Submitter : **Date: 03/19/2007**

Organization : **AARP**

Category : **Other**

Issue Areas/Comments

GENERAL

GENERAL

(SEE ATTACHMENT)

CMS-2258-P-244-Attach-1.PDF

#244

March 19, 2007

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

http://www.cms.hhs.gov/eRulemaking

RE: **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

To Whom It May Concern:

We offer comments on the proposed rule to limit Medicaid payments to government-owned health care providers to the cost of their services and to require these providers to retain the full amount of these payments.

AARP appreciates concerns with current rules that allow above-cost payments to government-owned providers. Some states have used this flexibility to obtain more funding than they would have received under the federal matching formula. In some cases, states may have used intergovernmental transfers (IGTs) to divert the additional funding for purposes other than providing health care to the poor, and we support carefully targeted efforts to prevent such abuse.

In many states, additional federal funding obtained under current rules has been used to strengthen the health care safety net, filling gaps not addressed in federal policy, and providing services to people who cannot afford the health care that they need.

The proposed rule would curtail both the good and bad use of these funds. It would not merely prevent abuse, but also would directly result in loss of funding and threaten the viability of important safety net services and institutions. It also could increase the number of uninsured and amount of uncompensated care by forcing states to make cuts in eligibility or service coverage.

The proposed rule projects that it would generate $3.87 billion in savings over five years, primarily by taking funds away from safety net providers.

It states that, "We expect this rule to have a significant economic impact on a substantial number of small entities, specifically health care providers that are operated by units of government."

That is a serious problem.

Efforts to prevent abuse of state financing mechanisms are perfectly legitimate and laudable. Allowing these efforts to create new holes in our tattered health care safety net is not.

We therefore urge you to take a carefully targeted approach to ending and preventing misuse of state financing mechanisms. Specifically, we urge you to work with states on a case-by-case basis to determine how beneficiary access and safety net providers would be affected by any changes in federal regulatory policy intended to prevent abuse. CMS should also help affected states develop waivers, state plan amendments, or other concrete steps to ensure that access to care and the viability of safety net providers is maintained.

Thank you for considering our comments. If you have any questions, please contact Paul Cotton on our Federal Affairs staff at (202) 434-3770.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Relations and Advocacy

Submitter : **Mrs. Laura Appel** **Date: 03/19/2007**

Organization : **Michigan Health & Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-245-Attach-1.PDF

#245

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

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, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

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

As drafted, the rules to implement this policy are unclear and the MHA believes will result in unintended harmful consequences. Making specific comments on this rule is difficult given this lack of clarity.

The rule imposes new restrictions on how states fund their Medicaid program and further restricts how states reimburse hospitals. These changes would cause major disruptions to our state Medicaid program and hurt providers and beneficiaries alike. The narrow definition of government health care providers will eliminate certain funding for university-based hospitals, public nursing homes and other providers. At a minimum this will reduce federal funding for Michigan's Medicaid program by $80 million annually, and potentially four times that amount. In the worst case, this could mean the loss of over a billion dollars for Michigan's health care safety net in the next five years. These amounts are detrimental to Michigan's ability to provide health care to its neediest citizens. It is also a sudden reversal of policy that has been in force and granted federal approval for several years.

The MHA urges 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.

SPENCER JOHNSON, PRESIDENT
CORPORATE HEADQUARTERS ◆ 6215 West St. Joseph Highway ◆ Lansing, Michigan 48917 ◆ (517) 323-3443 ◆ Fax (517) 323-0946
CAPITOL ADVOCACY CENTER ◆ 110 West Michigan Avenue, Suite 1200 ◆ Lansing, Michigan 48933 ◆ (517) 323-3443 ◆ Fax (517) 703-8620
www.mha.org

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. This is of crucial importance to Michigan hospitals. We are working to improve the supply of physicians in our state, both through residency programs, and innovative recruiting strategies. Curtailing funding for GME and physician on-call services would undermine the ability to grow the physician supply and could further hamper the ability to retain physicians in rural areas of the state.

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. This policy will adversely impact community access to vital services such as trauma centers, which tend to be located in our public facilities. We find 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,

David Finkbeiner
Vice President, Advocacy

Peter Schonfeld
Sr. Vice President, Policy and Data Services

Submitter : **Mr. Joel Wernick** **Date: 03/19/2007**

Organization : **Phoebe Putney Memorial Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-246-Attach-1.DOC

PHOEBE PUTNEY
MEMORIAL HOSPITAL

417 Third Avenue
Albany, Georgia 31701
Telephone 229-312-1000

#246

March 06, 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:

As the President of Phoebe Putney Memorial Hospital, I appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. Phoebe Putney Memorial Hospital is a 450-bed tertiary hospital located in Southwest Georgia (Albany, GA); one of the poorest congressional districts in the country. Per our audit for fiscal year 2006, Phoebe provided more than $32,000,000 (cost, not charges) of care to indigent and charity patients. Of this amount, a mere $9 million was supported through Georgia's Indigent Care Fund Program. Through your proposed rules discussed below, this reimbursement would be eliminated. I oppose this rule and would like to highlight the harm its proposed policy changes would cause to our hospital and the patients we serve.

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

CMS estimates that the rule will cut $3.9 billion in federal spending over five years. This amounts to a budget cut for safety-net hospitals and state Medicaid programs that bypasses the congressional approval process and comes on the heels of vocal congressional opposition to the Administration's plans to regulate in this area. I believe this significantly understates the impact on our nation's health care systems. Rough estimates of between $250 million to $400 million a year on Georgia hospitals translates into between $1.25 billion to $2.00 billion a year for Georgia alone. Our nation's shaky safety net hospitals cannot withstand such an impact without substantial impact on the most needy in our communities.

I urge CMS to permanently withdraw this rule, and I would like to outline my 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.

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.

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.

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.

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. As indicated above, I believe the result will be many times larger than $3.87 billion. I oppose the rule and strongly urge CMS permanently withdraw it.

Sincerely,

Joel Wernick, FACHE
President/CEO
Phoebe Putney Health System

Submitter : Mr. Santiago Munoz **Date:** 03/19/2007

Organization : University of California, Office of The President

Category : Academic

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

Please see attached letter

GENERAL

GENERAL

Please see attached letter

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Please see attached letter

Regulatory Impact Analysis

Regulatory Impact Analysis

Please see attached letter

#247

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

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

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

Submitter : **Mr. Paul Reinhart** **Date: 03/19/2007**

Organization : **State of Michigan, Medical Services Administration**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-248-Attach-1.DOC

#248

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,

Paul Reinhart, Medicaid Director

Submitter : Dr. Richard Bucciarelli **Date:** 03/19/2007

Organization : University of Florida College of Medicine

Category : Academic

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

see attachement

GENERAL

GENERAL

see attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

see attachment

#249

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

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

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

Submitter : **Ms. Lynne Barnes** **Date: 03/19/2007**

Organization : **Carle Foundation Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

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.

