Submitter : **Robert Russano** **Date: 01/31/2007**

Organization : **N/A**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

I think that cutting medicare funding is not the answer. If the President took .5 billion from the money being spent on a war that we don't need and applied it to medicare in a year & half there would be more than enough to cover the cost. The answer is DO NOT pass this docket. Get the money from the military budget. That .5 billion would also do a lot to improve the drug plan.

Submitter : **Ms. Barbara Bertucio** **Date: 01/31/2007**

Organization : **Ms. Barbara Bertucio**

Category : **Nurse**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

The Cost Limit for Providers Issue if approved and allowed to go through would be devastating and an embarrassment to the U.S Healthcare System and Government. Once again the elderly, disabled, and the children are left with no means of health care or decent healthcare. President Bush and our government leaders wake up and look outside your window. Life is not a bowl of cherries. I would look at the departments that truly waste our taxpayers money..not take away services that maintain a quaility of life for many. Look at your own salaries and healthcare coverage. My aren't you lucky!

Barbara Bertucio, RN, CPC, CLNC

Submitter : Mr. Gary Carnes **Date:** 01/31/2007

Organization : All Children's Hospital

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

The proposed changes in the funding of Medicaid, through greatly reducing inter-governmental transfers, would devastate an already challenged Medicaid patient population. In Florida, these reductions in payment would exceed $900 million/year. The hospitals most affected are the very "safety net" facilities that currently care for the very sick and fragile Medicaid recipients.

There are only two specialty licensed children's hospitals in Florida. For each, our Medicaid and charity percentage (combined) exceeds 55%. We estimate the reduction in payment to All Children's Hospital in St. Petersburg would be $31 million/year. A change of revenue of this magnitude would cause us to have to curtail or eliminate key critical services to ALL patients, not just Medicaid. The healthcare status and condition of children would decline.

There is no way around this fact: A reduction anywhere near the level proposed would cause a total disruption in the healthcare system for children. There would be bsolutely NO WAY for providers to adjust and "make this work." Healthcare would become a privilege of the wealthy - not a basic service available to all.

Submitter : **Date: 02/02/2007**

Organization :

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

We should limit the income of government officials before cutting healthcare. Those people really need it and if we cut health crime will rise sharply as a direct result.

Submitter : **Mrs. Tammy Faircloth** **Date: 02/02/2007**

Organization : **Ga. Dept of Human Resources**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

It does not make sense that Medicaid will be cut only to turn around and give 'Affordable Choices' grants to the states as President Bush has said. Why not just leave it the way it is now? Either way, the funds will be given to the states! As an employee of a state-operated facility which serves the Mentally Retarded and Mentally Ill, I see first hand how cutbacks hurt these individuals. Over the past several years, budgeted funds have been shifted from the state institutions to community-based homes. The result of the cuts have been poor medical care. The mental patients are stablized and discharged only to be readmitted over and over again. Employee salaries are some of the lowest in the state and employee benefits are cut year after year. The only employees the state can recruit are ones who can't get a job anywhere else. They really don't care about the patients' well-being as they should. The Congress needs to work with the state governments to improve healthcare for the indigent. Healthcare coverage constantly declines but insurance premiums for the covered continues to rise.

Submitter : Dr. Robert Maley **Date:** 02/07/2007

Organization : Dr. Robert Maley

Category : Pharmacist

Issue Areas/Comments

GENERAL

GENERAL

The proposed AMP definition under CMS-2238-P Prescription Drugs will cause great harm to my pharmacy. It is estimated that the reimbursement will be far below what it actually costs my pharmacy to buy the drugs. I respectfully request that CMS redefine AMP so that it reflects what I actually pay for the product. If reimbursements do not cover costs, many independents may have to turn their Medicaid patients away.
A proper definition of AMP is the first step towards fixing this problem. I understand that the Secretary of the Department of Health and Human Services (HHS) has been given wide leeway in writing that definition. I ask that AMP be defined so that it reflects pharmacies' total ingredient cost. If AMP were defined so that it covers 100% of pharmacists' ingredient costs, then an adequate reimbursement could be attained. As it is currently defined, AMP is estimated to cover only HALF the market price paid by community pharmacy. Currently, each manufacturer defines AMP differently, and without a proper definition, Medicaid reimbursement will not cover pharmacy acquisition costs.

Pharmacies that are underpaid on Medicaid prescriptions will be forced to turn Medicaid patients away, cutting access for patients, especially in rural communities. Additionally, the reimbursement cuts will come entirely from generic prescription drugs so unless AMP is defined to cover acquisition costs an incentive will be created to dispense more brands that could end up costing Medicaid much, much more.

Please issue a clear definition of Average Manufacturers Price that covers community pharmacy acquisition costs. The definition should be issued as soon as possible, before AMP takes effect.

Submitter : **Ms. Debra Shaw** **Date: 02/08/2007**

Organization : **Triplitt Drug Corp, Independent Pharmacy**

Category : **Pharmacist**

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

To more accurately reflect actual dispensing costs with each prescription dispensed, you must consider drug cost + cost of dispensing. Cost of dispensing includes many factors such as pharmacist time, tech time, label cost, ink cost, bottle cost, consulting time, overall operating costs, clerk time, etc. The figure is in the $10 per prescription area. If you want to make drug cost figures more reflective of drug cost, then you must also make dispensing time (related fees) more reflective of reality. AWP was an appropriate way to calculate drug costs 25 years ago when very few generics existed. AWP is not really a good way today. AMP may be nearer to reality, but please don't ignore the second component to prescription dispensing which is generated at the pharmacy. AMP is different for many organizations. Government agencies dictate what they will pay. Large corporations (like mail-order and retail giants like Walmart, CVS, and Walgreen) have buying power capacity. Independent pharmacies have neither opportunity for cost containment. Even our wholesalers, who profess to be looking after us, are more interested in getting their fair share (as it is when you have stockholders watching every move).
Please don't forget your independent pharmacist who has worked very hard to build pharmacy into the most respected profession in the U.S.A. We want to continue to help people understand their medicine and to help them sort through the Medicare Part D information, and be the professional they can talk to.
Changing AWP to AMP without also making the dispensing fee in line with reality will negatively impact independent pharmacy's ability to survive.

Submitter : Mrs. Lynn Miller **Date:** 02/09/2007

Organization : Washington County Regional Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Healthcare in the United States is broken. The state of Georgia by eliminating the DiSH and UPL will cause severe financial difficulty for hospitals that treat the uninsured and underinsured. It will probably cause many to close their doors and put even more strain on a system that is overburdened with patients who need medical care and have no where to turn but to the local hospital for care. Many of these patients do not have a physician and depend on the local hospital for health care.

The only way that these hospitals can stay operational is from funding from the DiSH and UPL. If these programs are eliminated, may thousands of people will go without needed care because hospitals will not be able to provide services or even stay in business.

It is very sad to live in the greatest nation but not be able to have a working solution to take care of the health care needs of our citizens.

A solution must be found and found soon before we jeopardize the health care system not only in Georgia but the United States.

