the Provider Tax Amendments of 1991 (72 Fed. Reg. at 2240). We submit that section 1903(w)(6)(A) is not a limitation on the nature of public entities contributing to the non-federal share of financial participation. Rather, it was a limitation on CMS’s authority to regulate in this area. It states that notwithstanding any other provision:

States also ask that CMS consider that this overly restrictive approach would exclude the “governmental entities” approved by CMS in some states’ existing section 1115 demonstrations. We strongly believe CMS has failed to consider that there is a broad range of mechanisms and relationships beyond taxing authority, including contractual arrangements, grants, sale or lease of land, litigation funds, and many other sources beyond taxing authority, that link government entities to the Medicaid program.

For these reasons, APHSA and NASMD urge CMS to reconsider the overly restrictive and complex language defining a “unit of government.”

Differentiating between public and private entities

States request that CMS refrain from imposing an arbitrary distinction between public and private entities participating in the Medicaid program. States strongly disagree with the proposed regulation's sanctioning of higher reimbursements for private entities than for public entities simply because they are private. This differential treatment fails to consider the actual services delivered. In reality, services are not likely to differ based on the public or private nature of the facility or provider, but rather on their specialization and expertise. For example, many states design their reimbursement systems to differentiate payments between an acute care hospital and a psychiatric care facility. Public and private entities in the acute care hospital category would be paid the same rate based on the services they provide. States would develop a separate rate for a psychiatric care facility and apply it to the public and private entities in this group. The proposed regulation would essentially force states to dismantle this reasonable payment methodology.

Despite the clear national trend across the entire health care system to improve transparency and build pay-for-performance reimbursement models, this regulation impedes the ability of state Medicaid programs to do so by restricting reimbursement systems for Medicaid providers. States believe a more rational approach is to retain the current state flexibility to set rates based on service delivery categories and other models that reward high performance, quality care. States urge CMS to reconsider the rule as it would result in a differential treatment between public and private providers thereby driving the federal government and states further from their goal of ensuring the integrity of the program.

The proposed rule indicates that hospitals and nursing facilities are accustomed to using Medicare cost report forms to document costs. States believe this is a flawed approach as the Medicare cost report cannot be easily adapted for Medicaid purposes. States also note that there is no cost report for most other types of "public" providers, for example schools, universities, and other entities within state and local education systems. States are particularly concerned about how to interpret this rule with regard to higher education and university systems. In addition, states have long-standing partnerships with school systems due to the fundamental overlap between school-aged children who are simultaneously enrolled in the Medicaid program. The proposed rule could be a barrier to compliance with 42 USC 1396b(c) with respect to the Secretary of Health and Human Service's obligation to make federal financial participation (FFP) available for Medicaid services provided in schools where the Medical assistance is included in an Individual Education Plan or Individualized Family Service Plan under IDEA. In addition, it will create a new documentation and reporting structure for schools and school-based providers and clinics that could strain and eventually result in the severing of this important relationship.

Treatment of Tribal entities

In section 433.50(i), the proposed regulation indicates that a governmental unit will include Indian tribes. States request clarification as to how CMS can propose this language as it seems to directly conflict with the unique government-to-government relationship the United States has with Tribal governments. Specifically, the State Medicaid Director Letter (#05-004) issued on October 18, 2005 responds to questions about using expenditures certified by Tribal organizations to fulfill the state matching requirements for activities under the Medicaid program. The letter described CMS's policy regarding the conditions and criteria under which tribal organizations can certify expenditures as the non-federal share of Medicaid expenditures for administrative functions. On June 9, 2006, CMS issued a clarifying letter to state Medicaid directors (#06-014) that stated that federal funds awarded under the Indian Self-Determination and Education Assistance Act (ISDEAA) (P.L. 93-638) may be used to meet matching requirements. We believe this proposed regulation reverses those decisions by suggesting that CMS would only allow this federal matching if the tribe has generally applicable taxing authority.

§ 447.206 Cost limit for providers operated by units of government

Approval and oversight of reimbursement systems

On behalf of all states, we strongly oppose the restrictions the proposed rule imposes on current state flexibility to develop appropriate and reasonable Medicaid reimbursement systems. Specifically, we believe the cost limit could violate Section 1902(a)(30)(A) of the Social Security Act (SSA) by preventing states from adopting payment methodologies that are economic and efficient and that promote quality and access. It could also violate Section 705(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 by implementing upper payment limits that are not based on the proposed rule announced on October 5, 2000.

We also respectfully disagree with CMS' assertions in the proposed rule that states operate inappropriate financing structures. We submit to you that states have worked with CMS to ensure that their financing policies do not denigrate the integrity of the Medicaid program and have received approval by CMS for these systems. Further, states have been subject to significant state and federal audit reviews. These auditing practices occur on an ongoing basis. We believe these audits and other oversight mechanisms are completely capable of identifying any potential threats to the integrity of the program that could occur at some future point and oppose the duplicative and overly burdensome administrative procedures proposed by CMS.

We wish to emphasize that Medicaid reimbursement formulas are established by each state with the approval of the federal government and in accordance with federal guidelines. As such we believe it is irrational to implement this proposed rule since it

would overturn the approved systems currently in place. The proposed rule also does not accurately account for the fact that such actions must be undertaken on an ongoing basis.

State flexibility in reimbursement system design

Based on the proposed rule as currently written, many states believe they would have to undertake significant restructuring of their current reimbursement systems that would force them to revert to cost-based reimbursement systems. Reports from state Medicaid officials' indicate that such systems are nearly impossible to operationalize. In the past, cost-based systems also forced states to make excessive payments for services at the expense of other aspects of their Medicaid programs. Depending on the state-specific design of such cost-based systems, states also were compelled to reconcile payments with providers, another inefficient and administratively burdensome aspect of such systems.

In response to the new reimbursement requirements and desire to phase-out cost-based systems, states have developed a range of different approaches to provider reimbursement. Such variation is fundamental to the Medicaid program's flexibility in adapting to state and local needs and policies. States have implemented reimbursement systems that are well researched and audited to ensure Medicaid provides the most appropriate reimbursement to providers. Such flexibility also allows states to respond to the demand and supply at each level within the state and local health care marketplace. It also provides states with the tools necessary to develop adequate provider networks to meet the needs of their residents.

As an example, some states use Medicare rates that may reflect an "above-cost" Medicaid payment. A number of states report that this payment structure has helped to equalize payments to providers regardless of the specific payer. In turn, this has helped to minimize traditional bias against the Medicaid program and allowed states to sustain adequate provider networks. Other states have developed prospective payment systems (PPS) based on Medicare's diagnosis-related groups (DRGs). States then periodically rebase their systems. States' current payment structures seek to reflect the actual costs of providing services in today's healthcare marketplace within the fiscal parameters of the state budgets.

As noted above, these reimbursement systems were developed in light of inefficiencies identified within cost-based reimbursement systems. State Medicaid programs, similar to other payers, have adopted more rational reimbursement systems that encourage desired behaviors and have helped to contain costs. States overwhelmingly report that such systems and policies have improved overall efficiency in the Medicaid program. Regrettably, we believe it is reasonable to conclude that the proposed rule would force states to revert to inefficient cost-based systems. As such, we request that CMS continue to allow states to utilize prospective payment systems and that such systems not require states to reconcile payments.

States also are concerned with one of the underlying premises of the proposed rule – that paying the Medicare rate to Medicaid providers is excessive. We request that CMS provide clarification as to why states would not be able to use this rate methodology. States also offer for CMS' consideration that if the agency is concerned that Medicare payments are excessive, then the agency should address this issue through the Medicare program rather than overturning approved financing systems in Medicaid that have not proven to be a problem.

Additional payments to providers

On behalf of states we request that CMS provide further clarification on the treatment of graduate medical education (GME) payments to providers and that such payments be considered outside of the currently proposed cost limit. GME payments are an option that state Medicaid programs may choose to provide, subject to approval by CMS. States have the flexibility to determine how to best use available GME funds. GME payments are one tool that has allowed states to become more prudent, farsighted purchasers of care. Many states recognize that support for GME is a valuable tool for meeting the future health care provider needs of Medicaid beneficiaries and the public in general. For example, states increasingly are requiring that some or all Medicaid GME payments be directly linked to state policy goals intended to vary the distribution of, or limit, the health care workforce.

We also request that CMS clarify that the proposed rule's language at § 447.206(c)(1) that states, "[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." States request CMS clarify that the payment limit based on the cost of providing services to eligible Medicaid recipients does not exclude costs for disproportionate share hospital payments. In addition, several states have or evaluating proposals for state plan amendments that would pay for services provided to the non-Medicaid eligibles that are uninsured. States are unable to fully analyze the impact of the proposed rule on their Section 1115 demonstration programs without further clarification. States submit to CMS that restricting Section 1115 demonstration projects will stifle innovation in federal-state efforts to address the health care needs of low-income uninsured individuals.

States ask that CMS provide clarification on the proposed rule's applicability to managed care organizations (MCOs). States increasingly are contracting with MCOs because they have demonstrated cost-efficiencies in delivering services and managing care and they frequently offer a more choices with their expansive provider networks. The rule fails to address how the cost limit would apply to such entities and the negotiated capitated payments states pay. CMS also should provide clarification on how the cost limit applies to government providers participating in an MCO network. States submit that it is unreasonable to segment out public and private providers in such arrangements and, as noted above, this would disrupt the system of incentives for quality and cost-efficiency.

§ 447.271 Upper limits based on customary charges

As noted above, states respectfully request that CMS refrain from implementing a rule that would limit state flexibility to design reimbursement policies. Specifically, we believe that CMS has exceeded its authority by proposing to eliminate the aggregate nature of the payment limit. The proposed rule appears to impact existing state plan amendments in which CMS has approved an Upper Payment Limit calculation which is based on an aggregate cost limit for privately owned/operated facilities, government owned/operated facilities, and state teaching hospital facilities.

§ 457.628 Other applicable Federal regulations

CMS states in section 457.628(a) of the proposed regulation that the proposed cost limit provisions at section 447.206 do not apply to states' State Children's Health Insurance Programs (SCHIP). States request that CMS provide further clarification of this provision. Specifically, it is unclear if CMS is creating a new definition for what will be considered an "SCHIP provider." We note that in states that have chosen to design their SCHIP program as a Medicaid expansion, there is no distinction made between those providers who provide services to the SCHIP population and those who provide services to Medicaid enrollees. We request that CMS address whether there are different qualifications for SCHIP versus Medicaid providers. In addition, we ask CMS to provide further clarification whether, if a state's Medicaid providers are considered to be SCHIP providers, they are exempt from the cost limit provisions of 447.206 for that unit of government. Alternatively, if a state's Medicaid providers are not considered to be SCHIP providers and are required to meet the cost limit provisions of 447.206 for that unit of government, we ask that CMS address whether the state should exclude SCHIP costs and reimbursements when making the Medicaid cost limit and overpayment determination. We note for your consideration that if CMS does not allow exclusion of the SCHIP costs and reimbursements in the cost limit determination the result may be a cost shift from the Federal government to the state Medicaid Agency for the difference between the states' regular FMAP and the enhanced SCHIP FMAP.

Implementation Timeframe

We respectfully urge CMS to revise the effective date of the proposed rule for two main reasons. First, we submit to CMS that there is tremendous confusion among state Medicaid officials as to the interpretation of the proposed rule and in seeking clarifications from CMS staff, we note that there has been disagreement among the CMS staff themselves as to how to interpret certain provisions of the proposed rule. For example, at this time, many states have reported that they are still unclear as to who CMS will determine to be a government operated provider. We believe it is unreasonable to expect states to meet the proposed effective deadline if CMS staff is still working to

understand and clarify the proposed rule. In addition, CMS has indicated that it would take a team of individuals working with states on an individual basis to determine the specific state impact and application. We believe that CMS cannot in good faith ensure that it will be able to accomplish such a significant task within the proposed timeframe.