We urge CMS to permanently withdraw this rule. Our concerns can be summarized as the following: (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 Thank you.

Submitter : Mr. Santiago Munoz **Date:** 03/19/2007

Organization : University of Califoria, Office of the President

Category : Academic

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

Please see attached letter.

GENERAL

GENERAL

Please see attached letter.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Please see attached letter.

Regulatory Impact Analysis

Regulatory Impact Analysis

Please see attached letter.

CMS-2258-P-251-Attach-1.PDF

#251

UNIVERSITY OF CALIFORNIA

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SANTA BARBARA • SANTA CRUZ

OFFICE OF THE PRESIDENT --
CLINICAL SERVICES DEVELOPMENT

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March 19, 2007

Leslie Norwalk
Interim Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Ave, SW
Washington, DC 20201

SUBJECT: **CMS-2258-P** – 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 Interim Administrator Norwalk:

On behalf of the University of California (UC), Office of the President, Clinical Services Development Division, and the UC's five academic medical centers (AMCs) located in Davis, Los Angeles, Irvine, San Diego, and San Francisco, we are writing to express our opposition to Proposed Rule CMS 2258-P. The Proposed Rule exceeds the agency's legal authority, imposes significant payment policy changes, and will severely limit Medicaid hospital payments to the UC AMCs. We respectfully urge CMS to withdraw the Proposed Rule.

Together, the UC AMCs are the fifth largest healthcare delivery system in California, the leading provider of certain specialty services and medical procedures, and one of the state's largest providers of care to Medicaid patients. Annually, the AMCs provide patient care services valued at over $4 billion. In alignment with their patient care work, the UC AMCs also play a critical role in a number of broad public-policy goals, including the education of health professionals and the advancement of medical science through cutting-edge research. Specifically, the UC AMCs offer services that are essential to the health and well being of Medicaid beneficiaries including a broad-array of highly specialized services, such as cancer centers, geriatric and orthopedic centers of excellence, organ transplant programs, and world class primary and preventive care.

We are highly concerned about a number of troubling provisions contained in the Proposed Rule that would undermine our ability to serve vulnerable patient populations.

First, by limiting Medicaid payments to the cost of services furnished to Medicaid recipients, the Proposed Rule effectively eliminates funding for indigent non-Medicaid patients whose costs are currently covered under the Safety Net Care Pool, which is an integral part of California's Hospital/Uninsured Care Demonstration Project, approved under Section 1115 of the Social Security Act, ("Hospital Waiver"). The reduction to UC AMCs as a result of this change could exceed **$100 million per year** in Medicaid hospital payments. The impact to public hospitals statewide could exceed $500 million. Changes of this magnitude would severely undermine our ability to continue providing critical health care services to vulnerable populations.

The UC AMCs provide a full range of services to vulnerable populations, and specialty services to both the uninsured and insured that are not provided elsewhere in our communities. The Hospital Waiver pool exists under California's CMS-approved hospital financing waiver specifically for the purpose of providing financial assistance to safety net hospitals, such as the UC AMCs, that incur significant costs in treating uninsured patients. **If the Proposed Rule is applied to the hospital waiver, the UC AMCs could be forced to limit critical services, including care for the uninsured, trauma and burn care, specialty services, acute psychiatric services, and outpatient services.** Payment changes of this magnitude also could be harmful to California's entire health care system.

Though we understand that CMS staff may have orally indicated that adoption of the Proposed Rule would not affect California's hospital waiver, the potential harmful effects on the hospitals are such that we cannot rely on these oral assurances, particularly given the plain language of the Proposed Rule. The Proposed Rule explicitly states in the preamble that all Medicaid payments "made under the authority of the State plan and under Medicaid waiver and demonstration authorities are subject to all provisions of this regulation." 72 *Fed. Reg.* 2236, 2240. Moreover, the Special Terms and Conditions that govern the hospital waiver require that the State comply with any regulatory changes. Hence, the UC AMCs and California's other public hospitals, are highly concerned that, when the Proposed Rule's limit to Medicaid costs is applied to our state's hospital financing waiver, funding will be eliminated for indigent non-Medicaid patients whose costs are currently covered under the Safety Net Care Pool.

In addition, the Proposed Rule inappropriately limits states' ability to fund the nonfederal share of Medicaid expenditures by narrowing the types of public entities that can participate in that funding and by restricting the states' ability to use public funds for the Medicaid program. The impact of these restrictions will be dramatic for the UC AMCs and for California's Medi-Cal program as a whole. Notwithstanding the clear intent of Congress to allow states to use public teaching hospital dollars to fund their Medicaid expenditures, the proposed definition would preclude the five UC AMCs from participating in Medi-Cal financing in California. For over a decade, UC has contributed its funds to help the State finance its Medi-Cal program. **The loss of $100 million in federal Medicaid funding would be devastating for the State, the UC system and — most importantly — for the vulnerable patients we serve.**

This substantial loss of federal funds would be caused by the proposed amendments to sections 433.50 and 433.51, which inappropriately limit those entities qualified to provide the nonfederal share of Medicaid expenditures to units of government with generally applicable taxing authority. A provider will be treated as a unit of government only if it is operated by, or is an integral part of, a unit of government with taxing authority.

Under any reasonable definition, the UC AMCs must be recognized as governmental facilities. Indeed, the UC AMCs are owned and licensed by the University of California Board of Regents, a public entity **explicitly created** by Article IX, Section 9 of the California Constitution. Under the Proposed Rule, however, the University does not qualify as a "unit of government" because the Regents have no power to levy taxes. Thus, under the Proposed Rule, neither the University nor the UC AMCs would be able to participate in funding the Medi-Cal program through certified public expenditures ("CPE") or through intergovernmental transfers ("IGT").

CMS has provided no rationale for precluding states from using public funds appropriated to, and generated by, university teaching hospitals in support of Medicaid expenditures. Moreover, the legal analysis presented in support of the Proposed Rule is seriously flawed. First, there is nothing in Section 1902(a) (2) of the Social Security Act that supports restrictions on the types of units of government that can make Medicaid CPEs or IGTs. That section of the Medicaid statute, which has remained unchanged since 1967, recognizes the states' authority to use public funds, in addition to state funds, to finance Medicaid expenditures. The current regulation at Section 433.51 properly reflects the longstanding interpretation that allows a broad range of public agencies to do so.