Submitter : Mr. Scott Davis **Date:** 02/09/2007

Organization : Memorial Healthcare System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comments

CMS-2258-P-9-Attach-1.DOC

#9

Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL • JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST • MEMORIAL HOSPITAL MIRAMAR • MEMORIAL HOSPITAL PEMBROKE

February 2, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2238-P
P.O. Box 8017
Baltimore, Maryland 21244-8017

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

Dear Ms. Norwalk:

Thank you for this opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed rules regarding changes to the Medicaid program and payment limits for certain providers.

The South Broward Hospital District (d/b/a Memorial Healthcare System (MHS)) is a multi-hospital, governmental healthcare organization located in South Florida. We are comprised of four hospitals, a freestanding nursing home, and a number of outpatient clinics and health services. For the year ended April 30, 2006, we admitted almost 75,000 patients and furnished over 630,000 outpatient visits and more than 250,000 emergency room visits.

The powers and duties of the South Broward Hospital District (SBHD) are derived from the general laws of the state of Florida and from Ch. 24415, Laws of Fla. (1947), as amended, and as codified by Ch. 2004-397, Laws of Fla., which represents the "Charter" of the Hospital District. Under its Charter, South Broward Hospital District is legally distinct from, and independent of, Broward County. The South Broward Hospital District operates under the authority of a Board of Commissioners appointed by the Governor. MHS is a system of "non-State government-owned facilities" as that term is used in Medicaid regulations.

Section 26 of the SBHD Charter confers authority upon the District to levy taxes on real and personal property.

MHS is the safety-net provider of healthcare services for our market area, furnishing substantially all of the hospital and related health care services to the uninsured and underinsured population of southern Broward County, Florida. As such, we are gravely

concerned about the impact of these proposed rules on our ability to adequately serve the population of our district.

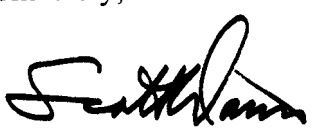
We applaud CMS's efforts to ensure the fiscal integrity of the Medicaid program. Continuing, appropriate payments from our State Medicaid program are vital to our mission, and we concur with the need to protect those funds against wasteful or inappropriate use.

However, as we explain in our attached comments, we believe that the approach proposed by CMS destroys effective, efficient, and innovative programs previously approved by CMS all in the name of curtailing a limited number of practices that could be more efficiently addressed in other ways.

We respectfully urge CMS to reconsider and withdraw these proposed regulations, retain the existing rules on Upper Payment Limits, and establish rules that are more targeted to the specific issues CMS proposes to address.

Memorial Healthcare System appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me.

Sincerely,



Scott J. Davis, CPA FHFMA
Director of Revenue Cycle Management
Memorial Healthcare System
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(954) 987-2020 ext. 5105
SDavis@mhs.net

Detailed Comments on Proposed Rule on Provider Cost Limits

Sources of State Share and Documentation of Certified Public Expenditures (§433.51)

Proposed section 433.51 proposes to redefine the allowable sources of State share of Medicaid expenditures to clarify that they may be contributed only by units of government. The intent stated is to conform the regulations to sections 1903(w)(6)(A) and 1903(w)(7)(G) of the Social Security Act.

However, the proposed section, as worded, fails to include "...funds appropriated to State university teaching hospitals..." as provided for in section 1903(w)(6)(A). Such funds may be an essential element of some State Medicaid plans, and should be explicitly permitted as a source of State share, as permitted by law.

Another concern we have is that the discussion in the preamble relating to State and local tax revenue would prohibit for transfer the use of tax revenue that is "committed or earmarked" or "contractually obligated" to provide indigent care. Even assuming that tax revenues are obligated for the financing of indigent care, CMS does not have the statutory authority to limit how a provider and unit of government go about using that tax revenue to *best* achieve the objective of providing indigent care.

By working together with the State to target the creation and maintenance of services that may be used by Medicaid recipients, indigent patients, and others, the amount of services provided to indigent patients may be increased over the amount that would be affordable if dollars were used simply to pay for charges on indigent patient accounts. It is not CMS's role to dictate how a unit of government and a provider should best interact.

CMS goes even further, though, and claims that providers that forego tax revenue obligated for indigent care are making a provider-related donations. In fact, section 1903(W)(6)(B) specifically states that funds the use of which the Secretary may not restrict under 1902(w)(6)(A) "...shall not be considered to be a provider-related donation or a health care related tax."

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

Proposed section 447.206 would limit Medicaid payments to *individual* providers operated by units of government to no more than that individual hospital's computed cost of Medicaid services. This is a significant change from current regulations that would permit payments to a *class* of non-State public hospitals to no more than the amount that would be payable under Medicare payment rules.

CMS claims that payments in excess of such limits are inconsistent with statutory principles of economy and efficiency required by section 1902(a)(30(A) of the Social Security Act.

The statute does not equate "cost" with "...efficiency, economy, and quality of care...." [SSA § 1902(a)(30)(A)]. There are a number of points to indicate that payments in excess of an individual provider's cost may still be appropriate for a State's Medicaid program overall.

First, section 1902(a)(30)(A) also requires that payment be "...sufficient to enlist enough providers so that care and services are available under the plan...." Providers who rely most on Medicaid payments are typically those who also have high Medicare and charity care patient use. This severely limits their ability to generate the margins necessary to operate effectively, replace or add to capital assets, and plan for growth. Disproportionate Share Hospital payments made under section 1923 of the Act are woefully inadequate to the task of covering the cost of charity care and providing for any margin on Medicaid services. Providers who cannot cover the cost of these services must necessarily reduce the amount of those services furnished if they are to survive.

Second, the existing rules on Upper Payment Limits (UPL) at §§447.272 and 447.321 set limits at an amount that reasonably estimates of what would be paid under Medicare payment principles. CMS's claim that these principles result in excessive payments to providers is illogical, as CMS is the agency that sets the Medicare payment rates as well. In adopting the current UPL regulations, CMS commented "...We believe that 100 percent UPL is more than sufficient to ensure access to services for Medicaid beneficiaries at public hospitals. Under this limit, States may pay public providers up to 100 percent of a reasonable estimate of what Medicare would have paid for services provided to Medicaid beneficiaries. States also retain some flexibility to make enhanced payments to selected public hospitals under the aggregate limit." [67 FR 2603, 1/18/2002]. CMS clearly believed at that time that Medicare payment principles result in reasonable payment rates. There is no logical basis for changing that determination now.

Third, the statutory requirement for efficiency and economy at section 1902(a)(30)(A) is a *general* requirement that applies to the Medicaid program as a whole. There is nothing in the statute that requires such determinations to be made on an individual provider basis. In fact, the Medicare program's prospective payment system recognizes that some providers will incur costs above Medicare payment rates, and others will incur costs that are below payment rates and achieve a level of Medicare profit. It is the opportunity for this profit incentive that helps providers focus on costs and pursue efficiency. It is justifiable overall, because the prospective payment rates are set at a level that *in the aggregate* ensures a savings to the Medicare program. Similarly, so long as the *aggregate* payments by a State Medicaid program are efficient and economical, States should be free to utilize payment rate differentials to incentivise desired provider behaviors (e.g., expansion of primary care services, trauma services, or other programs).