Second, states also have reported that they – and the Medicaid providers in their respective states – will need significant time to adapt systems, methodologies, change state plans, etc. Developing a process for reconciliation necessary to comply with the cost-based provisions of the proposed rule would itself take considerable time and would not be available before proposed effective date. Many states have reported that they would need to work with their state legislatures to address the impact of implementing the proposed regulation. They would need at least a year from the date of issuance of the final rule in order to have an opportunity to convene their legislatures. In some states, implementation may require additional funding, and, in turn, this may require the involvement of state legislatures.

In addition, some states are reporting that they have identified several hundred potential government providers that would need to be reviewed and reported to CMS. Many governmental provider types do not have individual Medicaid cost reports which will need to be developed and approved by CMS. As a result, CMS should provide states with transition periods leading to more reasonable time period for implementation.

Regulatory Impact Analysis

On behalf of states, we ask that CMS reevaluate its regulatory impact analysis. We believe there are three general aspects in which it fails to provide an adequate assessment: (1) the federal revenues generated; (2) the cost of implementation to the federal government; and (3) the absence of any state fiscal impact.

In its Regulatory Impact Analysis, CMS estimates \$3.9 billion in federal savings from the proposed rule over five years. We request that CMS provide additional information on its analysis and methodologies used in producing this estimate. States are perplexed that CMS to date has refused requests for further information on its methodology for deriving this number that could otherwise assist states in determining CMS' assumptions and how states should interpret the provisions of the proposed regulation.

Second, CMS fails to account for the initial and ongoing *costs* of implementation and compliance with the proposed regulation to the federal government and to states. The estimated federal revenues generated does not appear to include offsets for new needs, including additional staff that states and the federal government will hire, the information technology and infrastructure development and changes, and educational efforts among states, providers and other stakeholders that will be required of the federal government. Notably, the proposed regulation understates the tremendous administrative burden on

providers and the indirect impact that additional provider mandates could have on states' ability to develop adequate provider networks. We also request that CMS indicate if and how it accounted for these costs as they relate to states that do not use the financing mechanisms that the agency wishes to limit.

Finally, as noted previously in our comments, there will be a significant increase in administrative costs for all states to comply with the proposed rule. We believe CMS is disingenuous in its portrayal of the regulatory impact by providing estimates solely for federal revenues while failing to account for the fiscal impact on states. In addition to the limitations placed on states' financing policies, states will face an unprecedented administrative burden that will result from various new requirements including staff time and resources to develop cost reports, collect, analyze and report the information to and from providers and CMS, undertaking policy changes to comply with the proposed rule, implementing systems updates to comply with the proposed rule, educating and fielding questions from public providers who will newly have to comply with cost reporting requirements among other issues. For example, some of the tasks associated with implementation may include:

- Reviewing all documents, including inter-state agreements and other agreements, to ensure consistency with proposed regulations.
- Reviewing financial documents and other documentation of all entities that contribute certified public expenditures (CPEs) to ensure that they meet the definition of a 'unit of government.'
- Reviewing all providers who may be considered a 'unit of government' to see if they meet this definition, in order to identify if reimbursement to a given provider must be limited to costs.
- Creating and implementing methods for collecting expenditure data for all units of government, including creating new cost reporting mechanisms and imposing additional cost-related documentation requirements.
- Reviewing all reimbursement methodologies for all services across all providers that meet the definition 'units of government.'
- In cases where services are reimbursed through CPEs, (1) ensuring that reporting requirements are consistent with proposed regulations; (2) reviewing and, if necessary, amending state plan methodologies to reflect new payment structure; and (3) negotiating approval with CMS as needed.
- In cases where services are not reimbursed through CPEs, (but where the provider is a 'unit of government:'), states will need to (1) review and, if necessary, amend state plan methodologies to reflect limit of payment to costs; (2) review and, if necessary, amend regulations and state statutes to ensure that they reflect that payments to these providers are limited to costs; and (3) negotiate approval with CMS as needed..

Leslie V. Norwalk, Esq.

March 19, 2007

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We would be happy to provide you with additional information on our comments as you go forward. Please contact Martha Roherty, Directory of NASMD, at (202) 682-0100 if we can be of further assistance.

Sincerely,



Jerry Friedman
Executive Director
American Public Human Services Association



David Parrella
Chair
NASMD Executive Committee

Submitter : Mrs. Denise de Percin
Organization : Colorado Consumer Health Initiative
Category : Consumer Group

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-2258-P-227-Attach-1.DOC

March 19, 2007

To: Centers for Medicaid/Medicare Services

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

The Colorado Consumer Health Initiative is a member-based nonprofit organization dedicated to barrier-free access to quality, affordable health care for all Coloradans. We are concerned about the impact of CMS-2258-P on hospitals in Colorado that provide critical services to low-income and uninsured populations as part of Colorado's health care safety net.

Under the proposed rule, only those providers meeting a new definition of "unit of government" could qualify for "certification of public expenditures." This is the mechanism used to draw down federal funds for the purpose of partially compensating hospitals for providing medical care for individuals who qualify to receive discounted services, generally through the Colorado Indigent Care Program (CICP.) In FY '05'06 180,000 uninsured Coloradans were served in CICP.

Three urban hospitals (Denver Health Medical Center, University Hospital, and Memorial Hospital) account for 92% of the federal funds used to care for low-income Coloradans and the remainder are crucial parts of the safety net for underserved rural Coloradans. They will not meet the new definition of "unit of government."

The loss in federal funds to these providers who have historically been identified as publicly owned and have faithfully served low income Coloradans would be at least \$142.2 million per year. Without the ability to draw federal funds, these hospitals will be unable to continue to provide uncompensated care for Medicaid and other low-income Coloradans.

Under Colorado's constitutional tax restrictions, this money can not simply be replaced by the state. Certification of public expenditures is a critical funding mechanism because, as the law allows, it can replace the General Fund portion of the match used to draw down federal funds for Medicaid. This places our entire budgetary system and all our other state commitments, from education to investments in future energies, in jeopardy.

This ruling will have a devastating affect on Colorado's poorest and most vulnerable populations in a state that has over 774,000 uninsured, a rate of over 17%. Removing funding for services from these hospitals will amplify the health care crisis in Colorado, destabilizing our entire health care system. We join with the other hospitals, low-income advocates, health-care advocacy organizations, and consumer-interest groups in strongly opposing this regulation.

Submitter : Dr. Stephen Klasko
Organization : USF Health/USF College of Medicine
Category : Physician

Date: 03/19/2007

Issue Areas/Comments

**Collection of Information
Requirements**

Collection of Information Requirements

Please See Attachment

GENERAL

GENERAL

Please 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. Kenneth Cohen
Organization : San Joaquin General (County) Hospital
Category : Local Government

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

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

Submitter : Dr. Stephen Klasko
Organization : USF Health/USF College of Medicine
Category : Physician

Date: 03/19/2007

Issue Areas/Comments

**Collection of Information
Requirements**

Collection of Information Requirements

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CMS-2258-P-230-Attach-1.PDF

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

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

Dear Ms. Norwalk:

The University of South Florida College of Medicine ("USF Health") and the Council of Medical School Deans (the "Council") urge the Centers for Medicare and Medicaid Services ("CMS") to withdraw the proposed rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership," CMS-2258-P (the "Proposed Rule"). The Proposed Rule will have profound impact on USF Health and will, seriously compromise medical education, training and research as well as adversely affect access to primary and specialty physician care for Medicaid and uninsured patients in Florida. The impact on the Council members and their respective schools is estimated to be \$25 million - annually.

Faculty physicians employed by and under contract with USF Health are the state's providers of primary and specialty services for vulnerable populations, including Medicaid and uninsured persons. Through this critical access, USF Health trains and educates a significant portion of Florida's physician workforce, and is committed to developing advances in medicine through both clinical practice and research.

Our comments address six major components of the Proposed Rule, which are:

- Certified Public Expenditure regulations;
- Restrictions on the sources of non-federal share funding;
- Definition of a unit of government and health care provider operated by a unit of government;
- Cost Limits imposed on providers;
- Retention of Payments; and

- Effective Date.

The specific USF Health comments by section of the Proposed Rule are as follows:

I. Certified Public Expenditure

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

The Preamble to the Proposed Rule indicates that CPEs may only be used in connection with provider payments based on cost reimbursement methodologies. This restriction on the use of CPEs is unnecessary. In Florida, the only CPEs are claimed in conjunction with physician supplemental payments, and physicians are NOT reimbursed on a cost based methodology in Florida. Faculty physicians incur costs associated with care provided to Medicaid patients, whether they are paid on a cost basis or not; those costs are no less real or certifiable based on the payment methodology.

For example, physicians in Florida are paid approximately half of the amount they would receive under Medicare for services provided to Medicaid eligibles; and the reimbursement rates for physicians for such services have not been increased in years. To impose a cost based system on the faculty physicians - which are the only physicians eligible to receive supplemental payments - would result in faculty physicians incurring an additional cost simply to comply with a new reimbursement scheme, which is not used by another payer - public or private.

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

2. *CPEs do not need to be tax derived in order to be used as the non-Federal share of Medicaid payments.*

The Proposed Rule requires IGTs to be tax-derived, but this requirement does not appear to be imposed on CPEs. USF Health believes that any public funds should qualify as CPEs and that CPEs should not be subject to the "tax-derived" qualification.

In Florida, the physician supplemental payments are supported by CPEs – some of which are tax derived and others which are not. It is unclear whether state university funds or amounts paid to private universities by units of government qualify as CPEs; and, what, if any, qualifications are placed on the public funds paid to the private university in order for such to be eligible CPEs.

Recommendation: CMS should clarify that any public funds may serve as CPE for expenditures approved in the state plan amendment regardless of whether the receiving entity is a unit of government or a private entity.

3. *CPEs must be documented as a Medicaid expenditure.*

Once an expenditure is approved under the State plan, any public expenditure - whether contractual or otherwise - should qualify the non-federal share of such expenditure. Just as CMS wants assurance that the expenditure results in a demonstrable service so does the local governmental entity that is providing the CPE, and one way the local governmental entity can

hold the provider accountable is through a contractual relationship and contractual obligations. It is unclear, what public university expenditures for its faculty physicians would be allowed as a CPE under the Proposed Rule. For instance, would it be possible for the state universities to certify as an expenditure the portion of the faculty physicians' salary spent treating Medicaid patients? And, would it be possible for a unit of government that pays a private university for physician services to certify those funds under Medicaid, if the services provided by those physicians are approved under the state plan amendment?

Recommendation: Once CMS has approved a payment methodology in the State's plan, demonstration of the expenditure - other than the usual claim for the Medicaid service provided - should not be necessary.

4. *Units of government may certify an expenditure made to pay specific providers for the non-Federal share of Medicaid services within the state's approved Medicaid plan.*

It is unclear what, if any, expenditures by public entities qualify as CPEs, and the required subsequent documentation and approval process appears to be arbitrary. Any expenditure by a governmental entity to a provider should qualify as long as the provider is delivering Medicaid services as defined and approved in the state's plan. As noted above, when a public entity is contractually obligated to reimburse private faculty physicians, which are in turn obligated to provide services to the public entity's patients, those public payments should qualify as CPEs.

Recommendation: CMS should defer to the services and payment methodologies approved in the State plan, and however the public entity pays the provider should qualify as a CPE.

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

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

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

I. State and Local Tax Revenue

6. *State and local appropriations by a unit of government made directly for the benefit of a public or private university college of medicine, which operates a faculty practice plan, should be a permissible source of the non-Federal share of Medicaid expenditures.*

If the Proposed Rule is finalized in its current form, it is unclear if the appropriations made to non-governmental providers by a unit of government or governmental providers without taxing authority are eligible for match under the Medicaid program as either CPEs or IGTs. CMS should state that appropriations made directly to a provider will continue to be fully matchable under the new regulation, and that CMS will not disallow such taxpayer funding as an indirect provider donation.

For example, public and private universities in Florida receive state appropriations in support of undergraduate medical education, it is unclear whether these funds could be used as CPE for supplemental payments approved in the state plan for the faculty physicians employed by or under contract with those universities.

Recommendation: CMS should clarify that it will not view the transfer of taxpayer funding for a specific provider as an indirect provider donation and allow those appropriations to be considered IGTs or CPEs.