Second, the proposed regulatory definition is inconsistent with the plain language of the statutory definition of unit of government on which CMS relies. The Proposed Rule simply adds the requirement of "generally applicable taxing authority" to the statutory definition in Section 1903(w)(7)(G) of the Act. If Congress had intended to impose this additional requirement, it would have done so. Instead, Congress adopted a broad definition with the intent of maintaining then-existing policy allowing all types of public agencies to fund Medicaid. Moreover, application of the Proposed Rule in California would violate the clear language of Section 1903(w)(6) which expressly prohibits CMS from restricting a state's use of "funds appropriated to state university teaching hospitals."

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

Fourth, the Proposed Rule is directly inconsistent with the reason that Congress included these provisions in the 1991 Medicaid amendments. While Section 1903(w) generally,

was designed to limit certain types of Medicaid financing methods, paragraphs (6) and (7)(G) were intended to protect the states' ability to use local public funds to finance the nonfederal share of Medicaid expenditures. The purpose of these provisions was to make it clear that IGTs were not to be restricted like provider-related taxes and donations, which were considered abusive. The Conference Committee stated:

> The conferees note that current transfers from county or other local teaching hospitals continue to be permissible if not derived from sources of revenue prohibited under this act. The conferees intend the provision of section 1903(w)(6)(A) to prohibit the Secretary from denying Federal financial participation for expenditures resulting from State use of funds referenced in that provision.
>
> H.R. COM. REP. No. 102-409 (1991).

By limiting the definition of unit of government, the Proposed Rule is directly contrary to this Congressional directive and would result in the denial of federal financial participation for legitimate Medicaid expenditures made by the UC hospitals.

There is no legitimate federal interest in imposing these restrictions on California's ability to fund its Medi-Cal program and the Proposed Rule should be withdrawn. In the event that CMS goes forward with the Proposed Rule, however, it should modify the definition of unit of government to exclude the taxing authority requirement. The ability of UC hospitals to provide Medicaid funding could also be protected by the addition of an exception for separate, constitutionally established entities.

A related concern is based on language in the preamble, where CMS states that tax revenue is the only valid source of intergovernmental transfers. 72 Fed. Reg. 2238. While neither current law nor the Proposed Regulation expressly imposes such a requirement, the preamble statements suggest that CMS intends to adopt an interpretation that would limit local Medicaid funding to those funds derived directly from taxes. Any such limitation on the use of public funds would seriously limit the University's ability to participate in Medi-Cal funding, would be directly inconsistent with the long-standing implementation of the Medicaid statute, and would negate the protections intended by Congress in Section 1903(w)(6) of the Act.

Section 1902(a)(2) is the statutory provision that has long been interpreted as granting states authority to use public funds, in addition to state funds, to finance Medicaid expenditures. Beyond a broad reference to the adequacy of "local sources" of funds, the provision imposes no restriction on the sources of local funds that may be used by the states. Until 1991, when Congress imposed strict limitations on federal financial participation designed to preclude the use of provider-related taxes and donations to finance Medicaid expenditures, there were no statutes or regulations in place that imposed any such restrictions. At the same time, however, Congress chose to protect, rather than restrict, the use of public funds for Medicaid expenditures.

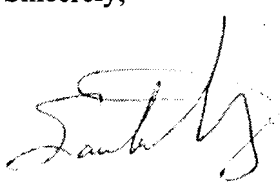
CMS has expressed no rationale for, or legitimate federal interest in, limiting Medicaid funding to tax revenues. Public entities obtain funds from a number of sources. For example, the University earns interest on amounts deposited in financial institutions, experiences gains on the sale of property, obtains donations from individuals, and earns revenues from various operations, including the operation of their health care providers. CMS has identified no valid policy reason to preclude the states form using these funds to support the Medicaid program.

Finally, there are a number of other legal and technical issues raised in the comment letter submitted by the coalition of California's public hospitals, which receive Medicaid payments under the Hospital Waiver. The UC AMCs supports those comments and incorporate them by reference in this comment letter.

The UC AMCs oppose the Proposed Rule and strongly urge CMS to withdraw it. If the Proposed Rule goes into effect, the UC hospitals will suffer harmful effects that will limit our ability to care for our patients and communities. In particular, CMS must withdraw the proposed changes to Sections 433.50 and 433.51. If CMS goes forward with a final rule, the definition of unit of government must be amended to allow recognition of the legitimate use of public funds of the University of California AMCs to finance the nonfederal share of Medicaid services.

Thank you for the opportunity to comment on the Proposed Rule. If I can answer any questions or provide any additional detail, please contact me at 510-987-9062 or santiago.munoz@ucop.edu.

Sincerely,



Santiago Muñoz
Associate Vice President – Clinical Services Development

Submitter : **Mr. Richard Morrison** **Date: 03/19/2007**

Organization : **Florida Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-252-Attach-1.TXT

#252

March 16, 2007

Honorable Michael O. Leavitt
Secretary
US Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Leavitt:

Florida Hospital and Adventist Health System have serious concerns about proposed Rule CMS-2258-P published in the Federal Register on January 18, 2007.

This rule change as proposed would have precipitous and significant consequences to many state Medicaid programs, even those granted. This proposed rule would create financial hardship for hospitals that see large numbers of Medicaid patients that are sole providers, or are located in underserved communities and who rely on a state's use of the IGT program for funding.

We recognize there have been instances of overpayment to the states, and that some states have used Medicaid funds for purposes other than health care services for Medicaid clients. We commend CMS' successful efforts to monitor and curb these abuses. These abuses can be fixed in a less draconian manner than is being suggested. We would urge that the rule be withdrawn and a study undertaken to determine the impact upon states of the rule as it is being proposed. The opportunity should also be taken to determine how a cooperative use of IGT between local communities, states and the Federal Government can enhance the overall access to care for the poor and underserved.

Sincerely,

Richard E. Morrison
Vice President, Adventist Health System
Regional Vice President, Florida Hospital

Cc: Leslie Norwalk

Submitter : **Dr. Richard Bucciarelli** **Date: 03/19/2007**

Organization : **University of Florida College of Medicine**

Category : **Academic**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

see attachment

GENERAL

GENERAL

see attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

see attachment

CMS-2258-P-253-Attach-1.PDF

#253

UF UNIVERSITY of FLORIDA

Office of the Associate Vice President for Health Affairs
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March 15, 2007

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 Florida College of Medicine(UFCOM) urges 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 the University of Florida College of Medicine 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 three participating medical schools in Florida (the University of Florida, the University of South Florida, and the University of Miami) is estimated to be $25 million - annually.