Fourth, CMS predicates its proposal on an assumption that paying more than cost for services furnished to Medicaid recipients is equal to paying for non-Medicaid services. What a provider does with funds it receives from *any* payer is separate and distinct from

what the provider does to earn those funds. By paying a provider more than cost for Medicaid services, CMS is *not* paying for non-Medicaid services. CMS is simply paying a rate that is necessary to ensure adequate access to services by Medicaid recipients. What the provider chooses to do with the amount received is not within CMS's authority to dictate.

Finally, CMS proposes a cost limit on payments only to providers operated by units of government. Yet, given the limited definition of "unit of government" that CMS also proposes in this rule, there are providers who today receive payments in excess of cost. Since CMS does not limit payment to those providers to cost, it should not apply a cost limit to public providers, either.

Retention of Payments (§447.207)

CMS proposes a requirement that providers receive and retain "...the full amount of the total computable payment provided to them...." The text of the regulation itself is sufficiently generic to not be objectionable. However, the interpretation given to that section in the preamble to this rule is highly problematic.

CMS assumes that any requirement that a governmentally-operated health care provider transfer more than the non-Federal share of a Medicaid payment means that Medicaid payments to that provider are not retained. Again, CMS links two independent actions that should not be linked.

Once a governmental unit transfers funds to the State, it is up to the State to do with those funds *whatever* the State deems is appropriate. It is not within the authority of the governmental unit, nor within the authority of CMS to dictate what the State can do with those funds.

To the extent that the State uses those funds to make allowable Medicaid payments, such use falls within section 1902(a)(30)(A), and federal financial participation is appropriate *to that same extent*. It should not matter what level of Medicaid payment the State is making or to which providers (those who do or do not make transfer payments); federal match should apply in its normal proportion. The amount of payment made by the State (the "State's net expenditure") is determined by the amount paid under the terms of its CMS-approved State plan, not by the sources of funds used to finance that plan.

Another problem is the assumption that providers who are units of government would maintain separate accounts for tax funds from other operating funds. Accounting records may be separate, but sound treasury operations may dictate that a consolidated cash account is most appropriate. Such consolidation not only facilitates good internal accounting controls, it can result in lower overall banking costs and assist with managing various automated transactions. Any requirement to maintain separate banking accounts for tax and non-tax funds adds a burden and cost to providers without adding any benefit.

Elimination of Payment Flexibility (§447.271(b))

Currently, this section reads:

> "The agency may pay a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider's charges were equal to or greater than its costs."

This section simply states that a nominal-charge provider is not limited to charges as its total payment. It does not state what amount the "same rate" would be if charges were equal to or greater than costs.

If CMS deletes this section, and retains section 447.271(a) (whether payments are otherwise limited to cost or some other amount), a nominal charge provider would be limited to charges as its total payment.

CMS states that this section is no longer relevant due to the new cost limit rules, but those rules do not affect the operation of the charge limit rule where charges are less than cost. Therefore, this section is *not* irrelevant and should be retained.

Other Conforming Changes (§§447.272, 447.321, 457.220, 457.628)

Because we believe that the cost limit rule is inappropriate for the reasons stated above, the conforming changes proposed would also be inappropriate.

Regulatory Impact Analysis

Costs and Benefits

CMS has projected program savings of $120 million in the first year and $3.87 billion of savings over five years. A measure of CMS's failure to understand the various State programs' use of intergovernmental transfers, Medicaid reform waivers, and payments targeted to overall healthcare system improvements (with Medicaid implications) is that CMS has vastly understated the potential effect of this rule.

The Florida Hospital Association has completed a financial analysis of the effect of this rule on the Florida Medicaid program and its reform waiver, and indicates a reduction in Medicaid payments of $932 million per year, or over $4.6 billion over five years *just for Florida hospitals*. The ultimate, national impact of these proposed rules far exceeds the estimate provided by CMS, just as the reach of this rule far exceeds addressing the issues CMS has identified as problems.

CMS notes that it has identified "numerous instances" of problems with Medicaid financing and payment arrangements. Yet, rather than addressing those identified

problems, CMS takes an approach that disables even those programs that do comport with the law.

Part of the discrepancy may be in what CMS perceives as problems, some of which we contend are not problems at all, but are the actual intent of Congress as stated in the law.

For example, CMS notes several arrangements where providers did not retain the full amount of their Medicaid payments, apparently assuming that transfers from units of government must be netted against State outlays for Medicaid services. This clearly is contrary to the plain meaning of 1903(w)(6) which restrict the Secretary from prohibiting the use of local tax dollars as the non-federal share of expenditures.

CMS also claims it would be beneficial to distribute payments more evenly across all governmental providers, without any analysis or support showing that differential payments to select governmental providers do not serve a rational, favorable purpose, such as promoting the development and maintenance of programs key to the success of the State Medicaid program (even if such services may also be accessed by other patients).

And CMS even claims, "...for the most part, private health care providers are not affected by this rule." This is not correct. Where a substantial portion of payments to private health care providers are for support of targeted Medicaid services, and funding is derived from intergovernmental transfers from units of government, the limitations placed on governmental provider payments will necessarily result in restrictions in the amount of funds available to transfer to the State, and by extension will reduce the payments made to *all* providers, not just governmental providers.

Alternatives Considered

CMS admits that there are alternatives that are more targeted to specific issues, but does not spell out what those are so that a public evaluation of those alternatives might be considered.

Clearly, a State claim for FFP on expenditures that were not actually made is inappropriate. More targeted procedures can be applied to eliminate those claims, leaving legitimate effective Medicaid programs unaffected.

Submitter : Ms. Kathleen Wasilewski RN **Date:** 02/11/2007

Organization : Ms. Kathleen Wasilewski RN

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

The proposed rule will cause closing of the trauma and psychiatric services in Southeast Georgia. In addition, there are children underserved under Medicaid all over Georgia and will be served less because of the proposed cuts. This is outrageous in view of the following: In Gwinnette GA, there is a program at the King David Center that (under a Medicaid grant) spends $52 per day to bus eighteen (18) elderly who live less than a mile from a $9 million dollar senior center on Vernon Woods Road in Sandy Springs, Fulton County GA to the King David Center, daily. These elderly are physically and mentally intact, and they attend the program near their home when something free is being given away. Their only problem, physical or mental is GREED. Busing is also provided to the Fulton County Center for these 18 people, and the expense ($32 per person per day)is incurred in Fulton County when these elderly do not attend). I believe it is incredibly poor management of resources to continue to spend more than $1400 (including the cost in both counties) per day to bus these 18 elderly to a program that is available to them within walking distance of their home. It is also unethical when people who need medical and psychiatric services in Southeast Georgia and the children of Georgia will be forced to bear the consequences of such poor resource management. Kathleen Wasilewski RN CCM MBE