7. *Payments made to a provider by a unit of government with taxing authority to fulfill the governmental entity's obligation to provide health care services would qualify as the non-Federal share of Medicaid expenditures.*

The Council urges CMS to reconsider the dictate that funds contractually obligated by a governmental entity to a health care provider cannot be used as IGTs; however, it is unclear if those funds would qualify as a CPE. For instance, a community in Florida has opted to tax itself to provide access to physician and hospital services, will the funds obligated and expended to pay faculty physicians qualify as a CPE for services approved and provided under the state plan.

Recommendation: CMS should modify the rule and allow tax revenues generated specifically for health care services, which are contractually obligated to both governmental and non-governmental providers to be eligible CPEs.

II. Defining a Unit of Government (§ 433.50)

8. *If a new definition of unit of government is adopted, CMS should clarify that the unit of government definition applies only for purposes of the payment limits and financing restrictions and not to other areas of Medicaid law and policy.*

The public universities' faculty practice plans are private corporate entities separate and apart from the university; therefore, it is unclear whether the employees of the public universities that bill Medicaid for services rendered under the private practice plan would still be considered "units of government" or operated by a "unit of government" under the Proposed Rule.

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

II. Cost Limit for Providers Operated by “Units of Government” (§ 433.206)

9. *The Proposed Rule does not specify whether and under what circumstance physicians would be considered to be governmentally operated.*

The Proposed Rule applies the cost limit to “health care providers that are operated by units of government.”¹ It is clear from the text of the regulation that it applies not just to hospital and nursing facility providers, but also to “non-hospital and non-nursing facility services.”² Beyond this clarification, the scope of the term “providers” is unclear. It might be possible for a state to determine that the cost limit extends as far as physicians employed by governmental entities or physicians under contract with governmental entities. CMS should clarify that it does not intend the regulation’s reach to extend this far.

Cost-based methodologies are particularly inappropriate for physician services. Moreover, given the difficulties of calculating costs for professional providers, the additional administrative burden on states and the impacted professionals would far exceed the value of the cost limit. This issue should subsequently be resolved as to CPEs for physician payments, which are not typically conducive to cost based methodologies. Further, if physicians are forced to convert to a cost based reimbursement methodology the costs associated with the reconciliation processes will be significant.

Recommendation: CMS should clarify that the cost limit applies only to institutional government providers and not to professionals employed by or otherwise affiliated with units of government; and that CPEs can be made for physicians, which are not subject to cost based reimbursement methodologies.

10. *The Medicare upper payment limit is reasonable and sufficient.*

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

It took significant time and effort to negotiate a reasonable UPL for faculty physicians in Florida, and the proposed Rule would potentially negate the critical supplemental physician payments.

¹ Proposed 42 C.F.R. § 447.206(a).

² Proposed 42 C.F.R. § 447.206(c)(4).

Recommendation: CMS should maintain the current upper payment limit principals.

11. The cost limit undermines important public policy goals.

At a time when the federal government is calling on providers to improve quality and access as well as invest in important new technology, is not the time to impose unnecessary funding cuts on governmental or safety net providers. Although disproportionately reliant on governmental funding sources, faculty practice plans have, in recent years, made significant investments in new (and often unfunded) initiatives that are in line with HHS' and AHCA's policy agenda.

For example, the College of Medicine has invested millions of dollars in adopting electronic medical records and other new information systems that have a direct impact on quality of care, patient safety and long-term efficiency, all goals promoted by HHS and AHCA. HHS has focused on expanding access to primary and preventative services particularly for low-income Medicaid and uninsured patients and reducing inappropriate utilization of emergency departments. Council members have been engaged in this effort, establishing networks of off-campus, neighborhood clinics with expanded hours, walk-in appointments, assigned primary care providers and access to appropriate follow-up and specialty care. These initiatives require substantial investments of resources. CMS does not appear to have considered the impact of the cut imposed by the cost limit on shared policy initiatives that HHS itself has established as key goals of America's complex health care system. The only goal achieved by the Proposed Rule would be the dismantling of Florida's safety net.

Recommendation: CMS should improve its review of the current cost limits as opposed to developing an extremely restrictive cost limit structure.

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

Under current Medicaid managed care regulations, states are prohibited from making direct payments to providers for services available under a contract with a managed care organization (MCO) and Prepaid Inpatient Health Plan or a Prepaid Ambulatory Health Plan.³ There is an exception to this prohibition on direct provider payments for payments for graduate medical education made to hospitals, provided capitation rates have been adjusted accordingly. Given the extreme funding cuts that will be imposed on faculty physicians by the imposition of the cost limit, the Council urges CMS to reconsider the scope of the exception to the direct payment provision. USF Health and the Council recommend that states be allowed to make direct Medicaid fee-for-service payments to faculty physicians for all unreimbursed costs of care for Medicaid managed care patients, including GME costs.

Because the payments would be based on costs pursuant to the new regulation, there would not be the danger of "excessive payments" that has concerned CMS in the current system. Moreover, to avoid double dipping, states could be required to similarly adjust capitation rates to

³ 42 C.F.R. §438.60.

account for the supplemental cost-based payments. If reimbursement to faculty physicians is going to be restricted to cost, it should include costs for all Medicaid patients, not just those in the declining fee-for-service population. This adjustment would be critical in states like Florida, where there has been a significant shift to managed care organizations, particularly under operation of Florida's 1115 waiver.

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

II. Retention of Payments (§ 447.207)

USF Health and the Council support CMS' attempts to ensure that health care providers retain the full amount of federal payments for Medicaid services. We do not believe, however, that the this provision will have a major impact on physician supplemental payments, which are supported by CPEs. Although CMS asserts that governmental providers will benefit from the Proposed Rule in part because of the retention provision, this new requirement does not come close to undoing the potential damage caused by the cuts to payments and changes in financing required by other provisions of the Proposed Rule.

13. *CMS should require states to pay all federal funding associated with CPEs to the provider.*

The retention provision requires providers to "receive and retain the full amount of the total computable payment provided to them."⁴ We assume this requirement applies to all payments, whether financed through IGTs, CPEs, state general revenues or otherwise.

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

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

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

⁴ Proposed 42 C.F.R. § 447.207(a).

under the Medicaid program. It does not have authority over providers' use of Medicaid payments received.

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

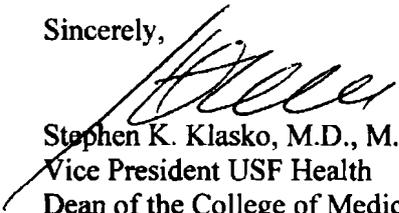
In addition to the issue specific comments, if such a Proposed Rule is to move forward, the Council urges CMS to consider replacement funding or at a minimum a transition period. Many state legislatures do not meet year-round. For instance, Florida just began its 60-day Legislative Session and if the Proposed Rule were to go into effect, it would difficult to reconvene the Legislature to make all of the necessary appropriations and statutory changes for Florida's program to be compliant with the new regulatory requirements.

15. CMS should provide for either replacement funding or a reasonable transition period for states to be compliant.

Recommendation: CMS should delay implementation of the Proposed Rule until such time that replacement funding can be determined; CMS should include a reasonable transition period for the effective date of the Proposed Rule.

This concludes the comments submitted by USF Health relative to the direct impact on Council members.

Sincerely,


Stephen K. Klasko, M.D., M.B.A.
Vice President USF Health
Dean of the College of Medicine

CC: Anthony Silvagni, D.O.,
Chair, Council of Florida Medical School Deans

Judy Genshaft, Ph.D.
President, University of South Florida

Submitter :

Date: 03/19/2007

Organization : University of Colorado Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-231-Attach-1.DOC



UNIVERSITY OF COLORADO
HOSPITAL

March 19, 2007

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

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

To Whom It May Concern:

Thank you for the opportunity to provide comment regarding the above cited Rule as proposed by the Centers for Medicare and Medicaid Services. As a general opening statement, we oppose the portion of the Rule that proposes to change the definition of “unit of government.” Its implementation would have a devastating impact on the University of Colorado Hospital and more than 20 additional “safety net” providers in the State of Colorado greatly compromising our overall ability to care for the State’s medically underserved population.

Background:

Since 1921, the University of Colorado Hospital (UCH) has served as the major teaching hospital for the University of Colorado, including its schools of medicine, dentistry, nursing, and pharmacy. UCH has historically been one of Colorado’s leading providers of care for the state’s medically underserved population – today UCH is the state’s second largest “safety net” provider.

Until 1991, UCH was a component of the University of Colorado, a “state institution” governed by the University of Colorado Board of Regents. In 1991, the Colorado General Assembly enacted a statute creating the “University of Colorado Hospital Authority” as a “body corporate *and political subdivision*” of the State of Colorado. The primary rationale behind this statutory/structural change was to permit UCH to operate more independently in a rapidly changing healthcare environment and continue to serve as the major teaching hospital for the healthcare professions education programs offered by the University of Colorado.

In addition, when the state legislature changed the statutory structure of UCH a provision was included in state law (**Colorado Revised Statutes 23-21-504. Mission of the authority – obligation to provide uncompensated care – action of the board of directors**) mandating UCH to provide care for the State's underserved population – now numbering more than 770,000 in Colorado. Not only does UCH have this statutory obligation, but we have historically maintained a strong moral and philosophical commitment to serve the State's medically indigent population. In fiscal year ending June 30, 2006, UCH admitted over 2,000 inpatients, qualifying under our State's Colorado Indigent Care Program (CICP), totaling nearly 11,000 patient days. In addition, UCH saw a total of more than 48,000 CICP outpatient visits during that same fiscal year. In total UCH wrote-off nearly \$168 million in net charges for indigent/charity care in FY 2006.

This background is important to set the foundation for our opposition to the change to the definition of "unit of government" proposed by the Rule 42 CFR – CMS-2258-P.

Proposed Rule 42 CFR – CMS-2258-P:

University of Colorado Hospital expresses its strong objection to this proposed CMS Rule and its scheduled implementation on September 1, 2007. Should this proposed Rule take effect our hospital stands to lose about \$30 to \$35 million each year in federal Medicaid Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) funds based on our unreimbursed Medicaid and low-income uninsured costs. In addition the State of Colorado as a whole would stand to lose as much as \$140 million in federal funding that supports the State's safety net and long term care providers. This loss of federal funding would be devastating to UCH's and the rest of the State's safety net providers' ability to provide care for Colorado's medically underserved population.

Specifically, by CMS's narrowly defining "government" or "public" hospital to be only those supported by "units of government having taxing authority", or hospitals that "have access to a unit of government that has taxing authority", and such taxing authority is "responsible for the expenses, liabilities and deficits" of such hospitals, it excludes Colorado's two largest indigent care providers, University of Colorado Hospital and Denver Health (DH) (also a "state authority"). Through Certification of Public Expenditures (CPE), it is our two hospitals together that have been able to acquire the federal Medicaid matching funds that have supported our institutions and many other safety net hospitals in Colorado. As "public authorities" neither UCH nor DH would meet the proposed definition and thus would not qualify as eligible providers to continue to participate in federal DSH and UPL funding. As statutory "public authorities" in Colorado our hospitals would still be expected to remain as significant providers of care for the medically indigent in the state. However, should the Rule take effect, it would be extremely difficult for UCH (and DH) to continue to serve as models in Colorado as dominant safety net providers. Subsequently, care for our state's medically underserved would be severely compromised; likely reducing access for thousands of Colorado's most medically vulnerable.

Also, the timing of the September 1, 2007 proposed effective date makes it very difficult for UCH and the State of Colorado to react, develop, and implement appropriate alternatives.

CMS notes in the "Background" discussion accompanying the Rule that title XIX of the Social Security Act (the "Act") requires that states share in the cost of Medicaid expenditures but permits the states to delegate some responsibility for the non-Federal share of the Medicaid expenditures to units of local governments under some circumstances. The Rule's revision to 42 C.F.R. section 433.50 would re-define when a hospital will be considered a "unit of government" and thus eligible to certify public expenditures. The Rule would do this by limiting the "unit of government" definition to a hospital that (1) has "generally applicable taxing authority" or (2) is able to access funding as an integral part of a unit of government that both has taxing authority and is legally obligated to fund the hospital's expenses, liabilities and deficits. The consequence of this re-definition is that a hospital that previously was considered a "unit of government" would no longer be one (in the eyes of CMS) if it is not able to satisfy one of these two new criteria and, significantly, would no longer be able to certify public expenditures.