Faculty physicians employed by and under contract at these institutions are the state's providers of primary and specialty services for vulnerable populations, including Medicaid and uninsured persons. Through this critical access, these medical schools train and educate Florida's physician workforce, and are committed to developing advances in medicine through both clinical practice and research.

My 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.

My specific 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 that are claimed are 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. The UFCOM 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 quality as the non-Federal share of Medicaid expenditures.*

The UFCOM 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 is 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.*

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[1] Proposed 42 C.F.R. § 447.206(a).
[2] Proposed 42 C.F.R. § 447.206(c)(4).

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.

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 Colleges of Medicine have invested millions of dollars in adopting electronic medical records and other new information systems that have a direct impact on quality of care, patient safety and long-term efficiency, all goals promoted by HHS 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. UFCOM has 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 UFCOM urges CMS to reconsider the scope of the exception to the direct payment provision. The UFCOM recommends 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.

[3] 42 C.F.R. §438.60.

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

The UFCOM supports CMS' attempts to ensure that health care providers retain the full amount of federal payments for Medicaid services. We do not believe, however, that the 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. UFCOM has 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 UFCOM 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 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 UFCOM 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.

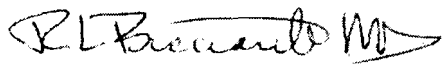
[4] Proposed 42 C.F.R. § 447.207(a).

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.

Thank you for allowing me to comment on this Rule.

With warmest regards,



R.L. Bucciarelli, M.D.
Associate Vice President for Health Affairs
For Government Relations

Submitter : Mr. Michael Deal **Date:** 03/19/2007

Organization : Southwest Behavioral Health Center

Category : Health Care Provider/Association

Issue Areas/Comments

Regulatory Impact Analysis

Regulatory Impact Analysis

My name is Michael Deal, Chief Financial and Administrative Officer of Southwest Behavioral Health Center, a mental health managed care organization in the State of Utah. I am writing to comment on the impact that proposed regulation CMS 2258-P will have on the Medicaid system in Utah, with specific emphasis on the Medicaid Mental Health System.

Utah has organized the Medicaid Mental Health Services under the State's 1915(b) waiver into nine Prepaid Inpatient Health Plans (PIHPs). A number of these PIHPs have been set up as government entities by one county or a group of counties to manage the risk-based Medicaid mental health PIHP contract. Under this arrangement, local dollars are paid to the PIHP for Medicaid match and these funds are then submitted to the state to cover the match.

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

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

Submitter : **Mr. Jim Sherrill** **Date: 03/19/2007**

Organization : **Cowlitz Indian Tribe**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-255-Attach-1.DOC

255

Cowlitz Indian Tribe
P.O. Box 2429 • 1055 9th Ave Suite D• Longview, WA 98632
Phone: 360-575-3307 • Fax: 360-577-7432

3/19/2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

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

Dear Ms. Norwalk:

I am Jim Sherrill, the Health and Human Services Director for the Cowlitz Indian Tribe. I 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 the 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

[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.")

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 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.

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").

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,

Jim Sherrill
Health and Human Services Director
Cowlitz Indian Tribe

Cc: National Indian Health Board

Submitter : Dr. terry mason **Date:** 03/19/2007

Organization : chicago department of public health

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2258-P-256-Attach-1.DOC

#256

City of Chicago
Richard M. Daley, Mayor

Department of Public Health

Terry Mason, M.D., F.A.C.S.
Commissioner

333 South State Street
Chicago, Illinois 60604
(312) 747-9884
(312) 747-9888 (24 hours)

http://www.ci.chi.il.us

Date: March 21, 2007

To: **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

From: **Terry Mason, M.D., F.A.C.S.**
Commissioner
Chicago Department of Public Health
333 South State Street, Suite 200
Chicago, Illinois 60604

Transmitted electronically to http://www.cms.hhs.gov/eRulemaking

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 Proposed Rule**

The Chicago Department of Public Health (CDPH) thanks the Centers for Medicare & Medicaid Services for the opportunity to comment on the Proposed Rule for the Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial partnership Proposed Rule, 42 CFR Parts 433, 447, and 457 (CMS-2258-P).

The Chicago Department of Public Health assures conditions in which Chicagoans can be physically and mentally healthy through promoting health and by providing effective, accessible health services at seven neighborhood health centers, six specialty clinics, and 12 mental health centers.

Given our commitment to providing quality health care for low income Chicagoans, we take a great interest in the Medicaid program. Nearly 60 percent of Chicago's 400,000 Medicaid enrollees are children. The majority of the 75,782 patients receiving care in our neighborhood health centers are very low income, and 24,351 are Medicaid enrollees. We submit certified public expenditures [CPEs], receive matching funds, and depend on them to provide needed health services. In the past two years, we expended $7 million of CPE-eligible taxpayer dollars to provide health services to nearly 100,000 very low income patients.

Illinois currently does not get its fair share of Medicaid. While home to nearly 4 percent of the national Medicaid population, Illinois receives only 3.6 percent of total Medicaid funds. IGTs and CPEs are fundamental and essential ways that Medicaid provides funding for our safety net in Chicago. We and other safety net providers need all of the federal Medicaid funding we currently receive. We will not be able to preserve the level and quality of care if our federal Medicaid funding is cut by $255 million each year. This Proposed Rule asks Chicago to bear more than its share of the $3.87 billion in cuts expected to be generated over the next five years. Fully one-third of the cuts will be borne by the safety net in Cook County and Chicago.

Reducing Medicaid resources in Chicago will severely restrict our ability to provide the level and quality of health care services for our low-income individuals, children, and families. Specifically the Proposed Rule will:

- < Reduce the number of entities that will be entitled to contribute to IGTs and CPEs;
- < Diminish the amount of local and state funding that will qualify for matching funds;
- < Shift the full cost for uncompensated care to the City of Chicago and other underfunded safety net providers;
- < Set "allowable" costs through rule and inhibit the ability of the health care marketplace.