Submitter : **Mrs. Helen Hallihan** **Date: 02/14/2007**

Organization : **Mrs. Helen Hallihan**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am one who is on Medicaid, albeit, Share of Cost. My Share of Cost is $1,908.00/month...my Social Security Disability is $1,500.00/month. I went on disability 2 years ago due to an operation in which I almost lost my life. Prior to this, I worked for the State of Florida and had all health benefits...health, dental, vision insurance for both me and my spouse. I was hospitalized 53 days, 10 days in ICU on life support...had 8 blood transfusions and Last Rites of the Catholic church because I was not expected to pull through. I also contracted MRSA while in the hospital and have been fighting that for 2 years. I had to have 40 hyperbaric chamber treatments and 9 months of visits to the Wound Care Center at St. Joseph's Hospital for open wounds on my leg. I am trying to keep my leg from being amputated. My hospital bill alone was $300,000.00! I challenge the President, Senators and Congressmen and women to live on $1,500.00 a month for 1 year and pay rent, electric, water, food, gas for their car, etc. and then have money left over to pay for medications such as mine ($2,000.00/month) as well as the doctor's bills, and some type of health insurance. I don't think any one of them would be willing to take up the challenge, yet many of us live with situations like this every day. I never thought I would be one to need public assistance of any kind, but you can see, if it weren't for Medicaid, I would be so far in the hole, I'd never get out. I'd probably be homeless, starving and may even be dead by now if it wasn't for Medicaid. And try to find doctors who will accept Medicaid...it's not easy. They know the payments will be minimal and will take a long time to receive. This insanity must stop! Don't kid yourselves folks, the 'illegal aliens' and people who come to this country are well taken care of by the USA, and are coached by their sponsors, friends and relatives on how to 'work or manipulate' the system. They come seeking the American Dream while those of us who were born here, work here, live here and will probably die here are living the American Nightmare! There is nothing for us...all the funding is going to other countries supposedly for 'their' people, yet often is taken by the government of that country for their own use. Wake up people! We have a country where prices continue to rise, jobs are dwindling, and the numbers of elderly, sick, homeless and starving people continue to rise. Mr. Bush has never had anything to worry about, and never will...he and his family will be taken care of the rest of his life, but that is not the case with the average American. My husband is a veteran of the Vietnam war and he cannot even get medical benefits from the Veterans Administration. He went there when we 'lost' our insurances and they want him to pay $50.00 a month on a $1,000.00 plus bill they sent him after he had gone there for treatment for a year...and they add interest too! What a pity that is...he and many others were put in harms way for the sake of this country and yet this country cannot take care of them. Please, I implore you, for the sake of those who need, now have, or will need care in the future, DO NOT reduce or take away the critical Medicaid funding to hospitals and medical facilities. We send money to those who hate us, would torture and kill our citizens, yet have nothing to spend on our own people. This may be a politically incorrect statement, but God help us all...we will need it if our government continues to dismiss the needs of it's own people. I will be eligible to receive Medicare in June of this year. I know it will be easier to find doctors who are willing to accept me as a patient, however, with my medications, which include Methodone and Lidoderm patches for the constant pain I have, plus others for my diabetes, heart disease and peripheral vascular disease, I'm scared to death wondering how I'll be able to afford it when they begin deducting premiums.

Submitter : **Mrs. Kelly cash** **Date: 02/16/2007**

Organization : **Exper-Med**

Category : **Drug Industry**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

Reimbursment for independant pharmacies on there generic purchasing determing by AMP(average manufacturing price)VS AWP(average wholesale price)

GENERAL

GENERAL

I work for a generic distributing company. I speak with several Independant pharmacy owners daily. If you proceed with this new way of reimbursment for medicare/medicaid patient providers you are garaunteed to force them into financial ruin. They will go out of business and there Will no longer be any independant pharmacys. Can you imagine the hundred of thousand people you are going to put out of there jobs. Not only the owners, but the employees and those who like me supply them with there generics. We have 100 people alone just in our facility. Worse yet think of your grandmother who does not live any where near a Walmart or CVS. She is diagnosed with a fatal illness. Who do you think delivers her medication to her. I assure you it is not your chain pharmacies. It's the little guy that truely cares and will send a driver to every day. Not only to deliver her medication but to check and make sure she is ok and has every thing she needs to be comfortable. You are making a huge mistake. I hope your family doesn't have to pay for it!

Submitter : **Mr. Frank Wishnia.R.Ph** **Date: 02/17/2007**

Organization : **WISH'S DRUGS #1 INC**

Category : **Pharmacist**

Issue Areas/Comments

GENERAL

GENERAL

AMP-BASED FULS ON AVERAGE ARE 36% LOWER THAN AVERAGE PHARMACY ACQUISITION COSTS. AMP IS NOT AN APPROPRIATE BASE FOR REIMBURSEMENT AND MUST BE BASED TO REFLECT PHARMACY COST.

THE FORMULA FOR AMOP-BASED FULs WILL NOT COVER PHARMACY ACQUISITION COSTS FOR MULTIPLE-SOURCE GENERIC MEDICATIONS.

AMP MUST BE DEFINED TO REFLECT THE ACTUAL COST PAID BY RETAIL PHARMACY.

WE HAVE BEEN OPERATING IN THE SAME LOCATION FOR 50 YEARS AND COUL NOT AFFORD TO STAY IN BUSINESS WHEN WE LOOSE THIS MUCH MONEY. WE WOULD NOT BE ABLE TO CONTINUE TO SERVE THIS POPULATION AND THEY WOULD HAVE TO FIND ANOTHER PHARMACY, NO PHARMACY WOULD CONTINUE TO PARTICIPATE LOSING THIS MUCH MONEY. EVEN THE ONE WITH "DEEP POCKETS" WOULD DEMAND HIGHER PRICES WHEN ALL THE REST OF US "LITTLE GUYS" WERE OUT OF BUSINESS.

PLEASE RECONSIDER AND OFFER A FAIR PRICE FOR THE ALREADY OVER-EXTENDED PHARMACIES/PHARMACISTS.

THANK YOU.
SINCERELY,
FRANK WISHNIA R.PH PRESIDENT
WISH'S DRUGS #1 INC
9615 WHIPPS MILL RD
LOUISVILLE KY 40242
502-425-1146
FAX 502-423-9668
WISHDRUG@BELLSOUTH.NET

Submitter : **Mr. peyton taylor** **Date: 02/17/2007**

Organization : **goochland pharmacy**

Category : **Pharmacist**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

Until retail pharmacy has a level playing field as far as discounts/rebates etc, this pricing structure will NOT work. Every retail pharmacy will have to drop out of the program. WE CANNOT ACCEPT ANY FURTHER REDUCTIONS IN REIMBURSEMENT.

GO AFTER THE MANUFACTORS & PBM'S - THEY HAVE THE MONEY.