UCH would not be able to satisfy either of the two new criteria and thus would not be able to certify public expenditures even though it is a political subdivision of the State of Colorado and incurs substantial expenditures from providing medical care to Medicaid and medically indigent patients. The Rule offers no statutory basis to support this proposed change in the definition of "unit of government" nor CMS's authority to make this change through administrative rule making. Further, the Rule offers no public policy rationale for why a hospital that has taxing authority or a hospital that is a component of a taxing authority entity that provides the hospital with funding and is legally obligated for its liabilities should be permitted to certify public expenditures but all hospitals that are a unit of government, but for this re-definition, should not be able to certify public expenditures.

The Rule cites and relies extensively on the fundamental principle of the Act that the Federal government is to pay only its proportional cost of the delivery of medical services under the Medicaid Program and is not to pay more. This principle can hardly be used to support the proposed change to the definition of "unit of government" because UCH and other hospitals that today are units of government and have been certifying their public expenditures have indeed incurred those expenditures which the Federal government is required to match. The Federal government has not been paying these hospitals more than its statutorily-required fifty percent match so, possibly unlike the situation with intergovernmental transfers, this proposed re-definition cannot be justified as needed to ensure that the Federal government is paying more than its match amount. The proposed re-definition will not change the fact that UCH and the other hospitals still have the costs of the medical expenditures but will eliminate the Federal government's payment of the federal match.

It is for the above stated reasons that we strongly encourage CMS to reevaluate the proposed Rule taking into consideration current statutory status of University of Colorado Hospital and the negative fiscal impact on our hospital, the State of Colorado, and numerous other hospitals in our

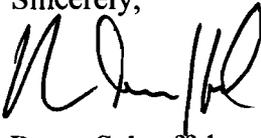
Comment to Proposed Rule CMS-2258-P

March 20, 2007

Page 4 of 4

State and throughout the country. Accordingly we urge CMS to withdraw this Rule or, at the very least, amend the Rule to broaden the definition of "government" or "public" hospital such that those traditional and statutorily recognized public hospitals, that have demonstrated a long history and commitment to treating Medicaid patients, and the under- and uninsured can continue to provide this much needed care.

Sincerely,

A handwritten signature in black ink, appearing to read "Bruce Schreffel". The signature is fluid and cursive, with a large initial "B" and "S".

Bruce Schreffel
President & CEO

Submitter : Mr. Arthur Gianelli
Organization : Nassau University Medical Center
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

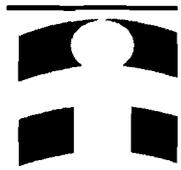
GENERAL

GENERAL

See Attachment

CMS-2258-P-232-Attach-1.WPD

CMS-2258-P-232-Attach-2.DOC



**NASSAU HEALTH CARE CORPORATION
NASSAU UNIVERSITY MEDICAL CENTER**

2201 Hempstead Turnpike
East Meadow, New York 11554
(516) 572-0123

March 19, 2007

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

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

Dear Ms. Norwalk:

On behalf of Nassau University Medical Center (“NUMC”), the acute care hospital operated by Nassau Health Care Corporation (“NHCC”), I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P (“the Proposed Rule”). The Proposed Rule jeopardizes critical financial support that has been provided to help continue NUMC’s and, to a lesser extent, AHP’s, safety-net mission. That support has been essential to our ability to serve as a major safety net health care system in our community, and we urge that it not be eliminated.

The Nassau Health Care Corporation (“NHCC” or the “Corporation”) was created by special New York State enabling legislation, which created NHCC as a New York State Public Authority and permitted the transfer to NHCC of operation of the hospital, nursing home and community health centers previously operated by Nassau County. The transfer of operations took place in September of 1999, at which point NHCC assumed responsibility for Nassau University Medical Center (“NUMC”), a 631-bed hospital; the A. Holly Patterson Extended Care Facility (“AHP”), an 889-bed Skilled Nursing Facility (“SNF”); and six community health centers, licensed as Diagnostic and Treatment Centers, and one school health clinic (collectively, the “Community Health Centers” or the “DTCs”).

Although NUMC operates in an area served by a number of other hospitals and nursing homes, NUMC and AHP have consistently served as the providers of last resort for the residents

**A. HOLLY PATTERSON EXTENDED CARE FACILITY
ELMONT HEALTH CENTER – FREEPORT-ROOSEVELT HEALTH CENTER – NEW CASSEL-WESTBURY HEALTH CENTER
INWOOD-LAWRENCE HEALTH CENTER – HEMPSTEAD COMMUNITY HEALTH CENTER – LONG BEACH HEALTH CENTER
The Office of Home Care, A Certified Home Health Agency**

of the six Nassau County communities that have high rates of poverty, and a correspondingly high number of residents eligible for Medicaid, or who are under-insured or uninsured.

NUMC is the predominant provider of inpatient, outpatient and emergency room services to Medicaid, underinsured and uninsured residents of the County. NUMC is a Level I Trauma Center, operates the County's only Burn Center, operates the only secure psychiatric emergency room in the County, provides substantial inpatient psychiatric services, and provides many other programs to serve the needs of the most disadvantaged members of its community, including operating a broad range of Outpatient Clinics. In recognition of its role as a key safety-net provider, NUMC has been designated a Disproportionate Share Hospital and has benefited from the support of its safety-net mission through several programs, including the Inter-Governmental Transfer ("IGT") program. Similarly, our nursing home, AHP, serves as a critically-needed resource of last resort to the County's most disadvantaged residents, many of whom are difficult to place in traditional nursing home settings.

The IGT program has provided a mechanism to support our safety-net mission. We depend on support from County government's participation in the IGT program in order to have the resources to carry out our safety-net mission. Several of the provisions in the Proposed Rule would add a layer of complication and/or would constrain the County's ability to provide County funded support to us through the IGT program. Our concern is that such impediments could either reduce the available sources of the County's support or erode the County's willingness to provide support through the IGT Program. Without this support, our ability to continue to carry out our safety-net mission would be placed into serious jeopardy.

As the major safety net provider in our community, we strongly oppose the Proposed Rule and respectfully request that you withdraw the Proposed Rule immediately. We also request that you clarify that, other than those federal funds that are not permitted to be used for this purpose, any County or State government assets or funding, from tax levy, tax anticipation and other borrowings or from any other County source of funding, as well as in-kind services provided by the County, are eligible to satisfy the local matching requirement of the IGT program.

Rather than discussing in detail the many technical and practical issues raised by the proposed rule, we join in the comments on the Proposed Rule by the National Association of Public Hospitals and Health Systems, submitted to the Centers for Medicare and Medicaid Services on March 8, 2007.

Thank you for the opportunity to comment on the Proposed Rule. Given the potentially devastating impact it would have on NUMC, on our patients and on our community as a whole, we request that you withdraw the proposed regulation immediately.

If you have any questions about this letter, please feel free to contact me.

Sincerely,

Arthur A. Gianelli
President and CEO

Submitter : Mr. Timothy Jefferson
Organization : Grady Health System
Category : Health Care Provider/Association

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachement

CMS-2258-P-233-Attach-1.DOC

March 20, 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
P.O. Box 8017
7500 Security Boulevard
Baltimore, MD 21244-8017

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

Dear Ms. Norwalk:

The following comments are prepared by Grady Health System, which urges the Centers for Medicare and Medicaid Services (CMS) to reconsider Proposed Rule CMS-2258-P (the Proposed Rule) for reasons explained below.

Specifically, the comments provided in this letter address the proposed limitation of Medicaid payments to cost for services for those facilities deemed by CMS to be “units of government” and are confined to two main issues, in this regard:

1. The differential payment reimbursement for those facilities deemed to be units of governments; and
2. The lack of clarity regarding how the cost cap will be calculated.

I. Introduction

Grady Health System (GHS) is one of the largest safety net hospitals in the Southeast – and includes Grady Memorial Hospital, Hughes Spalding Children’s Hospital, and ten neighborhood and airport health centers. Grady Memorial Hospital (Grady) is a 900+ bed Level I Trauma center located in Atlanta, Georgia and is the only level one trauma center within a 100-mile radius.

Grady is also an internationally recognized teaching hospital; twenty-five percent of all physicians practicing medicine in Georgia received some or all of their training at Grady.

In addition to its trauma care and teaching role, GHS serves a large number of low-income patients. As part of its commitment to the community, GHS specifically “maintains its historic commitment to the health needs of those most vulnerable . . . Grady shields other Atlanta hospitals from a massive burden of uncompensated care.”

The system receives financial support from Fulton and DeKalb counties. In 2006, Grady received approximately \$105 million from Fulton and DeKalb Counties. Approximately \$30 million of this amount was for debt service; the remaining amount was for indigent care services provided by Grady. Disproportionate share hospital (DSH) and upper payment limit (UPL) payments are critical to the survival of GHS, as the largest safety net facility in Georgia.

II. The Need for Federal Funding to Support Safety-Net Providers

The need for federal funding to support the healthcare safety-net system in this country is undeniable. In a 2004 paper for the National Health Policy Forum,¹ the authors found that hospitals – as opposed to community centers or individual physicians – are the nation’s providers of uncompensated care in this country.

Medicaid DSH is the largest source of federal funding used to support this uncompensated care. The burden of uncompensated care is highly variable dependent on the size, location, and governance of the locale. In some areas, uncompensated care is spread among a number of providers. In other areas, such as Georgia, the majority of uncompensated care is provided by one hospital.

In September 2002, a report completed by RAND and the Urban Institute for the Office of the Assistant Secretary of Planning and Evaluation (ASPE),² analyzed the distribution of DSH payments. According to the study, it was estimated that

Sixty-four percent of net Medicaid DSH payments went to hospitals with at least 30 percent low-income patients. Furthermore, it found that 63 percent of net Medicaid DSH payments went to hospitals with Medicaid utilization rates at least one standard deviation above their statewide average. Roughly 75 percent of net Medicaid DSH payments went to hospitals that had negative total margins before receiving these payments.³

Grady Hospital is the disproportionate share hospital in Georgia. It provides almost half of all low-income care in the state. Grady is paid significantly less than its total costs for all Medicaid and uninsured patients. The proposed rule will have a potentially devastating effect on GHS, Georgia’s healthcare safety net.

¹ See Robert E. Mechanic, “Medicaid’s Disproportionate Share Hospital Program: Complex Structure, Critical Payments,” NHPF Background Paper, September 14, 2004. Accessed February 7, 2007 at http://www.nhpf.org/pdfs_bp/BP_MedicaidDSH_09-14-04.pdf.

² Id.

³ Id.

III. Current Proposed Rule Change

A. Differential payment reimbursement for those facilities deemed to be units of governments as opposed to those facilities that are deemed private

1. Issue

While federal law uses the term “public entities,” the term has never been clearly defined, CMS is proposing to define “unit of government” for purposes of §447.206. The rule would go on to limit payments to providers owned or operated by a “unit of government and, narrow the permissible funding sources of the non-federal state share of Medicaid payments.

The rule change would limit payments to providers operated by units of government to “reimbursement not in excess of the individual provider’s cost of providing covered Medicaid services to eligible Medicaid recipients.” On the face, this change singles out facilities deemed to be units of government and limits their Medicaid reimbursement to costs. As currently proposed, only “public” providers would have their Medicaid reimbursements limited to costs, private providers would continue to be reimbursed up to their full charges for Medicaid services. On the other hand, entities that do not meet the proposed definition of a “unit of government” would be prohibited from contributing funding, not to exceed the appropriate non-federal share, of Medicaid expenditure through IGTs.

All hospitals – whether deemed public or private for Medicaid purposes – must remain financially viable in order to provide needed medical care to the community. As already discussed, however, certain providers have an even greater financial burden due to their commitment to Medicaid-covered patients, the uninsured, and providing medical education to doctors and other healthcare professionals.