As a public agency, we are very mindful of our responsibility to ensure that taxpayers' dollars are spent wisely and well. Federal law and CMS regulation have upheld for ten years the use of intergovernmental transfers [IGTs] and CPEs by us and other safety net entities in Chicago and Illinois. This Proposed Rule fundamentally revises these traditional and legal methods of equitably sharing among local, state, and federal governments the cost and responsibility of providing safety net services. Moreover, it requires that Chicago contribute considerably more than our fair share

Providing quality health care is a goal that we all share. To that goal, the Chicago Department of Public Health offers our comments in support of maintaining the existing provisions of the Medicaid program and trust you will consider our concerns as you deliberate this important issue.

Submitter : **Ms. Keri Disney** **Date: 03/19/2007**

Organization : **Dallas County Hospital District**

Category : **Hospital**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

CMS-2258-P-257-Attach-1.DOC

#257

Leslie V. Norwalk, Esp.
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:

I am writing to oppose the proposed Medicaid regulation published on January 18, 2007. This rule jeopardizes approximately $70 million in UPL funding annually for Parkland Health & Hospital System (Parkland).

Parkland is a 900 bed tertiary care facility that is the safety net provider for Dallas County, Texas. Parkland has level 1 trauma designation, a nationally-respected burn program, and is a critical player in the emergency response plan for Dallas County. The hospital trains over 500 residents annually, and provides care to more than 16,000 babies delivered at Parkland each year, including NNICU c are to many. The Emergency de partment provides approximately 146,000 visits annually and the facility sees 876,000 clinic visits annually, providing both primary and preventive care and acting as a key referral source for hard-to-access specialty care services. Parkland also coordinates a number of community services, such as jail health, at the request of the County. The health of Dallas county residents is better in part because of Parkland.

As the major safety net provider in our community, we oppose the Proposed Rule, and respectfully request you withdraw it immediately. Under the rule, Americans can count on compromised care and longer wait times. I am concerned that the Administration is planning to issue these regulations without the input from or approval by Congress, which explicitly rejected additional Medicaid cuts even last year. The rule amounts to a budget cut for safety-net hospitals and state Medicaid programs that bypasses the congressional approval process. Below, you will find detailed comments on specific portions of the proposed rule.

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

Currently, states are permitted to provide Medicaid reimbursement to hospitals up to the amount that would be payable using Medicare payment principles in aggregate. The rule would reduce that limit to Medicaid costs for governmental providers only, resulting in drastic cuts to Parkland.

Parkland receives supplemental Medicaid payments of approximately $ 90 million annually, based on the upper payment limit. In part, these payments allow Parkland to serve as a health care safety net in Dallas County. Without this funding, Parkland may be forced to drastically scale back services.

Nearly 27 years ago, Congress moved away from cost-based reimbursement for the Medicaid program, because cost-based reimbursement formula contained no incentives for efficient performance. Yet now, CMS is proposing to resurrect a cost-based limit that Congress deemed inefficient over two decades ago. CMS is also changing position from 2002 court documents, where they indicated the states had considerable flexibility to allocate payment rates within categories. The documents further note flexibility to allow states to direct higher Medicaid payment to hospitals facing stressed financial circumstances.

Limiting Medicaid payments to cost for safety net providers such as Parkland is extremely short-sighted public policy. CMS asserts that the cost limit is necessary because public 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. 2241) Parkland does not return Medicaid payments to Texas as a source of revenue. Imposition of these rules would punish providers in states that are meeting federal guidelines.

To the extent that Parkland uses Medicaid (or Medicare, commercial or patient) funds to support the financial viability of the critical services described above, we believe such activities are integrally related to Medicaid. Dallas County needs a viable and financially state Level I trauma center. We need future physicians to practice in the community and support that end by hosting the residency program for the University of Texas Southwestern. Parkland invests in accessible community-based clinics with hours that are compatible with the schedules of the working poor, providing a medical home for families that would otherwise receive only limited care through the Emergency Room. I would assert that these services are essential to the entire community, especially to underserved populations such as Medicaid recipients.

This change singles out facilities deemed units of government, limiting their Medicaid reimbursement to cost. As currently proposed, only public providers would be so limited. A fairer approach would be to limit all Medicaid reimbursements to a hospital's cost of care of serving Medicaid and uninsured patients—whether the facility is deemed a unit of government or not.

Governmental providers have a special role in the health care system, one that is entirely compatible with the goals of the Medicaid program. CMS should not single out governmental providers for such a particularly harsh and rigid reimbursement limit. We urge you to retain the current regulatory upper payment limits.

Certified Public Expenditures (CPEs) (Section 447.206(d)-(e))

Parkland objects to the discussion in the preamble of the regulation (not repeated in the text of the regulation) that units of government that are providers can only certify their expenditures if they are paid on a cost basis. There is no reason to impose this limitation on the use of CPEs. The preamble acknowledges that units of government that are not providers may certify their payments to providers even if the state plan payment methodology is not cost-based. I cannot understand why this methodology would not be applied to the provider itself. The costs that Parkland incurs in connection with services to Medicaid patients are no less real than the costs a non-provider unit of government would incur if they paid us for providing Medicaid services. Please confirm that the regulatory text stands on its own and rescind the preamble discussion requiring providers to be paid on a cost basis in order to certify expenditures as the non-federal share.

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

CMS has approved a state plan amendment that allows some Texas physicians to receive enhanced Medicaid reimbursement. Given the disproportionate burden that our physicians undertake in serving low income Medicaid and uninsured patients, this enhanced funding has been critical to their financial viability as well. The cost limit contained in the Proposed Rule does not specify whether it applies only to institutional providers or also to professional providers. A cost limit would be inappropriate for professional services. We request that CMS clarify that the provisions of the Proposed Rule do not apply to professionals.

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

CMS proposes to implement the Proposed Rule as of September 1, 2007—an ambitious schedule given the nature of the changes proposed. Our legislature will have convened by the time the final rules are issued. It will not be able to properly consider any changes to our program that may be required under the final regulation. Between the Medicaid agency developing and obtaining approval for SPA changes required, changes to state rules/provider manuals, and establishing cost reporting mechanisms, the state will be faced with months of work. Considering the sweeping changes, Parkland requests that any changes be transitioned over a minimum of three years.

I appreciate the chance to comment on the Proposed Rule. Given the devastating impact that it would have on Parkland, our patients and Dallas County, I request that you withdraw the regulation immediately.

If you have any questions about this letter, please feel free to contact me at kdisne@parknet.pmh.org or (214) 590-4171.