Submitter : Mr. TILAK MARWAHA **Date:** 02/19/2007

Organization : MADISON PINE PHARMACY

Category : Pharmacist

Issue Areas/Comments

GENERAL

GENERAL

I AM A PHARMACY OWNER CURRENTLY SURVING APPX 2000 PAIENTS IN A UNDERSERVED AREA OF CHICAGO. AMP PRICING FOR MEDICAID WILL SEVERELY IMPACT MY BUSINESS AS I CURRENTLY DO APP 60% OF MEDICAID PRESCRIPTIONS. OUR PHARMACY ASSOCIATION STUDY SHOWS THAT 59 DRUGS OUT OF 77 SAMPLED HAVE APPX 36 PERCENT LOWER PRICE THAN MY ACQUISITION COST. I CAN NOT IMAGINE TO CONTINUE FILLING PRESCRIPTIONS AT A LOSS AND MAY HAVE TO CLOSE THE BUSINESS. IF THIS IS THE INTENT OF CMS OR CONGRESS, YOU WILL SUCCEED IN YOUR AGENDA. PLEASE RECONSIDER THE PRICING STRUCTURE AND MAKE SURE THAT THE PHARMACIES ARE REIMBURSED FOR THEIR ACQUITION COST PLUS THE DISPENSING FEE. WHO EVER CAME UP THE IDEA OF AMP MUST BE A GENIOUS IN HIS OWN SENCE WHO MUST HAVE THOUGHT OF SAVING THE MONEY AT THE COST OF OTHER.

PLEASE PLEASE PLEASE RE RETHING

THANKS

Submitter : **Delanie Sullivan** **Date: 02/21/2007**

Organization : **University of Tennessee College of Pharmacy**

Category : **Pharmacist**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-16-Attach-1.DOC

#16

February 20, 2007

Centers for Medicare and Medicaid Services
Attention CMS 2238-P Mail Stop C4-26-05
7500 Security Blvd
Baltimore, Maryland 21244-1850

Subject: Medicaid Program: Prescription Drugs; AMP Regulation
CMS 2238-P RIN 0938-AO20

I am pleased to have the opportunity to submit these comments to the Centers for Medicare and Medicaid Services (CMS) regarding CMS' December 20, 2006, proposed regulation that would provide a regulatory definition of AMP as well as implement the new Medicaid Federal Upper Limit (FUL) program for generic drugs. I am a student pharmacist at the University of Tennessee College of Pharmacy and am interested in community retail pharmacy practice. I work at Super D Drugs, a community retail pharmacy located at 231 Northgate Drive, McMinnville, TN 37110, and I am familiar with the challenges in retail pharmacy practice.

1. Definition of "Retail Class of Trade" – Removal of PBMs and Mail Order Pharmacies

CMS is proposing an overly broad inclusive definition of "retail class of trade" for use in determining the AMP used in calculating the FULs. The proposed regulatory definition of AMP would not reflect the prices at which retail pharmacies can purchase medications. Only manufacturers' sales to wholesalers for drugs sold to traditional retail pharmacies should be included in the AMP definition. Excluding PBMs and mail order pharmacies from the AMP determination recognizes that these are not community pharmacies, where the vast majority of Medicaid clients have prescriptions dispensed. Mail order pharmacies do not meet the "open to the public" distinction, as they require unique contractual relationships for service to be provided to patients. PBMs do not purchase prescription drugs from a manufacturer or wholesaler or dispense drugs to the general public. Both these types of organizations do not dispense to the "general public" and, therefore, should be excluded from the information used in the calculation of the AMP to be used for determining an FUL. The more extensive comments submitted by the Tennessee Pharmacists Association have addressed differentiation, consistency with federal policy, and the benefits of excluding these data elements.

2. Calculation of AMP – Removal of Rebates, Concessions to PBMs and Mail Order Pharmacies

AMP should reflect prices paid by retail pharmacies. Including the elements defined in the proposed regulations is counter to Congressional intent. Rebates and other concessions paid by manufacturers to entities such as mail order pharmacies and PBMs are not shared with community retail pharmacies and, thus, do not reduce the prices pharmacies pay for drugs and are not available to the "general public." These rebates and concessions must be excluded from the calculation of the AMP used to determine the FULs.

While the AMP data is not currently publicly available, so that retail pharmacies can actually determine what the relationship will be between the proposed AMP-based FULs and the prices retail pharmacies pay to acquire the drugs, the GAO has conducted an analysis of this relationship. The GAO used the highest expenditure and the highest use drugs for Medicaid in the analysis. The GAO reported that retail pharmacies will be reimbursed, on average, 36% less than their costs to purchase the drugs included in the analysis. A business can not be sustained if it is forced to continuously sell its products below its actual acquisition costs.

The CMS claims that almost all stores sell goods other than prescription drugs, and that overall sales average more than twice as much as prescription drug sales. This is not the case in the pharmacy in which I work where over 95% of our business comes from prescription drugs. What the "other sales" in the pharmacy are should not be used in any decision regarding determination of the FULs. FUL pricing should be based solely on the prices retail pharmacies pay for drugs.

3. Removal of Medicaid Data

Medicaid pricing is heavily regulated by the state and federal governments. Medicaid should be treated consistently with other federal payor programs, and also be excluded from AMP in the proposed regulation.

4. Manufacturer Data Reporting for Price Determination – Address Market Lag and Potential for Manipulation

The actual implementation of the AMP Regulation could create an avenue for market manipulation. The risk of both price fluctuations and market manipulation, due to timing of manufacturer reporting and the extended ability to revise reported data, are amplified under the proposed structure. In order to address these concerns, the Tennessee Pharmacists Association (TPA) proposes a "trigger mechanism" whereby severe price fluctuations are promptly addressed by CMS. Furthermore, the TPA comments on the lack of clarity on "claw back" from manufacturer reporting error.

5. Use of 11-Digit NDC versus 9-Digit NDC

We believe that CMS should use the 11-digit AMP value for the most commonly-dispensed package size by retail pharmacies to calculate the FUL for a particular dosage form and strength of a drug. Some drug products are sold in extremely large drums or package sizes (e.g., 5,000, 10,000, 25,000 or even 40,000 tablets or capsules) that are not practical for a typical retail pharmacy to purchase due to the excess amount of product and carrying cost that would result from holding this large quantity in inventory for a much longer than usual time. In some community retail pharmacies, the product would go out of date before it could be dispensed. It simply would not be feasible or practical to purchase in these quantities. The prices used to set the limits should be based on the most common package size dispensed by retail pharmacies. Current regulations specify that the FUL should be set on package sizes of 100 tablets or capsules or the package size most commonly dispensed by retail pharmacies. These entities can only be captured if the 11-digit package size is used.

In conclusion, I support the more extensive comments that are being filed by the Tennessee Pharmacists Association regarding this proposed regulation. I appreciate your consideration of these comments and ask that you please contact me with any questions.

Sincerely,

Delanie Sullivan
683 Harbor Edge Circle #302
Memphis, TN 38103

cc: Senator Lamar Alexander
Senator Bob Corker
Representative Lincoln Davis

Submitter : Ms. Augusta Zimmerman **Date:** 02/25/2007

Organization : n/a

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Rule change CMS-2258-P must be blocked because it is bad public policy. This will leave even more poor, uninsured people without healthcare than exist today. You cannot, in good conscience, decrease this already substandard level of healthcare and consider yourself a caring, concerned electorate.

Submitter : **Ms. Barbara A. Sciandra** **Date: 02/26/2007**

Organization : **Ms. Barbara A. Sciandra**

Category : **Federal Government**

Issue Areas/Comments

GENERAL

GENERAL

I VEHEMENTLY oppose this proposal. The federal government needs to:
1) STOP illegal immigration,
2) curtail immigration of people who cannot support themselves or be supported by another individual, and
3) raise the standard of living of poor people, and
4) provide federal healthcare for all CITIZENS.