Given this, it is even more puzzling why CMS would limit Medicaid reimbursement to cost for some providers and not others. CMS’ proposed cap on public hospitals’ Medicaid payments seemingly stems from concerns over public hospitals’ use of intergovernmental transfers. But the proposed cap limits payments to public hospitals without directly addressing the issue of IGTs.

To the extent that CMS is concerned about abuse of IGTS, it should directly limit IGTs by capping IGTs at an amount not to exceed the state share percentage of a public hospital’s cost of care to Medicaid and uninsured individuals minus payments received for care of these individuals. Abusive IGTs can and should be dealt with but without a punitive cap on Medicaid payments.

2. Recommendation

CMS should limit Medicaid reimbursement to all hospitals based upon a hospital's cost of caring for Medicaid and uninsured patients and should directly limit IGTs from public providers based upon the state share of the provider's unreimbursed costs. This would be a fairer approach.

B. Lack of clarity regarding how the cap will be calculated

1. Issue

Not only is the proposed cost cap inequitable, the definition of "costs" for purposes of capping reimbursements is vague and ill-defined under the Proposed Rule. Because the extent of potential cuts is dependent upon what costs CMS will and will not allow the states to reimburse, this lack of clarity is of grave concern to Grady.

CMS must clarify what costs will be allowed for purposes of limiting Medicaid reimbursements. In doing so, CMS should specifically allow for all costs necessary to operate a safety-net facility such as Grady. To remain viable and thus continue to provide the services that "shield" other providers from a larger burden of care to the uninsured, Grady must meet salaries, contractual payments to physician groups, and support of community clinics. In addition, Grady incurs legitimate costs for capital costs, and investments in technology. Moreover, as noted above, Grady has a great responsibility for the training of medical personnel; thus, as one of the largest teaching hospitals in Georgia, it incurs significant medical education costs.

Safety-net providers such as Grady also have other costs that are appropriate for reimbursement under Medicaid or DSH but which are not allowed for purposes of Medicare reimbursement. In considering capping reimbursements to costs, CMS must consider that safety net facilities provide care for the uninsured that is beyond current Medicaid reimbursement. Absent universal health coverage, Grady must rely on Medicaid reimbursements to help subsidized the large financial burden of providing safety-net services to the community.

Finally, it is imperative that GME costs are allowed for purposes of this cost calculation. As noted above, Grady provides a valuable service to the whole state of Georgia by virtue of its training of medical personnel. This adds to Grady's financial burden and cannot be borne by the teaching hospital alone.

2. Recommendation

Given the above, Grady recommends that CMS adequately define what will be determinant of "costs" for purposes of capping reimbursements. In addition, any graduate medical education cost should be allowed as a legitimate cost under the Proposed Rule.

V. Conclusion

The Proposed Rule is a blunt approach to addressing CMS' legitimate concerns over states' funding of their Medicaid programs. CMS and the Office of Inspector General have aptly demonstrated instances of recycling of federal funds and of IGTs. These abuses can and should be remedied.

But the Proposed Rule does not directly address these abuses, and it carries the risk of significant harm to safety net providers such as Grady. CMS should ensure fair and equitable Medicaid reimbursement for all providers regardless of their public or private status. To the extent that there are abuses of intergovernmental transfers, these should be directly addressed by the Rule not indirectly through an inequitable cost cap.

Again, Grady appreciates the opportunity to comment on the proposed rule changes.

Sincerely,

Timothy Jefferson, Esq.
Interim President/CEO
Grady Health System

Submitter : Mr. Thomas Lackey
Organization : Highlands Medical Center
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-234-Attach-1.DOC

March 19, 2007

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

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

Dear Ms. Norwalk:

Highlands Medical Center appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospital and the patients we serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. These changes would cause major disruptions to our state Medicaid program and hurt providers and beneficiaries alike. And, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

CMS estimates that the rule will cut \$3.9 billion in federal spending over five years. This amount 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 plan to regulate in this area. Last year 300 members of the House of Representatives and 55 senators signed letters to Health and Human Services Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. More recently, Congress again echoed that opposition, with 226 House members and 43 Senators having signed letters urging their leaders to stop the proposed rule from moving forward.

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

Limiting Payments to Government Providers

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

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

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

New Definition of "Unit of Government"

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

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

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

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

Insufficient Data Supporting CMS's Estimate of Spending Cuts

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

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

Sincerely,

Thomas O. Lackey, CEO
Highlands Medical Center

Submitter : Mr. Charles Ackers
Organization : The Elms
Category : Long-term Care

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

In regards to CMS 2258-P The Elms of McDonough County feels:

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.

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.

Submitter : Jan Hudson
Organization : Michigan Medical Care Advisory Commission
Category : Association
Issue Areas/Comments

Date: 03/19/2007

GENERAL

GENERAL

See Attachment

CMS-2258-P-236-Attach-1.PDF

CMS-2258-P-236-Attach-2.PDF

Medical Care Advisory Council

Advisory Council to the Medicaid Director

March 19, 2007

Members

Patricia Anderson
Health Care Association of Michigan

Roger C. Anderson
St. John Hospital and Medical Center

Dan Briskie
Mott Children's Health Center

Priscilla Cheever
Office of Services to the Aging

Vernice Davis-Anthony
Greater Detroit Area Health Council

Jackie Doig
Center for Civil Justice

Andrew Farmer
AARP Michigan Office

Dianne L. Haas
Haas Consulting Services

Dave Herbel
MI Assn. of Homes and Services for the Aging

Diana Hines
Detroit, MI

Alison E. Hirschel
Michigan Poverty Law Program

Dave LaLumia
MI Assn. of Community Mental Health Boards

Anita Liberman-Lamphear
University of Michigan Health System

William Mayer
Family Health Center of Battle Creek

Jackie McLean
Sault Tribe of Chippewa Indians

Gregory E. Piaskowski
Area Agency on Aging of Northwest Michigan

Peter J. Schonfeld
Michigan Health and Hospital Association

Paul N. Shaheen
MI Council for Maternal and Child Health

Kim Sibilsky
Michigan Primary Care Association

Dean Sienko
Ingham County Health Department

Walt Stillner
Michigan Protection and Advocacy Service

Mark Tucker
Midwest Health Plan

Jocelyn Vanda
Michigan Department of Human Services

Larry Wagenknecht
Michigan Pharmacists Association

Warren C. White, Jr.
Southwestern Medical Clinic, P. C.

Daniel J. Wilhelm
Michigan State Medical Society

Claude Young
Detroit, MI

Harvey Zuckerberg
Michigan Home Health Association

Jan Hudson, Chair
Michigan League for Human Services

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

Dear Ms. Norwalk:

On behalf of the Michigan Medical Care Advisory Council, the federally mandated advisory body to the State Medicaid director, I am writing to urge withdrawal of the proposed rule CMS - 2258-P, *Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership*, issued January 18, 2007. We oppose this rule and believe implementation and enforcement of such a rule would be seriously detrimental to the Michigan Medicaid program's ability serve the people it was created to serve.

This proposed rule represents a major departure from long standing Medicaid policy and practice by imposing new restrictions on how states fund their Medicaid programs without any identified need for such a dramatic change. This proposed policy alters the definition of public entities in such a way that many public entities in Michigan would likely be unable to continue their current role in helping to finance Medicaid program services, even though they would still be expected to provide the Medicaid eligible services to Medicaid eligible recipients. Public health departments, public schools, public universities, and public long term care facilities could all be at-risk if the proposed policy is adopted.

We urge you to withdraw the proposed rule which could certainly result in dire consequences for Medicaid recipients and public providers in Michigan. We also recommend that in the future, the data and facts supporting a proposed change be provided for review with the proposed change; no information was provided with this proposed rule to demonstrate its need.

Sincerely,



Jan Hudson, Chairperson
Michigan Medical Care Advisory Council

cc: Janet Olszewski, Director Michigan Department of Community Health
Paul Reinhart, Director, Michigan Medicaid Program
Michigan Congressional Delegation

Submitter : Mr. Wayne McElroy
Organization : Pickens County Medical Center
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-237-Attach-1.DOC

#237

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, N0. 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. Pickens County Medical Center alone will lose approximately \$300,000 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,

H. Wayne McElroy
Administrator
Pickens County Medical Center

Submitter : Mr. Jerry Friedman
Organization : The Ohio State University Medical Center
Category : Other Health Care Provider

Date: 03/19/2007

Issue Areas/Comments

**Collection of Information
Requirements**

Collection of Information Requirements

See attachment

GENERAL

GENERAL

see attachment

CMS-2258-P-238-Attach-1.DOC



Office of Health Sciences
370 West Ninth Avenue
200 Meiling Hall
Columbus, OH 43210

March 19, 2007

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

Attention: **CMS-2258--P**

Dear Administrator Norwalk:

The Ohio State University Medical Center (OSUMC) appreciates him this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) 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).

We agree with the American Association of Medical Colleges (AAMC), the American Hospital Association (AHA) and the National Association of Public Hospitals and Health Systems (NAPH) that the proposed rule should be withdrawn. The breadth of proposed changes as to how the state's qualify their non-federal matching funds will do serious damage to state Medicaid program financing. The nature of the fundamental changes proposed well exceeds the department's administrative authority as granted by Congress. Rather than unilaterally altering the federal state compact on Medicaid, CMS should work with Congress to determine whether, and to what extent, policy changes to the Medicaid program are needed.

As a major teaching hospital, OSUMC and its clinical physician faculty take seriously their commitment to treating the nation's poor by providing a disproportionate amount of healthcare to Medicaid recipients and uninsured patients while maintaining their core missions of education, research and innovative patient care.

In addition to being important participants in our community's and central Ohio's health care "safety net", we fill unique roles that extend beyond the normative patient care services: i.e., high risk OB, Burn Center, Level I trauma Center. Due to the concentration of health science colleges at OSU, our facilities are also sites for the clinical education of all types of health professional trainees; providing environments in which clinical research can flourish; and being sources of specialized, unique, and referral/standby services. Because of our education and research missions, teaching hospitals typically offer the newest and most advanced treatments and technologies, and often care for the nation's sickest and most complex patients. Today, our hospitals also are looked to as front-line responders in the event of a biological, chemical or nuclear attack and they are constantly refining their capabilities to fulfill this role, as well as responding to natural disasters. .

Undertaking these missions carry with it significant financial investment and important financial consequences. Even though we carry additional missions compared to other hospitals in our community, we must compete with them for business with health plans, employers and consumers. If Medicaid is not paying its fair share, those costs must be born in our charge structure by those other payers. If Medicaid is not paying its fair share, our commercial services may be priced out of the competitive market.

In Ohio, we are just beginning to understand the beneficial relationship between implementing policies of patient centered, evidence-based, clinical care management as well as programs of health and wellness. We have seen examples of other state Medicaid programs which have relied upon the academic medical community to ensure that the health care needs of Medicaid patients are met while allowing teaching hospitals and their faculty to also fulfill their other missions. Consequently, it is important that changes to the Medicaid program are viewed within this context. We are concerned that the totality of the changes in the proposed rule, if finalized, would significantly upset the delicate balance of resources that teaching hospitals rely on to fulfill their patient care and other missions.

When I last heard you speak in Columbus you articulated the necessity of implementing a culture of health and wellness within the Medicaid program. You understood quite clearly that transforming the delivery system from one of sick care to one of health care is the only way that Medicaid, and indeed healthcare for all of us can remain affordable and sustainable. That transformation requires funding services creatively and providing service dollars that can stimulate cost effective and efficient innovation.

Ohio does not have the additional budgetary resources within its general revenue fund to support these initiatives. It does however have significant investments in its public medical schools and their related provider networks to create waves of change across healthcare delivery and financing in Ohio. The proposed changes in rules will make it difficult if not impossible for the Ohio Medicaid program to work with its publicly funded academic medical centers to transform healthcare in Ohio.