Respectfully,

Keri E. Disney, Director
Government Reimbursement
Parkland Health & Hospital System

Submitter : **Date: 03/19/2007**

Organization :

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-258-Attach-1.PDF

CMS-2258-P-258-Attach-2.PDF

#258

March 19, 2006

Ms. Melissa Musotto
CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development-A
Room C4-26-0526-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Ms. Musotto:

These comments by the Safety Net Hospital Alliance of Florida ("SNHAF") are directed solely at the Tool to Evaluate the Governmental Status of Providers[1] (the "Tool"), which was released by the Centers for Medicare and Medicaid Services ("CMS") in conjunction with 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"). SNHAF believes that the Proposed Rule, as well as the Tool, exceed the agency's legal authority, defies the bipartisan opposition of a majority of the Members of Congress, and would dismantle the Florida's intricate Medicaid-based safety net system, which will seriously compromise access for Medicaid and uninsured patients. As noted in our comments on the Proposed Rule, the effect on Florida's safety net is devastating - an estimated $932 million reduction in Medicaid payments annually.

While CMS' intent for drafting the Tool is admirable, we believe that it does not actually assist providers in determining their governmental status under the regulation, because once the Tool is completed, there is no indication of the outcome. Accordingly, we offer the following comments expressly related to the Tool:

1. CMS should revise its "Tool to Evaluate Governmental Status of Providers."

A provider is not required to be included on the unit of government's consolidated financial report to be considered a "health care provider operated by a unit of government." However, it is not clear based on the Tool whether the comment above is actually true and accurate. Based on the reading of the Proposed Rule, a provider might believe that they are still a unit of government, but the same conclusion cannot be drawn

[1] Proposed Rule at 2242. A copy of this form is available at: http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=2&sortOrder=descending&itemID=CMS1192476&intNumPerPage=10.

by completing the form. Likewise, the unit of government is not required to be liable for a provider's operations, expenses, liabilities, and deficits in order for the provider to be considered a "health care provider operated by a unit of government under the language of the Proposed Rule. However, again, it is unclear when reviewing responses to the Tool, what the outcome is. The disconnect between the Proposed Rule and the Tool will make it very difficult for states, governmental entities, and providers to determine whether they qualify as a "unit of government" under the regulation.

2. CMS should place a deadline on determinations made using the "Tool."

Under the Proposed Rule, States would be required to provide the completed "Tool" on each applicable provider within three months of the effective date of the final rule. However, there is no stated deadline for CMS' response to the information provided.

Recommendation: CMS should impose a three-month deadline for decisions and determinations made using the Tool.

3. CMS should provide a procedure for challenging decisions made using the "Tool."

Neither the Tool nor the Proposed Rule appears to provide the opportunity to amend the information provided on the form or challenge any decision made based on the information provided.

Recommendation: CMS should implement due process procedures relative to the "Tool"

This concludes the comments submitted by the Safety Net Hospital Alliance of Florida regarding the "Tool."

Sincerely,

Anthony P. Carvalho

Anthony P. Carvalho
President

258-2

March 19, 2007

Leslie V. Norwalk, Esq.
Department of Health & Human Services
Attention: CMS-2258-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Ms. Norwalk:

The Safety Net Hospital Alliance of Florida ("SNHAF") urges 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 exceeds the agency's legal authority, defies the bipartisan opposition of a majority of the Members of Congress, and would dismantle the Florida's intricate Medicaid-based safety net system, which will seriously compromise access for Medicaid and uninsured patients.

Without any plan for replacement funding, CMS would eliminate $932 million in payments to Florida's safety net hospitals annually. These payments have traditionally been used to ensure that the Florida's poor and uninsured have access to a full range of primary, specialty, acute, and long-term care. This critical funding has made it possible to ensure that our communities are protected with adequate emergency response capabilities, have highly specialized but under-reimbursed tertiary services (such as trauma care, neonatal intensive care, burn units and transplant centers), and have the trained medical professionals they need. The result of this regulation would be a severely compromised safety net health system, unable to meet current demand for services, and incapable of keeping pace with the fast-paced changes in technology, research, and best practices that result in the highest quality care.

SNHAF endorses CMS' stated goal of ensuring accountability and protecting the fiscal integrity of the Medicaid program. Over the years, Congress and CMS have taken a series of steps to advance these goals with respect to both provider payments and non-federal share financing. These efforts have included restrictions on provider taxes and donations, statewide and hospital-specific limitations on Disproportionate Share Hospital ("DSH") payments, and a series of modifications to significantly restrict upper payment limit payments ("UPL"). All of these steps were taken by or with the consent of Congress. Over the last three years, CMS has significantly increased its oversight of payment methodologies and financing arrangements in state Medicaid programs, working

with states to restructure their programs as necessary to eliminate inappropriate federal matching arrangements. Officials from the Department of Health and Human Services ("HHS") have repeatedly claimed success from this initiative, stating that they have largely eliminated "recycling" from those programs under scrutiny. CMS points to no evidence that the legislative, regulatory, and administrative steps taken to date have been insufficient to eliminate the financing practices about which CMS is concerned, nor does the agency explain how the restrictive policies in the Proposed Rule will further its stated goals. In fact, in Florida, even prior to the implementation of Florida's Section 1115 waiver, CMS repeatedly reviewed and approved of all of the state's financing mechanisms and provider payments. The Proposed Rule imposes payment and financing policies that go far beyond merely institutionalizing the oversight procedures CMS has used successfully to date. These policies would cut deep into the heart of Medicaid with no measurable increase in fiscal integrity.

In course of CMS' recent approval Florida's Section 1115 waiver, which resulted in the creation of Florida's Low Income Pool program ("LIP") and significant Medicaid reform, Florida relied upon terms and conditions negotiated with CMS. The terms and conditions included reliance on the establishment of a CMS approved alternative UPL program for providers, essentially the LIP program. Under the waiver, CMS has reviewed and approved Florida's sources and use of intergovernmental transfers ("IGTs"). To impose the Proposed Rule on Florida negates the agreement made in good faith between CMS and Florida's Agency for Health Care Administration ("AHCA").

In its Regulatory Impact Analysis, CMS asserts that the Proposed Rule will not have a significant impact on providers for which relief should be granted, and it projects "this rule's effect on actual patient services to be minimal."[1] CMS estimates $3.9 billion in federal savings from the Proposed Rule over five years, but provides no detail on how it derived this estimate. The impact on Florida hospitals alone as estimated by SNHAF and AHCA is $4.7 billion over five years - and that does not include the potential impact on other providers in Florida including physicians, nursing homes and federally qualified health care centers. It is clear that CMS has significantly understated the impact of the Proposed Rule on providers, on patients and on total federal Medicaid funding provided to states.