Hard-working citizens already pay enormous amounts of their incomes for taxes, and such citizens in states with MILLIONS of poor people, especially immigrants, should not have to bear the inequitable burden of taking care of them.

Submitter : Mr. Dave Potter **Date:** 03/01/2007

Organization : Monterey County Board of Supervisors

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2258-P-19-Attach-1.PDF

#19

MONTEREY COUNTY

THE BOARD OF SUPERVISORS

February 28, 2007

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

SUBJECT: Proposed CMS Rulemaking (CMS-2258-P)
Lowering Medicaid caps to reimbursement to Public Hospitals in the US

Dear Administrator Norwalk:

The Centers for Medicare and Medicaid Services (CMS) is in the midst of public comment period on a rule to materially lower Medicaid "caps" to reimbursement for public safety net hospitals all across the US. The national reimbursement reduction totals $3.8 billion, which equates to a $550 million reduction for the State of California, and an $8 million annual reduction in funding for each of the next three years for Natividad Medical Center (NMC), Monterey County's only public safety net hospital. The comment period for this very concerning rule ends March 19, 2007.

Important Facts About NMC:

- NMC receives approximately $23.4 million in safety net care pool (SNCP) monies annually for Medicaid. Even after including these special SNCP monies, NMC loses $10 million annually on its Medicaid book of business.
- NMC loses $9 million annually on its Medicare population, as reimbursements do not cover the full cost of care to Medicare enrollee's.
- NMC loses $8 million annually on its growing uninsured population.
- In 2005, based on the California Office of Statewide Health Planning and Development (OSHPD) discharge data, NMC treated 92% of all of the indigent discharges receiving hospital care in Monterey County.
- Medicaid, Medicare and self-pay clients comprise 85% of all of NMC's business.
- As a result of these payor mix challenges, NMC lost $25 million in fiscal year 2006.
- NMC is the only teaching hospital for physician residents in Monterey County.
- Further material cuts will not allow this 125-year-old facility to survive.

Important Facts About California's 21 Public Safety Net Hospitals:

NMC is one of California's 21 public safety net hospitals. These 21 public safety net hospitals:

- Represent less than 6% of the state's total hospitals, yet they operate more than 60% of the state's top-level trauma centers;
- Train half of all the physician residents in California;
- Provide over 11 million outpatient visits per year to patients;
- Provide over 60% of the state's emergency psychiatric care; and
- Provide over 85% of all indigent care in their respective counties across California.

In summary, the County of Monterey requests that the proposed CMS Medicaid rule lowering the reimbursement "cap" to NMC be retracted and not implemented. Your careful consideration and acceptance of this request is critical to the survival of NMC

Sincerely,

Dave Potter

Dave Potter
Chair, Board of Supervisors

cc: Herb B. Kuhn, CMS Deputy Administrator (Acting)
Senator Dianne Feinstein
Senator Barbara Boxer
Congressman Sam Farr
Assembly Member Anna Caballero
Assembly member John Laird
Senator Jeff Denham
Senator Abel Maldonado
John Freshman, Troutman Sanders Public Affairs Group LLC
John Arriaga, JEA & Associates
Monterey County Board of Supervisors
Lew C. Bauman, CAO-Monterey County
Nicholas E. Chiulos, Interim Chief of Intergovernmental Affairs-Monterey County

Submitter : **Ms. Jean Francis** **Date: 03/02/2007**

Organization : **All Children's Hospital**

Category : **Nurse Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

This proposed rule will affect states' ability to finance their Medicaid programs, which in many states are already sorely underfunded or provide coverage for only minimal health care.
Medicaid provides health care coverage to one in four children. Children's Hospitals are the safety net for most of our nation's children. Over 50 to 70% of patients in a Children's hospital are covered by Medicaid. If the overall state program is cut or access to amtching federal funds are significantly curtailed, those cuts will impact safety net providers and result in programs and services in the Children's hospitals will be unfunded or underfunded. Such a loss could result in limiting significant programs and services across the board,making them unavailable not just to those children covered by Medicaid but to ALL children and the community..irregardless of their funding source.
Please note that all of the free standing Children's hospitals provide not only acute care but also provide the community with health promotion and disease prevention services. These programs improve the health of the community but would likely to be the first to be cut if funding of acute services is impacted through this rule change.

The magnitude of thc funding cuts arc such that it will be impossible to find alternate sources of funding or make up for funds by cost control measures. The only alternativc would be program /servicc curtailment.

Note also that there already is a severe shortage of healthcare providers and particularly pediatric subspecialists. Cuts to the Medicaid programs will further erode the willingness of physicians to care for children covered by Medicaid and impede the ability to attract new physicians into a field in which their services are not compensated at even a cost of service level.
Diminshing the care of children is not just a short term problem. It's effects will be felt for generations.

Submitter : Calvin Popovich **Date:** 03/05/2007

Organization : All Children's Hospital

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I am against the Administration's proposed rule to cut Medicaid payments to safety net providers by an estimated $3.8 billion over five years-a loss to Florida of $932 million annually. Over $558 million or 60% of these cuts target the teaching, public and children's hospitals that comprise the Safety Net Hospital Alliance of Florida. Florida is significant and uniquely affected. The proposed rule negates the policies adopted and approved by the Federal Government for Florida s Low Income Pool and Medicaid Reform waiver-and the access to care provided by these programs. The impact of these cut on All Children's is severe and devastating in being a safety net hospital for 13 west central Florida counties and the pediartic population it serves.

Submitter : **Ms. lisa dean** **Date: 03/05/2007**

Organization : **all childrens hospital**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

This will be devestating to All Children's Hospital if the proposed CMS rule change occurs .

Submitter : Ms. Kay Rhoades **Date:** 03/05/2007

Organization : All Children's Hospital, Florida

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

As a employee and supportor of Childrens Hospitals around the country this cut in funding would greatly impact the care that we can deliver to children. Remember children are amonst the highest uninsured and the highest poverty level of all in our country. Hospitals such as mine delivers health care that many cannot afford. To continue to provide these services and function--we need to continue to recieve this funding. The success of institutions like ours means we can sucessfully care for the under or non-insured. We can give these kids a quality of life they would never experience. We can be state of the art like many private businesses. This state of the art MEANS the difference between LIFE or DEATH in many instances! Please do not cut this funding. I have worked w/ criticlly ill and serverly injured children for over 20 years. We can never do enough to care for our children.

Submitter : **Miss. Lorrie Cervello** **Date: 03/05/2007**

Organization : **All Children's Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

The proposed CMS rule change is devestating and will directly inpact All Children's Hospital.

Please prevent these reductions.

Submitter : Ms. Sharon Kimball **Date:** 03/05/2007

Organization : All Children's Hosptial

Category : Nurse

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

The Administration s proposed rule will cut Medicaid payments to safety net providers by an estimated $3.8 billion over five years-a loss to Florida of $932 million annually. Over $558 million or 60% of these cuts target the teaching, public and children s hospitals that comprise the Safety Net Hospital Alliance of Florida.