If government-operated hospitals are limited to each entity's cost of providing Medicaid services to Medicaid recipients, the extra program to costs which we incur and that ultimately inure to the benefit of the Medicaid program will be foreclosed. Currently, state Medicaid programs have "upper payment limits (UPLs)" which, for government-operated providers, are based on what Medicare would pay for the same services and are calculated at an aggregate level. This allows states the flexibility to vary the amount paid to hospitals within the category, so long as the aggregate limit is not exceeded. This flexibility allows the state to target reimbursements to those facilities and providers who are providing value through efficient and effective care for Medicaid beneficiaries.

CMS asserts in the proposed rule that facility level cost limits are necessary because providers "use the excess of Medicaid revenue over cost to subsidize health care operations that are unrelated to Medicaid, or they may return a portion of the supplemental payments to the State as a source of revenue." (72 Fed. Reg. at 2241). This rule proposal is overly broad since CMS has already effectively required that providers retain all supplemental payments, at least that has been our experience in Ohio. Moreover in court filings, the Agency has explicitly recognized the value of allowing states flexibility to direct higher payments to certain hospitals having special needs (See AHA Comment Letter at 5-6).

The proposed rule does not address specifically what costs would be included in the determination of the facility specific-cost limits. For teaching hospitals, such costs include those associated with graduate medical education. Because medical education is a public good, its costs must be born across all consumers of teaching hospitals and other academic medicine service settings. Since the adoption of the PPS in Ohio in 1985, Medicaid's fair share of the costs of GME have been recognized by the state of Ohio. While historically Medicare and Medicaid have been among the few explicit payers for these mission-based services, we have struggled to leverage similar payments with managed care organizations and other payers to recognize their fair share of these costs and secure the benefits of academic medicine for their beneficiaries.

The President's fiscal year 2008 budget request includes an administrative proposal to eliminate Medicaid graduate medical education (GME) funding. We strongly oppose this budgetary proposal. We also question whether the Administration can implement such a proposal without explicit statutory direction. If the Administration does choose to raise this as a regulatory issue, we presume that CMS would pursue a distinct and explicit notice and comment rulemaking process.

The proposed rule would redefine the phrase “unit of government” and although we believe that the Ohio State University medical center would continue to qualify as a state owned and operated entity, on a statewide basis the narrowing of this definition will have significant impact on Medicaid's overall ability to finance its services. If this proposed change is enacted, it will drastically limit the number of providers that may participate in the state financing of Medicaid through allowable intergovernmental transfers (IGTs) or certified public expenditures (CPEs). Because of the cooperative nature and framework of the Medicaid program, undermining state authority to define governmental entities which are capable of performing Medicaid reimbursable services strikes at the heart of the programs unique ability to blend state and federal health care financing and delivery.

We agree with comments by the AHA and NAPH that this redefinition is both incompatible with and contrary to the Medicaid statute.

NAPH's comments eloquently and articulately describe such restructuring arrangements. They also discuss how these reconfigurations enhance the fiscal viability of the health care safety net, as well as improve access, quality, program responsiveness and public accountability. While perhaps not fully contemplated by the Agency, we believe CMS's proposal would result in an operational retrenchment of no benefit to states, hospitals and, most importantly, Medicaid beneficiaries.

We urge the Agency to withdraw the proposed redefinition.

If finalized, in combination with its redefinition of “unit of government,” the proposed rule would drastically restrict states' abilities to use allowable IGTs to finance the non-federal share of Medicaid payments. Specifically, the proposed rule preamble states that where a governmentally operated health care provider has transferred the non-Federal share in order to receive matching federal payments, the state must be able to demonstrate that “the source of the transferred funds is State or local tax revenue (which must be supported by consistent treatment on the provider's financial records).” (72 Fed. Reg. at 2238).

In the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234), Congress modified the use of provider taxes and donations to finance the non-federal share of Medicaid payments, but explicitly made clear that those restrictions did not affect IGTs (see Social Security Act 1903(w)(6)(A)). Given Congress' clear intent to protect states' uses of IGTs and CPEs as financing mechanisms, such direction must come from Congress and should not be unilaterally implemented through regulation.

As stated above, we believe the prudent course of action is for CMS to withdraw this proposed rule and work closely with the Congress and the health care community to address Agency concerns about current Medicaid policies. However, if CMS decides to move forward with some form of final regulation, we believe that a) the effective date for the new cost limit, unit of government definition, and limitations on IGTs and CPEs must be extended beyond September 1, and b) the final rule must be accompanied by a significant transition period. Both states and providers will need time to accommodate to the new policies and find alternative funding sources to minimize access and financing problems. We support NAPH's recommendation that such a transition period be 10 years.

The Ohio Medicaid program and the Ohio State University Health System have a long history of patient care, education and health services research that has helped to ensure that poor and uninsured patients have access to high quality care and the programmatic and policy decisions are made in an informed and deliberative fashion. We also believe it has a bright future. The proposed rule runs the risk of unraveling this mutually beneficial relationship. We urge the Agency to rescind the proposed rule and work with states and providers alike to initiate improvements to the Medicaid program that both strengthen it and ensure its long term financial viability.

If you have questions concerning these comments, please do not hesitate to contact me at (614) 292-3856 or Jerry.Friedman@osumc.edu

Sincerely,

Jerry Friedman, Assistant Vice President,
Health Policy and Government Relations
Office of Health Sciences

Submitter : Mr. Harold Reed
Organization : Fayette Medical Center
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2258-P-239-Attach-1.DOC

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. Fayette Medical Center alone will lose approximately \$200,000 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,

Harold Reed
Administrator
Fayette Medical Center

Submitter : Mr. Joseph Parker
Organization : Georgia Hospital Association (GHA)
Category : Hospital

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment" from Georgia Hospital Association (Word Document)

Trying PDF as site would not accept my *.doc file at 2:45 p.m.

CMS-2258-P-240-Attach-1.PDF

CMS-2258-P-240-Attach-2.PDF

#240



March 19, 2007

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

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

Dear Ms. Norwalk:

The Georgia Hospital Association, on behalf of its 172 member hospitals and health systems, appreciates this opportunity to comment on the above-captioned Proposed Rule imposing Medicaid cost limits on governmental providers. For the reasons specified below, and in the interest of protecting our most vulnerable citizens, we respectfully urge CMS to permanently withdraw its Proposed Rule.

General Comments

In its preamble to the Proposed Rule, CMS acknowledges that §1903(w)(vi)(A) of the Social Security Act, relating to intergovernmental transfers ("IGTs"), "was meant to **continue to allow** units of local government, including government health care providers, to share in the cost of the State Medicaid program." (72 Fed. Reg. at 2238.) However, far from allowing units of local government to continue participating in the cost of Medicaid, the Proposed Rule essentially eviscerates such participation. As will be shown below, the Proposed Rule is so restrictive that only one general acute care hospital in the State of Georgia would qualify as a "unit of government" – a fact that strongly suggests this proposal exceeds not only CMS's statutory authority, but also Congressional intent.

Specifically, the Proposed Rule inappropriately restricts the type of government hospital allowed to utilize IGTs, imposes undefined and long-abandoned "cost" limits on government hospitals, and cripples states' efforts to provide needed health care services to Medicaid beneficiaries. It must be emphasized the Proposed Rule only imposes these new cost limits on government-operated hospitals, thereby guaranteeing such hospitals will be paid **less than** private hospitals. There can be no rational basis for this distinction, especially considering the fact that government hospitals generally treat a much higher percentage of low-income patients.

Finally, while CMS states the intention of this Proposed Rule is to stop certain financing arrangements which CMS considers to be improper, the Proposed Rule goes far beyond this

Leslie Norwalk
March 19, 2007
page two

stated intention, prohibiting the very type of IGTs which Congress has consistently supported and allowed. As a result, the Proposed Rule will drastically reduce Medicaid reimbursement for Georgia's neediest institutions -- those "safety net" hospitals which treat the largest number of Medicaid, indigent and uninsured patients -- with no evidence such hospitals or the Georgia Medicaid agency even utilize any of the financing arrangements this Rule is purportedly designed to erase.

For these and other reasons set forth in more detail below, the Georgia Hospital Association implores CMS to permanently withdraw its Proposed Rule.

1. The Proposed Rule Exceeds CMS's Statutory Authority

The Proposed Rule surpasses CMS's legal authority by attempting to impose unauthorized limits on IGTs. Section 1903(w)(6)(A) of the Social Security Act specifically provides "the Secretary *may not restrict* States' use of funds where such funds are...transferred from...units of government within a State." Yet the Proposed Rule does precisely what is statutorily prohibited, by placing unprecedented restrictions on a state's ability to utilize funds transferred from local governmental units such as Georgia hospital authorities.

In addition, the Proposed Rule attempts to administratively amend the statutory definition of governmental unit -- something CMS cannot do without the consent of Congress. Section 1903(w)(7)(G) of the Social Security Act defines the term "unit of government" to include "a city, a county, a special purpose district, *or other governmental unit in the State.*" This statute places no additional requirements on a provider to qualify as a governmental unit. Section 433.50 of CMS's Proposed Rule, however, impermissibly amends this statutory definition by adding a requirement that the governmental unit must also have "generally applicable taxing authority" -- a requirement neither contained nor contemplated in the statute. Under the logic of this provision, CMS itself would not be considered a "unit of government" because it has no independent taxing authority. If CMS wishes to impose new obstacles on the accepted and long-established practice of IGTs, the lawful way to accomplish this goal is to ask Congress to amend the law.

2. The Definition of "Unit of Government" is Overly Restrictive

The Proposed Rule is so restrictive that only one general acute care hospital in the entire State of Georgia would qualify as a "unit of government." Such a result ignores the vital role played by hospital authorities in this state, and cannot possibly have been the result contemplated by Congress when it defined the term.

In Georgia, the State owns only one general hospital (in conjunction with its medical school), and none of Georgia's 159 counties own a hospital. This is because the Georgia General Assembly elected over six decades ago to create local hospital authorities to discharge the government's

Leslie Norwalk
March 19, 2007
page two

legal duty of caring for their indigent sick. See, *DeJarnette v. Hosp. Authority of Albany*, 23 S.E.2d 716, 723 (Ga. 1942) (the purpose of the Hospital Authorities Law “was to authorize counties and municipalities to create an organization which could carry out *and make more workable* the duty which the State owed to its indigent sick”). In effect, the State of Georgia has determined that semi-autonomous governmental entities known as hospital authorities would do a better job (i.e., “make more workable”) satisfying the state’s obligation of caring for the indigent. The Proposed Rule will cripple Georgia’s efforts in meeting this important obligation.

The wisdom of the General Assembly’s decision is supported by the facts. While in 2005 Georgia’s only state-owned general hospital provided \$27.6 million in un-reimbursed costs in treating the uninsured, the state’s hospital authorities combined to provide 36 times that amount, or approximately \$667.7 million in un-reimbursed costs treating the uninsured.

Both the law creating hospital authorities and subsequent judicial precedent consistently confirm that Georgia hospital authorities are indeed local units of government. See, e.g., O.C.G.A. §31-7-72(a) (describing a hospital authority as “a public body corporate and politic”); O.C.G.A. §31-7-75 (every hospital authority is “deemed to exercise public and essential governmental functions”); *Cox Enterprises, Inc. v. Carroll City/County Hospital Authority*, 273 S.E.2d 841 (Ga. 1981) (hospital authority, which lacked some of the attributes of sovereignty such as the power to tax, but which was a creature of statute, was defined as a “public body corporate and politic,” was tax exempt, was deemed to exercise public and essential governmental functions, exercised power of eminent domain and received tax revenues, and whose board was appointed by governing body of the relevant political subdivisions, was a “governmental entity”). As agencies or instrumentalities of the county or municipality that created them, hospital authorities are irrefutably one of the “other governmental units in the State” described by Congress in Section 1903(w)(7)(G) of the Social Security Act.

Hospital authorities, however, do not have the power to tax. Instead, the General Assembly granted counties and municipalities the power to impose taxes and to agree **by contract** to utilize those tax revenues to reimburse hospital authorities for their construction, maintenance and cost of providing indigent care. See O.C.G.A. §31-7-85. But since §433.50(a)(1)(ii)(B) of the Proposed Rule stipulates that a “contractual arrangement” cannot be the primary or sole basis for receiving tax revenues, virtually every hospital authority in the state would be disqualified as a unit of government. This includes Grady Memorial Hospital in Atlanta, Georgia’s largest hospital, which in 2005 alone received \$103 million in tax revenues from its sponsoring counties and provided \$ 182.1 million in un-reimbursed care for the uninsured. CMS’s Proposed Rule would severely impact Georgia’s government hospitals, not because of their governmental status, but simply because of the method through which they receive their funds – through contract rather than direct appropriation.