Florida has never been identified by CMS as abusive; on the contrary, CMS has repeatedly reviewed in detail the hospital payment and financing programs in Florida and approved them as legitimate. Despite the recent review and approval of Florida's program by CMS, the Proposed Rule would undermine Florida's LIP program and will

[1] Proposed Rule at 2245.

cut payment rates and eliminate approved sources of non-federal share funding. As a result, Florida's safety net health systems' ability to serve Medicaid and uninsured patients will be severely compromised and state Medicaid programs will face substantial budget shortfalls with no apparent gain in fiscal integrity. Moreover, CMS would impose these cuts immediately, effective September 1, 2007, providing no time for Florida legislators to overhaul program financing to come into compliance with the new requirements. The Florida Legislature regularly meets one time each year for a 60-day session; the 2007 Regular Session began March 6, 2007, and the Legislature has until May 4, 2007, to conduct the state's business. Therefore, if the Proposed Rule goes into effect September 1, 2007, Florida's budget would need to be over-hauled after the fact since the Proposed Rule affords no transition period or replacement funding.

CMS' response to concerns about lost funding for important health care needs is that it is Congress' job to determine whether such federal support is needed for Medicaid and uninsured patients. SNHAF respectfully submits that Congress has already determined that such federal support is appropriate, and that states, like Florida, may use their Medicaid programs to provide access to uninsured person. Above-cost Medicaid payments based on Medicare payment principals and rates have been part of the Medicaid payment system for years. Congress has explicitly rejected CMS' proposals to impose provider-specific, cost-based payment limits;[2] it has required the adoption of regulations with aggregate rather than provider-specific limits;[3] it long ago freed states from mandatory cost-based payment systems to allow for the proliferation of payment systems more tailored to localized needs;[4] and it has acquiesced with no expressed concern in the development of supplemental Medicaid payment systems in which states have used the Medicaid program as the primary source of federal support for safety net health care. If Congress is the only entity that can authorize replacement funding, then Congress should also be the entity to consider the types of sweeping payment and financing changes that CMS proposes.

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[2] Budget of the United States Government, Fiscal Year 2005, pages 149-150; Budget of the United States Government, Fiscal Year 2006, pages 143; Letter from Michael O. Leavitt, Secretary of Health and Human Services, to the Honorable Richard B. Cheney, President, United States Senate, August 5, 2005 (transmitting legislative language to Senate implementing the fiscal year 2006 proposals); Letter from Michael O. Leavitt, Secretary of Health and Human Services, to the Honorable J. Dennis Hastert, Speaker of the House of Representatives, August 5, 2005 (transmitting legislative language to House of Representatives implementing the fiscal year 2006 proposals). Significantly, despite the inclusion of language in the budget for fiscal years 2005 and 2006 and the transmittal of legislative language Congress did not pass and no member of Congress even introduced legislation to implement these proposals.

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

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

In the wake of President Bush's FY 2007 budget proposal to restrict funding and payment flexibility by regulation, 300 Members of the House of Representatives and 55 Senators in the 109th Congress went on record urging the Administration not to move forward administratively. Since the Proposed Rule was issued on January 18 of this year, a significant number of Senate and House members have similarly opposed the Proposal Rule. Given the overwhelming bipartisan opposition to this Proposed Rule and the means by which it is being adopted, CMS should withdraw its proposal immediately and seek authorization from Congress to impose the changes it believes necessary.

After providing a summary of our comments, we raise significant legal and policy concerns, as well as technical issues regarding the major aspects of the Proposed Rule, which are:

- Application of the Proposed Rule on states with approved waivers;
- Limit on payments to governmental providers to the cost of Medicaid services;
- Definition of a unit of government and health care provider operated by a unit of government; and
- Restriction on sources of non-federal share funding.

Thereafter, we comment on CMS' Regulatory Flexibility Act analysis.

SUMMARY OF COMMENTS

SNHAF's major concerns with the Proposed Rule center around (1) application of the rule on states like Florida with approved and heavily scrutinized Section 1115 waivers; (2) the cost limit on Medicaid payments to governmental providers; (3) the new and restrictive definition of a "unit of government" and operative application of a "health care provider operated by a unit of government"; and (4) the restrictions on sources of non-federal share funding.

Florida's waiver included significant concessions by the state, including increased scrutiny on the sources and uses of IGTs. Florida relied on CMS' approval and made major changes in its Medicaid programs that are effectively "undone" by application of the Proposed Rule. Those changes took time and were carefully crafted to meet unique circumstances in Florida and requirements imposed by CMS; the Proposed Rule undermines those efforts and will leave patients that rely on the resulting services without a safety net.

The cost limit would impose deep cuts in funding for Florida's health care safety net, with serious repercussions on access and quality for low-income Medicaid and uninsured patients. The cuts would not result in any measurable improvement in the fiscal integrity of the Medicaid program. The cost limits for hospitals in Florida were negotiated under Florida's LIP program and are based on the hospital's Medicaid cost and the costs of providing care to the uninsured and underinsured. Paragraphs 94 and 97 of the Special terms and conditions ('STC"), which are part of Florida's approved Section 1115 waiver defined the criteria that hospitals would have to meet in order to receive federal matching dollars under the LIP program. Additionally, the STC required the Florida Medicaid program to submit detailed definitions of how a hospital's individual cost limit will be calculated, and these definitions were submitted to CMS in the Reimbursement and Funding Methodology document on November 22, 2006, for their review and approval. The cost limits currently being in place have been reviewed and approved both by the Florida Medicaid program and CMS as being reasonable and guard against any excessive payments. These limits are reasonable and allow states appropriate flexibility to target support to communities and providers where it is most needed. Neither Medicaid nor Medicare pays excessive rates.

Moreover, governmental providers, who disproportionately serve the uninsured, should not be subject to a more restrictive limit than private providers. Imposing a cost limit on governmental providers would undermine important policy goals shared by the Administration and providers alike – such as quality, patient safety, emergency preparedness, enhancing access to primary and preventative care, reducing costly and inappropriate use of hospital emergency departments, graduate medical education, adoption of electronic medical records and other health information technology and reducing disparities. Finally, the cost limit would 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, and would violate Section 705(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 by adopting upper payment limits that are not based on the proposed rule announced on October 5, 2000. CMS should not modify the current upper payment limits or the limits negotiated in good faith by Florida, which is operating under a Section 1115 waiver.