GENERAL

GENERAL

Please intervene as soon as possible to halt implementation of this regulation. A moratorium on this proposed rule will protect Florida s uninsured and Medicaid-eligible children's access to health care services.
This decrease in funding would be devestating to the care of children in Florida. Organizations would be forced to severly decrease services to children and impacting the work life of many health care providers.

Submitter : Mr. Sandy Wismer **Date:** 03/05/2007

Organization : All Children's Hospital

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I would like to comment on the potentially devastating impact that this proposed rule change would have on safety net hospital and the providers of indigent health care, particularly Children's Hospitals

This rule change would be even more devastating for Florida hospitals that treat Medicaid and indigent patients. These hospitals would lose $932-million a year. With this rule change, perversely, those that carry the heaviest load taking care of those most in need would be hurt the most. These hospitals serve an irreplaceable role in modern health care, treating all patients without regard to their ability to pay. That's why they have rightfully received a portion of Medicaid reimbursement through the years that helps offset some of their extraordinary costs.

In Florida, CMS previously examined the local taxes used as a match for the federal money and the distribution formula for the hospitals, and approved both. This well thought out approval should not now be reversed.

Florida state lawmakers, in turn, found the hospital payments to be so vital that they made them a condition of the Medicaid reform. This waiver authority, says the law, "is contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals."

This rule change, if allowed to take effect on Sept. 1, would undermine both the Florida safety net hospitals and the reform law.

CMS needs to recind these rule change, or at a minimum, exempt Florida from the rule.

Thank you.

Sandy Wismer

Submitter : **Mrs. Johnnie Fox** **Date: 03/05/2007**

Organization : **All Children's Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Government funding has already been been cut to such a degree with the Children's Medical Services in this area that the Florida children under this program are being denied for supplies and services they need. Please do not cut more funding, the quality of health care for our children is suffering to much as it is.

Submitter : Dr. jack hutto **Date:** 03/05/2007

Organization : All CHildren's Hospital

Category : Physician

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

accelerates the cost of care for special needs children for catastrophic care that results from increased barrier to access for problems when minor. Underpays for actual cost of services passing on hidden tax to private employers clients who acess the same system of care.

GENERAL

GENERAL

Please do not allow the rule to reduce the federally mandated insurance for children at state or national level; that insurance already pays below margin for our future voters and labor intellectual resoures. Keep children on par with Medicare rates whatever Medicare rates float even if you shift cost to states, the fairncss for children as non-voters must be recognizcd as a ntional responsibility. Cost wherc I carc for these children will be reduced further by more than $500 per day in system alrcady unable to mect the resources for labor pool. Those Medicaid insurcd children account for >50% of the volume in days for which no other regional resource cxists to absorb the care. Keep thc statcs engaged but manadate the retention of federal support for these eitizens with voice.

A proposed rule change by the federal agency that oversees Medicaid could cost All Children's Hospital more than $31 million. Please intervene to halt implementation of this regulation. Removal of the proposed rule will protect Florida s uninsured and Medicaid-eligible children's access to health care services.

CMS proposed rule will cut Medicaid payments to safety net providers by an estimated $3.8 billion over five years-a loss to Florida of $932 million annually. Over $558 million or 60% of these cuts target the teaching, public and children s hospitals that comprise the Safety Net Hospital Alliance of Florida.

Florida is significant and uniquely affected. The proposed rule negates the policies adopted and approved by the Federal Government for Florida s Low Income Pool and Medicaid Reform waiver-and the access to care provided by these programs.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Increasing collcction of information costs and validation of various differing definitions of data fields drive the cost of care more than than the president realizes. In thc absencc of standardizcd national taxonomy, computer venodrs do not supply the labor to collect the required information.

Regulatory Impact Analysis

Regulatory Impact Analysis

Some specialty care safety net institutions collect the referrals from the rank and file community hospitals of rfurther more concentrated focus on specialty care that does not require the learning curve or have the volume in the local community for quality serivces at lower cost. Optimal care would be to lack barries to move those special patients earlier in course to reduce costs by avoiding complications and establish accountability.

Submitter : Mrs. Shelly Ash **Date:** 03/05/2007

Organization : All Children's Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

As an employee of a not for profit children's hospital, it is clear to me that this bill would significantly impact care for children from the lowest socioeconomic background. We have a responsibility to these children and cannot compromise their needs in the name of dollars and cents to this capacity!

Submitter : Mr. Tim Robic **Date:** 03/05/2007

Organization : All Children's Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

The proposed CMS rule change would directly impact All Children's in a devastating way.

Submitter : **Dr. Jan Wencel** **Date: 03/05/2007**

Organization : **All Children's Hospital**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I do not support any cuts to children's medical services. In our particular case, sixty percent of our hospital case load is Medicaid for children. We are the last resort for care for some of these children. To trade our own children's health care to support the war in Iraq is absolutely unspeakable.

Submitter : Rose Stern **Date:** 03/05/2007

Organization : Rose Stern

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

The proposed change to reimbursement rates that will result if this is allowed to go forward will be devastating to the nation's healthcare system as well as to the individuals who will no longer be able to receive care. The services that individuals receive as a result of the current expenditure of these funds should be the right of every American. Even at current funding levels, the money is not enough and millions of Americans go without care that is sorely needed. If anything, the funds should be significantly increased to make healthcare available to everyone but especially the children, the working poor, and the elderly who cannot afford basic healthcare.

Submitter : Mr. Joseph LeValley **Date:** 03/05/2007

Organization : Mercy Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-35-Attach-1.DOC

#35

Mercy
MEDICAL CENTER
DES MOINES
A member of Mercy Health Network

March 5, 2007

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

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

Dear Ms. Norwalk:

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

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

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

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

Limiting Payments to Government Providers

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

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

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

New Definition of "Unit of Government"

The proposed rule puts forward a new and restrictive definition of "unit of government," such as a public hospital. Public hospitals that meet this new definition must demonstrate they are operated by a unit of government or are an integral part of a unit of government that has taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Contrary to CMS' assertion, the statutory definition of "unit of government" does not require "generally applicable taxing authority." This new restrictive definition would no longer permit many public

hospitals that operate under public benefit corporations or many state universities from helping states finance their share of Medicaid funding. There is no basis in federal statute that supports this proposed change in definition.

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

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

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

Insufficient Data Supporting CMS's Estimate of Spending Cuts

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

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

Sincerely,

Joseph LeValley
Senior Vice President

Submitter : Mrs. Susanna Deitz **Date:** 03/05/2007

Organization : All Children's Hospital

Category : Nurse

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

All Children's Hospital delivers the best care avaialable for children. We are already working with limited funds and it will be imposible for our children to receive the care they deserve. I am begging you to please not pass this proposed rule. We must speak for the children and do what is right for them.

Submitter : Mrs. GRETA VIA **Date:** 03/05/2007

Organization : ALL CHILDREN'S HOSPITAL

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

The proposed funding reductions in the bill would have a huge impact on the patients and families I work with. The patients are the underserved and undervoiced population in Florida.