3. The Proposed Limit to “Cost” Reimbursement is Inefficient

Section 447.206 of the Proposed Rule imposes a new reimbursement limit for government hospitals based on “the individual provider’s cost of providing covered Medicaid services to

eligible Medicaid recipients,” while §447.272 proposes a similar limit for reimbursement under CMS’s upper payment limit (“UPL”) rule. GHA has serious concerns about these provisions.

First, since both Medicaid and Medicare abandoned “cost” reimbursement principles years ago as unworkable, the reason for their sudden reemergence in the Proposed Rule is unclear. Moreover, the Proposed Rule contains no definition of “cost,” but merely a statement that CMS will determine cost-identifying methods in the future. (See §447.206(c)(2).) Hospitals cannot reasonably be expected to develop viable financial plans when, beginning in only five months, a significant percentage of their revenue will be based on a reimbursement system that is unknown and undefined, and dependent on a cost report that takes several years to finalize.

Second, contrary to CMS’ assertions, the current UPL program does not result in excessive payments to hospitals, since such payments are based on Medicare rates, universally understood to be non-excessive. Limiting a government hospital’s Medicaid payment to the undefined “cost” of its services merely punishes those hospitals who have struggled to reduce their cost.

Third, this portion of the Proposed Rule only imposes such UPL cost limits on government hospitals, which means that such institutions will receive less reimbursement than private hospitals. (See proposed §447.272, under which government hospitals are reimbursed “cost” while private hospitals are reimbursed under “Medicare payment principles”.) CMS has neither articulated any basis for this proposal nor produced any evidence to justify paying government hospitals less than private hospitals. In most cases, such hospitals treat a much higher percentage of low income patients than private hospitals. Absent such evidence, the proposed cost limit cannot be rationally supported.

4. The Effect of the Proposed Rule will be Financially Devastating to Georgia

The proposed rule will impact Medicaid disproportionate share payments (DSH) to 93 Georgia hospital authorities which in providing the earlier mentioned \$668 million in 2005 un-reimbursed costs treating the uninsured, also sustained a 2005 Medicaid operating loss of \$120 million (excluding supplemental payments this rule would essentially eliminate.) If these rules go into effect, these hospitals would lose approximately \$218 million in federal DSH payments and more than \$35 million in federal upper limit payments, which amount to \$243 million total to help support \$788 million in Medicaid and uninsured payment shortfalls.

The UPL amount of \$35 million is a reduction from approximately \$115 million in federal UPL funds paid in previous years due to CMO implementation for 1 million of 1.4 million Georgia Medicaid recipients.

The Medicaid operating loss grows each year, since the last hospital rate increase for Medicaid in patients was on July 1, 2002 and there is no rate increase provided for in the Governor’s budget recommendations for hospitals on July 1, 2007.

Additionally, in Georgia there are 78 hospital authority nursing homes, many of which are part of a hospital authority system, which will lose an estimated \$60 million in UPL payments.

Leslie Norwalk
March 19, 2007
page five

Compounding the problem is that Georgia acute care community hospitals, the vast majority of which are hospital authorities will lose money in 2007, approximately \$209 million, on expenses for treating Medicare patients (who account for 31% of hospitals costs vs. 17% for Medicaid.)

As a number of hospital authority facilities operate each year at a financial loss, the proposed reductions in federal payments to help cover Medicaid payment shortfalls and serving the uninsured will result in hospital closures around Georgia, as these monies are often needed to cover bi-weekly payrolls.

5. The Proposed Effective Date of the Rule is Unworkable

CMS states the intended effective date of this Proposed Rule, at least for cost limit purposes, is September 1, 2007. We fail to see how CMS can effectively propose and then finalize workable definitions of "cost" in the five months between now and September 1st.

Moreover, under such an aggressive schedule, states like Georgia will have no time to react to the rules' inevitable budgetary impact. Georgia's Legislature meets only 40 days a year, and absent a rare and costly special session called by the Governor, it would not be able to address the financial shortfalls caused by this Proposed Rule until January 2008, by which time the damage will be irreparable.

While we strongly believe the Proposed Rule should be rescinded, if it is finalized in any form, we request it be given a later effective date with a suitable transition period to allow time for states to adjust their budgetary priorities.

In summary, CMS cannot legally adopt a regulation that conflicts with a federal statute, nor can it impose undefined cost limits only on governmental hospitals without articulating a rational basis for doing so. The financial impact of the Rule will devastate our "safety net" hospitals, unravel state budgetary efforts, and most importantly, deprive thousands of Medicaid recipients with adequate access to treatment. The Georgia Hospital Association therefore respectfully urges CMS to permanently withdraw this Proposed Rule.

Sincerely,



Joseph Parker
President

Submitter : Mr. Bill Riley
Organization : Jamestown S'Klallam Tribe
Category : Other Government

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-241-Attach-1.DOC

Subject: (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

We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule published on January 18, 2007 at 72 Federal Register 2236. As currently written, we oppose the proposed rule and would like to offer suggested regulatory language that we believe will address tribal concerns consistent with existing CMS policy.

Statements made by the Acting Administrator, Deputy Administrator and other CMS officials during the most recent meeting of the Tribal Technical Advisory Committee made it clear that it was CMS's intent that this proposed rule have no effect on the opportunity of Indian Tribes and Tribal organizations to participate in financing the non-Federal portion of medical assistance expenditures for the purpose of supporting certain Medicaid administrative services, as set forth in State Medicaid Director letters of October 18, 2005, as clarified by the letter of June 9, 2006. Unfortunately, we are convinced that, as written, the proposed rule would, in fact, negatively affect such participation. We discuss our concerns and offer proposed solutions below.

Criteria for Indian Tribes to Participate

The proposed rule attempts to make clear that Indian Tribes may participate by specifically referencing them in proposed section 433.50(a)(1). However, as currently proposed, an Indian Tribe would only be able to participate if it has "generally applicable taxing authority," a criteria applied to all units of government referenced here. Although in principle Indian Tribes do enjoy taxing authority, as with all other matters about Indian Tribes, the law is complex and fraught with exceptions. To impose this requirement will burden each State with trying to understand the specific status of each Indian Tribe and to make decisions about the taxing authority of the Tribe – a complex matter often the subject of litigation between Indian Tribes and States. A requirement to make such determinations will almost certainly negatively affect the willingness of States to enter into cost sharing agreements with Indian Tribes since an error in the determination regarding this undefined term could have potentially negative effects for the State.

Since other provisions of the proposed rule address the limitations on the type of funds that may be used, other funds of the Indian Tribe, including funds transferred to the Tribe under a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, should be acceptable without regard to whether they derive from "generally applicable taxing authority." Accordingly, we propose the following amendment to the proposed language for section 433.50(a)(1)(i):

(i) A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State (~~including Indian tribes~~) that has generally applicable taxing authority, and includes an Indian tribe as defined in section 4 of the Indian Self-Determination and Education Assistance Act, as amended, [25 U.S.C. 450b].

Criteria for Tribal Organizations to Participate

We oppose this rule as currently written because we believe it will negatively affect the participation of tribal organizations to perform Medicaid State administrative activities. The CMS TTAG spent over two years working with CMS and Indian Health Service (IHS) resulting in an October 18, 2005, State Medicaid Director (SMD) letter clarifying that tribes and tribal organizations, under certain conditions, could certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services provided by such entities. However, the proposed rule does not reflect that the criteria approved by CMS recognizing tribal organizations as a unit of government eligible to incur expenditures of State plan administration eligible for Federal matching funds. As part of these comments, we have enclosed a copy of the SMD's letter of October 18, 2005, and clarifying SMD letter dated June 9, 2006.¹

Under the proposed rule, participation will be available only if two conditions are satisfied:

- (1) the unit that proposes to contribute the funds is eligible under the proposed amendment to 42 C.F.R. § 433.50(a)(1); and
- (2) the contribution is from an allowable source of funds under the newly proposed section 447.206.²

Most tribal organizations will not meet the proposed standard for criteria (1). The basic participation requirement in proposed 433.50(a)(1) sets a new standard for the eligibility of the unit that will exclude many tribal organizations by imposing a requirement that there be "taxing authority" or "access [to] funding as an integral part of a unit of

¹ The October letter contained the incorrect footnote that said ISDEAA funds cannot be used for match. But the SMD letter dated June 9, 2006, corrected this error. "[T]he Indian Health Service has determined that ISDEAA funds may be used for certified public expenditures under such an arrangement [MAM] to obtain federal Medicaid matching funding.")

2/ The language in proposed 447.206(b) that provides an exception for IHS and tribal facilities from limits on the amounts of contributions uses language consistent with the October 18, 2005, State Medicaid Director Letter ("The limitation in paragraph (c) of this section does not apply to Indian Health Service facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638)").

government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities, and deficits . . .” The new proposed rule at 433.50(a)(1) provides:

(i) A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority.

(ii) A health care provider may be considered a unit of government only when it is operated by a unit of government as demonstrated by a showing of the following:

(A) The health care provider has generally applicable taxing authority; or

(B) The health care provider is able to access funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities, and deficits, so that a contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues.

In the explanation of the proposed rule, the problem is exacerbated in the discussion of section 433.50. Many tribal organizations are not-for-profit entities. The explanation of the rule suggests that not-for-profit entities “cannot participate in the financing of the non-Federal share of Medicaid payments, whether by IGT or CPE, because such arrangements would be considered provider-related donations.”

None of these criteria: taxing authority; governmental responsibility for expenses, liabilities and deficits; nor a prohibition on being a not-for-profit are limitations contained in the October 18, 2005 SMD letter. None of these criteria are consistent with the governmental status of tribal organizations carrying out programs of the IHS under the Indian Self-Determination and Education Assistance Act (ISDEAA), which is the basis of the State Medicaid Director letters.

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). Furthermore, we believe there is no authority in the statute for CMS to restrict cost sharing 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* cost sharing as the source of authority that *all* cost sharing must be made from state or local taxes. The proposed change is inconsistent with CMS policy as outlined in the October 18, 2005 and the June 9, 2006 SMD letters.

Based on the comments made by Leslie Norwalk during the TTAG meeting February 22, 2007, it is clear that the proposed rule regarding conditions for inter-governmental transfers was not intended by the Department to overturn any part of the SMD letters of October 18, 2005, and June 9, 2006, regarding Tribal participation in MAM. This was further confirmed by Aaron Blight, Director Division of Financial Operations, CMSO,

on a conference call held with the CMS TTAG policy subcommittee as well as the second day of the CMS TTAG meeting held on February 23.

We therefore suggest that the regulations be amended to include the criteria contained in the October 18, 2005 SMD letter as a new (C) to 433.50(a)(1)(ii), as follows:

(C) The health care provider is an Indian Tribe or a Tribal organization (as those terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (ISDEAA); 25 U.S.C. 450b) and meets the following criteria:

(1) If the entity is a Tribal organization, it is—

(aa) carrying out health programs of the IHS, including health services which are eligible for reimbursement by Medicaid, under a contract or compact entered into between the Tribal organization and the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, and

(bb) either the recognized governing body of an Indian tribe, or an entity which is formed solely by, wholly owned or comprised of, and exclusively controlled by Indian tribes.

(2) The cost sharing expenditures which are certified by the Indian Tribe or Tribal organization are made with Tribal sources of revenue, including funds received under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, provided such funds may not include reimbursements or payments from Medicaid, whether such reimbursements or payments are made on the basis of an all-inclusive rate, encounter rate, fee-for-service, or some other method.