Submitter : Mrs. Laurie Chalifoux **Date:** 03/05/2007

Organization : All Children's Hospital

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

This proposed rule change will have a devestating impact on All Children's Hospital's ability to serve our patients - the children of our community. Please put a halt to this change.

Submitter : Mr. **Date:** 03/05/2007

Organization : Mr.

Category : Nursing Aide

Issue Areas/Comments

GENERAL

GENERAL

NOT ONLY AM I A EMPLOYEE OF A CHILDRENS HOSPITAL ON THE ONCOLOGY FLOOR, BUT MY DAUGHTER WAS A LONG TIME PATIENT OF THE HOSPITAL. TO CUT THE CMS PROGRAM WOULD BE DEVESTATING TO THE HOSPITAL AND JUST ALIKE DEVESTATING TO FAMILIES THAT DEPEND ON CMS TO HELP GET THEM THROUGH THE LIFE ALTERING, DEVESTATION OF AN ILLNESS SUCH AS CHILDHOOD CANCER.

Submitter : Mrs. Monica Gray **Date:** 03/05/2007

Organization : All Children's Hospital

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Please do not make this change to the CMS. The impact would hurt the children of Florida who receive healthcare at facilities like All Children's Hospital

Submitter : **Date: 03/05/2007**

Organization : **Lucas County Health Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-41-Attach-1.DOC

#41

LUCAS COUNTY HEALTH CENTER

March 5, 2007

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

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

Dear Ms. Norwalk:

Lucas County Health Center in Chariton, Iowa is located in a very rural part of Southern Iowa. More than 60 percent of our patients are dependent on Medicaid and/or Medicare. We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to the patients we serve and to our hospital.

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

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

1200 N. Seventh St. • Chariton, Iowa 50049
(641) 774-3000 • www.lchcia.com

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

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

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

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

Restrictions on Intergovernmental Transfers (IGTs) and Certified Public Expenditures (CPEs)
The proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). There is no authority in the statute for CMS to

restrict IGTs to funds generated from tax revenue. CMS has inexplicably attempted to use a provision in current law that *limits the Secretary's authority to regulate* IGTs as the source of authority that *all* IGTs must be made from state or local taxes. Not only is the proposed change inconsistent with historic CMS policy, but it is another instance in which CMS has inappropriately interpreted the federal statute.

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

Insufficient Data Supporting CMS's Estimate of Spending Cuts

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

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

Sincerely,

Lucas County Health Center Management Team
Daniel B. Minkoff, FHFMA, CPA - Chief Executive Officer
Veronica R. Fuhs, RHIA, MHA - Assistant Administrator
Lana Kuball - Administrative Services Director
JoBeth Lawless, RN, BSN - Director of Nursing & EMS Services
Karen Wilker - Marketing Director

Submitter : Ms. Joyce Davis **Date:** 03/05/2007

Organization : All Children's Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

The proposed funding reductions would be devastating to the health care of Florida's children. This rule negates policies adopted and approved by the Federal Government for Florida's Low Income Pool and Medicaid Reform wiaver and the access to care provided by these programs. The two children's hospitals of Florida, All Children's Hospital in St. Petersburg and Miami Children's, will be severely affected. Please do not allow these CMS funding cuts to proceed.

Regulatory Impact Analysis

Regulatory Impact Analysis

The proposed rule change will have severe financial impact on the children's services that can be rendered children's hospitals in the state. Please intervene to hault implementation of this proposed change.

Submitter : Mr. David Kremzier **Date:** 03/05/2007

Organization : All Children's Hospital

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I am asking your help to not allow these CMS funding cuts to proceed. The proposed funding reductions would be devastating to the health care of Florida's children. The two children's hospitals of this state, All Children's and Miami Children's, would be severely affected.

Submitter : **Judith Hughes** **Date: 03/05/2007**

Organization : **All Children's Hospital**

Category : **Other Technician**

Issue Areas/Comments

GENERAL

GENERAL

Please do not cut funding to CMS facilities and put our precious children at risk for lack of care. These families already have much to deal with and cutting funds will just add to their stress levels and cause us to have uncontributing adults, costing the government more in the long run.

Submitter : **Miss. Lia Filitti** **Date: 03/05/2007**

Organization : **University of S Florida/All Children's Hospital**

Category : **Nurse Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Any change to CMS would be detrimental to our pediatric population in Florida. ALL children regardless of social or immigrant status deserve the best possible medical care. What does it say of our society if are unwilling to care for those who can not help their situation. We must take care of all children who require our help.

Bilions of tax dollars are being used to fund 'pet projects' in every state. Is it not better to care for the living?

Sincerely,
Lia Filitti, MS, ARNP, CPNP

Submitter : Mr. Timothy Crowley **Date:** 03/05/2007

Organization : Clinton Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-46-Attach-1.DOC

#46

March 5, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW, 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:

On behalf of Clinton Memorial Hospital in Wilmington, Ohio, we appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospital and the patients we serve.

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

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

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610 West Main Street, PO Box 600, Wilmington, Ohio 45177-0600, (937) 382-6611, www.cmhregional.com

Ms. Leslie Norwalk
March 5, 2007

Limiting Payments to Government Providers:

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

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

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

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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.

Ms. Leslie Norwalk
March 5, 2007

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

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

Sincerely,

Timothy J. Crowley, FACHE
President and CEO

TJC/tsp

610 West Main Street, PO Box 600, Wilmington, Ohio 45177-0600, (937) 382-6611, www.cmhregional.com

Submitter : Mrs. Monique Rowe-Confident **Date:** 03/05/2007

Organization : All Children's Hospital

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

All Children's Hospital takes all measures to ensure that the future leaders of tomorrow, "OUR CHILDREN", receive the most accurate and direct care by professionals who care. The Medicaid Program already underpays their contracted members for the professional services provided to their clients and I find that as a professional myself that the result of this docket, should it go through, will take away from me and other healthcare providers financially. If you want to cut finances from organizations that render care to others, that you should find some other program to make cuts to. The professionals, the procedures and the supplies cost money and just because you decide to pay less money does not lessen any of the previously mentioned items. Not only will you be taking away from the hospital and it's employees, you will also be stealing away from the well-being of the citizens of the U.S., once again, who are in need of our care.

Submitter : Mr. Dan Petrick **Date:** 03/06/2007

Organization : All Children's Hospital

Category : Other Health Care Professional

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

The proposed funding reductions would be devastating to the health care of Florida's children. The two children's hospitals of this state, All Children's Hospital and Miami Children's Hospital would be severely affected. What are our government representatives thinking? If we, as a nation, don't care for the health and well being of our children, then shame on us. We're making enough mistakes as a nation, please DO NOT add this to the list.

GENERAL

GENERAL

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Submitter : Mr. Roy Jones **Date:** 03/06/2007

Organization : Mr. Roy Jones

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Bottom line = If we can spend $93 Billion on Iraq in FY07 to secure oil fields we can spend whatever it takes to support our own ill citizens & the institutions that care for them.

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

Organization : **All Children's Hospital**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Please reconsider this bill. It would greatly reduce the amount of Medicaid funding to hospitals that are provides to many patients with this insurance. It could eventually cause facilities to be unable to continue to provide services to these patients.