The caveat to paragraph (2) above regarding the source of payments was added to expressly address a new limitation that CMS proposed on February 23, 2007, with regard to approving the Washington State Medicaid Administrative Match Implementation Plan to exclude any “638 clinics that are reimbursed at the all-inclusive rate from participation in the tribal administrative claiming program.” No such exclusion was ever contemplated by CMS when it sent the SMD letters referred to earlier. Such an exclusion would swallow the rule that allows Indian Tribes and Tribal organizations to participating in cost sharing.

This new requirement could be interpreted as undermining the commitment made in the SMD letters, which had no such limitation, notwithstanding hours of discussion among CMS, Tribal representatives, and IHS about how reimbursement for tribal health programs is calculated. There was an understanding that the all-inclusive rate does not include expenditures for the types of activity covered by Administrative Match Agreements and therefore avoids duplication of costs. CMS well knows that most Indian Health Service and tribal clinics are reimbursed under an all-inclusive rate. We have to

hope that instead this is another instance in which the individuals responding to Washington State were simply “out-of-the-loop” regarding the extensive discussions with the TTAG prior to the issuance of the SMD letter.

We appreciate the challenges that face a large bureaucracy like CMS in making sure that all of its employees are equally well informed. Given that this request to Washington State reflects yet another breakdown in internal communication, we believe that the caveat at the end of the (C)(2) is essential (or some other language that makes clear that the form of Medicaid reimbursement received by an Indian Tribe or Tribal organization will not disqualify it from participating in cost sharing).

We appreciate the opportunity to comment and appreciate thoughtful consideration of these comments.

Sincerely,

Bill Riley, Director
Health and Human Services
Jamestown S’Klallam Tribe
1033 Old Blyn Hwy
Sequim, WA 98382
(360) 681-4660

Submitter : Mr. Paul Reinhart
Organization : Michigan Medical Services Administration
Category : State Government

Date: 03/19/2007

Issue Areas/Comments :

GENERAL

GENERAL

See Attachment

CMS-2258-P-242-Attach-1.DOC

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 MICHIGAN

The State of Michigan, through its Department of Community Health, submits these comments on the regulations published on January 18, 2007, that would severely limit the ability of states to finance their Medicaid programs. Michigan has joined in the Joint Comments, submitted on behalf of a group of states in opposition to the proposed rules. Those Comments set forth compelling reasons for CMS to abandon the proposal, and Michigan asks that CMS do so without further delay. These additional comments are intended to explain how the proposed regulations would damage the Medicaid program in Michigan, to the detriment of those the program seeks to serve as well as those who provide them their health services.

The impact of the proposed regulations on Michigan cannot be divorced from the true crisis confronting the State at this time over its ability to maintain the current level of Medicaid (and other state services) in the face of the most severe budget shortfall in the State's

history. Primarily because of the difficulties confronting the domestic automobile manufacturing industry, on which Michigan is so dependent, but also due to retrenchments in other sectors, the State is facing a revenue shortfall in the current fiscal year of close to \$1 billion. The projection for the next fiscal year is much worse--the revenue shortfall is currently estimated to be close to \$3 billion.

The shortfall represents approximately ten percent of the State's anticipated revenues for the year. Contingency plans now under serious consideration include an across the board reduction in Medicaid rates for all providers, elimination of entire categories of optional services and/or the complete elimination of some eligibility categories.

The Michigan economic crisis is pervasive. The State ranks last among all states in the most recently released Index of State Economic Momentum, which measures changes in personal income, employment and population. Michigan was the only state with negative employment growth in 2006. Its unemployment rate is the highest in the nation. The percentage reduction in its tax collections is the largest in the nation.

In these circumstances, any changes in federal Medicaid financing policy like those contained in the proposal under consideration would only make a bad situation much worse. No changes ought to be considered that would have the effect of further restricting Michigan's ability to receive federal Medicaid funding. In particular, changes like those proposed, which the Joint Comments show to be neither legally sustainable nor programmatically justified, should be abandoned.

The proposed regulation changes threaten to impact Michigan, Michigan providers and Michigan recipients in several ways. The State uses IGTs from local units of government as match for DSH payments which enable hospitals to support local health care

initiatives for indigent individuals. These programs reduce costs by controlling ER use and by avoiding more costly inpatient stays. Even though it was recently approved by CMS, this innovative approach to indigent health care is threatened by sections of the proposed regulation which address limits on intergovernmental transfers and sources of non-federal share.

In addition, the State makes payments to county-operated nursing homes and public hospitals that are within the upper payment limit established in current regulations but not necessarily limited to each provider's cost. The school districts that provide vital services to children would be required to assume cost reporting burdens that could well lead many of them to cease participation in the program. Moreover, because they are separate districts without direct taxing authority, the proposed rules place a cloud over their ability to certify their expenses for purposes of federal matching. CPEs are also the basis for payments to the hospital operated by the University of Michigan, which is governed by an independent Board of Regents.

The highly restrictive proposed rules on the definition of a "unit of government" also cast a cloud on whether this type of certification would continue to be permitted. The proposed rules put uncertainty around locally financed payments to Community Mental Health Boards even though they are clearly defined as governmental entities in state law and transparently receive significant funding from local units of government, primarily counties. They are jeopardized because they cover multiple counties. Consequently, no specific county is liable for financial deficits and they do not have taxing authority as an independent entity.

The funding methods used in Michigan's Medicaid program are all appropriate, and are supported by many years of acceptance by the federal government. To be forced to change those methods now, in the midst of the most serious budget crisis in the State's history, would truly threaten the Medicaid program with a fiscal meltdown. Michigan urges in the

strongest possible terms that CMS not go forward with these unnecessary, unjustified and potentially destructive proposed regulations.

Respectfully submitted,

A handwritten signature in black ink that reads "Paul Reinhart". The signature is written in a cursive style with a large, prominent initial "P".

Paul Reinhart, Medicaid Director

Submitter : Mr. Darrell Winningham
Organization : Tennessee Health Care Association
Category : Long-term Care

Date: 03/19/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-243-Attach-1.DOC



#243

T E N N E S S E E H E A L T H C A R E A S S O C I A T I O N

March 19, 2007

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

The Tennessee Health Care Association (THCA) appreciates the opportunity to comment upon the proposed rule, **Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, CMS-2258-P, 72 Fed. Reg. 2236**. THCA is a non-profit trade association representing eighty percent of the nursing facilities in Tennessee including for-profit, non-profit, and government owned.

The proposed rule, published in the Federal Register on January 18, 2007, would significantly modify existing regulations by restricting the manner in which states generate funding for their share of Medicaid costs. Specifically, the proposed rule would enact new limitations on the health care providers eligible to participate in intergovernmental transfers (IGTs) and certified public expenditures (CPE) processes used to help fund state Medicaid programs. THCA will comment on aspects of the proposed rule that most directly affect nursing facilities in Tennessee.

Problems Identified by the Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) states in the proposed rule that its experience of reviewing and processing over 1,000 State Plan Amendments since 2003 has permitted it to develop a better understanding of state funding arrangements and the changes necessary to ensure compliance with statutory intent in accordance with 1902, 1903, and 1905 of the Act. In particular, CMS cites section 1903 (w)(6)(A) that reads:

Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a state as the non-Federal share of expenditures under this title, regardless of whether

the unit of government is also a health care provider, except as provided in section 1902 (a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

In addition, the proposed rule cites Section 1903 (w)(7)(G) of the Act as identifying four types of entities, in addition to states that are considered units of government. They are cities, counties, special purpose districts, and other governmental units in the state.

It is asserted by CMS that the above statutes require that health care providers participating in IGTs and CPEs must be a unit of state or local government. Funds derived from participants not deemed to be a unit of government would be considered a donation or tax and ineligible to be considered as the non-Federal share. The proposed rule is presented as a mechanism to conform CMS regulations to existing statute and to further define the units of government for Medicaid funding purposes.

When discussing IGT and CPE processes, the proposed rule points out several issues including the lack of accounting continuity among states. According to CMS, the lack of common structure for IGT and CPE processes makes it extremely difficult to track the flow of funding. Further, the proposed rule criticizes instances in which proceeds were used by states for non-Medicaid purposes.

THCA Comments

While THCA appreciates the difficult role CMS has in ensuring that federal matching funds are spent appropriately, the assumptions expressed in the proposed rule regarding statutory intent are not supported with any evidence. CMS appears to have made an arbitrary decision to implement broad-based rules that would result in desired expenditure reductions for its Medicaid program and/or to address a perceived area of concern in which it feels states may have been obtaining federal matching funds inappropriately.

Rather than attempting to interpret legislative intent and implementing a rule that would potentially eliminate IGT and CPE processes, CMS should get a more true measure of intent and work with President Bush and Congress to enact legislation addressing this issue. As presented, we are hard pressed to understand the logic that would take legislative intent from existing statute to the extreme remedies that would be enacted in the proposed rule. It certainly appears that the argument of legislative intent is overstated and that the proposed rule stretches the limits of reasonable regulatory action.

THCA supports the efforts by CMS to develop accounting standards that will ensure that federal matching funds are being spent appropriately. However, it is often very difficult or even impossible for state and local governments to determine the exact origin of taxpayer dollars being expended from their General Funds. Regarding the usage of funds derived from these processes, we agree that the proceeds should be used for services within the Medicaid program. In the case of Tennessee, all proceeds derived from our previous IGT and existing CPE processes have been used for Medicaid services.

Proposed Rule Provisions- Units of Government Defined

The proposed rule includes the criteria to be met for an entity to be considered as a unit of government. This includes a state or local government entity that can demonstrate that it has taxing authority, or any state, county, or city operated health care provider that can prove that it can access funding and is an integral part of a governmental unit with taxing authority.

A contractual arrangement between an entity and state or local government to provide Medicaid services in a nursing facility would not qualify. Under the proposed rule, government must be responsible for funding the entity's operations, expenses, liabilities and deficits.

THCA Comments

As proposed, the definition of unit of government is far too restrictive. It is very common for local governments to own the infrastructure, including buildings and land, used to provide nursing facility services. However, the actual delivery of services is often leased to another entity because the local government does not have the expertise necessary to operate a nursing facility. These facilities typically exhibit all the characteristics of any other publicly owned facility in that they have a high Medicaid census and serve as a safety net for nursing services provided to Medicaid beneficiaries in the community.

In these situations, there is still a fiduciary responsibility borne by the local government to ensure the financial stability of the nursing facility. This could include providing financial support to cover budgetary shortfalls when needed, partnering with the entity by issuing bonds to finance facility capital improvements, paying for physical plant and infrastructure maintenance and repairs, etc.

Further, as discussed previously, there is no expressed intent in existing statute that justifies the narrow definition of a unit of government in the proposed rule. We believe that nursing facilities leased by state and local governments to other entities should have the same status as those

facilities owned and operated by local or state governments. This approach is consistent with current practices.

Rule Impact Summary

Should the proposed rule be enacted, the impact on Tennessee nursing facilities would be significant. First, some of the facilities that have been eligible for IGT and CPE processes for many years under current guidelines would no longer be permitted to participate. As a result, they would no longer qualify for supplemental payments that are possible under our current reimbursement system.

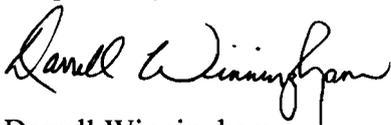
Second, while THCA supports efforts to better document the CPE process, we also know that it is very difficult for the state to positively identify the origin of each tax dollar being spent. The proposed rule could result in the significant reduction or elimination of Tennessee's CPE efforts.

Finally, the proposed rule could negatively impact the CPE process used to help fund TennCare services delivered by hospitals. While hospital payments are not directly tied to Medicaid reimbursement for nursing facilities, the loss of CPE funds for hospitals would require TennCare to re-examine its spending plan for the upcoming state fiscal year. In order to help mitigate the funding shortfall for hospitals, the state would be forced to reduce payments to other providers, including nursing facilities.

THCA Recommendation

CMS should withdraw the proposed rule. It does not follow expressed intent in current statute and attempts to enact restrictions that would be harmful to state and local governments. Should CMS continue to feel that a remedy is needed, it should work with President Bush and Congressional leadership to develop legislation addressing the issue.

Respectfully submitted,



Darrell Winningham

THCA Director of Reimbursement