We also believe that CMS does not have the authority to redefine a "unit of government" more narrowly than prescribed by statute, nor does CMS have the authority to determine what constitutes a "health care provider operated by a unit of government." The statutory definition contained in Section 1903(w)(7)(G) of the SSA does not limit the term to

entities that have taxing authority and does not delve further by applying that definition to create a separate class of providers. CMS is far exceeding its authority in placing such a significant restriction and application thereof on the much broader definition adopted by Congress. Congress' definition afforded due and appropriate deference to states' determination of which of its instrumentalities are governmental, as required by Constitutional principles of federalism. CMS' proposed definition is an unprecedented intrusion into the core of states' rights to organize themselves as they deem necessary. The definition also undermines the efforts of states and localities to deliver a core governmental function ensuring access to health care through the most efficient and effective means. Countless governments have organized or reorganized public hospitals into separate governmental entities or leased public hospitals to private entities in order to provide the hospitals with the autonomy and flexibility needed to deliver high quality, efficient health care services in an extremely competitive market, yet the Proposed Rule does not likely recognize such structures as governmental. Similarly, there is no statutory basis for the invention of "health care providers operated by units of government"; this is simply an extension of the unauthorized definition of "unit of government." CMS should defer to state designations of governmental entities.

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

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

Intergovernmental Transfers ("IGTs")

- CMS should allow the use of IGTs to finance payments for categorical Medicaid payments.
- CMS should confirm the use of IGTs to finance Medicaid payments approved in the State plan.

State and Local Tax Revenue

- CMS should confirm the use of any state and local appropriation to finance approved Medicaid services.
- CMS should allow any payments made to providers by governmental entities responsible for providing health care services to be used as IGTs.

Cost Limit

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

Unit of Government Definition

- CMS should eliminate the requirement that only units of government with taxing authority are able to provide IGTs.
- CMS should defer to state law determinations of public status.
- CMS should not attempt to define or classify "health care providers operated by a unit of government".
- CMS should clarify the federal or state law interpretations of public status are not altered outside of the confines of the Proposed Rule.

- CMS should revise its Tool to Evaluate Governmental Status of Providers to indicate what determination would result from answers to the questions posed.

Certification of Public Expenditures ("CPEs")

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

Retention of Payments

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

Section 1115 Waivers

- CMS should clarify that waiver states like Florida may maintain its approved LIP program and expanded coverage established through Section 1115 demonstration projects notwithstanding the Proposed Rule.
- CMS should honor the terms and conditions agreements reached with waiver states.

Provider Donations

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

Effective Date

- CMS should extend the effective date of the regulation and provide generous transition periods.
- CMS should clarify that all parts of the regulation will be imposed prospectively only.

Finally, SNHAF believes that in its Regulatory Flexibility Act analysis, CMS has seriously underestimated the impact that the Proposed Rule will have. The Proposed Rule will impose significant costs on Florida and Florida's safety net providers in connection with new administrative burdens it establishes. The cost to states of

developing new payment systems, adopting new financing mechanisms to pay for the non-federal share, developing new cost reporting systems, and administering and auditing them will be significant. The cost to providers of complying with these new requirements is also substantial. More importantly, however, CMS vastly understates the direct and significant impact that the Proposed Rule will have on patient care, as providers and states struggle to cope with multimillion dollar funding cuts. The impact on Florida alone is in excess of the estimate for all states. In addition, the Proposed Rule will negatively impact local economies that are built around providers affected by this regulation. CMS should reevaluate its estimate of the impact of the Proposed Rule and the need for regulatory relief under the Regulatory Flexibility Act.

MAJOR LEGAL AND POLICY CONCERNS BY SECTION OF THE PROPOSED RULE

I. Intergovernmental Transfer (IGT)

1. *Units of government within a state may be required by state law to transfer local tax revenue to the Medicaid agency for use as the non-Federal share of categorical, non-specific provider Medicaid payments.*

Under Florida law, counties are required to contribute to the non-Federal share of payments made to hospitals and nursing homes, and it is unclear if this long-standing practice would be adversely affected by the Proposed Rule. To allow otherwise will significantly reduce Florida's ability to reimburse hospitals and nursing homes.

Recommendation: CMS should clarify that the Proposed Rule does not affect the involuntary transfer of local governmental funding for non-provider specific Medicaid payments.

2. *Units of government within a state may voluntarily transfer local tax revenue to the Medicaid agency for use as the non-Federal share of Medicaid payments.*

Florida's UPL and now LIP program are dependent upon IGTs voluntarily provided by municipalities and counties; the Proposed Rule should not override local communities' ability to support safety net providers in their communities by disallowing those funds to be used as the non-Federal share of approved Medicaid expenditures.

Recommendation: CMS should clarify that the Proposed Rule allows governmental entities to voluntarily transfer funds for the benefit of providers in their community.

3. *Certain provider taxes may be used as the non-Federal share of Medicaid payments.*

Florida imposes a Public Medical Assistance Trust Fund provider tax of 1.5% of net hospital inpatient revenues and 1% of net outpatient revenues for use as the non-Federal share of Medicaid hospital expenditures. It is unclear if those taxes would continue to be appropriate and allowable IGTs under the Proposed Rule.

Recommendation: CMS should expressly state that the Proposed Rule has no effect on rules and regulations pertaining to provider taxes.

4. *Disproportionate share ("DSH") payments may include costs associated with providing services to uninsured persons, and IGTs may be used to make DSH payments.*

The Proposed Rule is ambiguous with regard to how DSH payments can be determined and financed. The costs associated with providing services to uninsured persons should continue to be used in determining allowable DSH payments, and any willing government entity should have the ability to pay for the non-Federal share of DSH payments through either IGTs or CPEs.

I. Certified Public Expenditure

5. *CPEs do not need to be tax derived in order to be used as the non-Federal share of Medicaid payments; only IGTs must be tax derived.*

Neither CPEs nor IGTs should be required to be tax-derived. Any public source of funds should qualify as CPEs or IGTs. By imposing this new restriction, CMS is exceeding its Congressional authority. Section 1902(a)(2) of the SSA allows states to rely on "local sources" for up to 60 percent of the non-federal share of program expenditures. This provision of federal law does not limit the types of local sources that may be used.

When Congress has intended to restrict the local sources of Medicaid match, it has rejected CMS' attempts to impose limits by unilaterally regulation and has insisted on legislating such significant limitations itself. For example, in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991,[5] Congress adopted significant restrictions on sources of local funding after imposing a series of moratoria on

[5] Pub. Law No. 102-234, 105 Stat. 1793.

HHS' attempts to restrict local sources of funding administratively.[6] CMS is without legal authority to insist that local funding from units of government be limited to tax dollars only - a public dollar is a public dollar.

Recommendation: CMS should not require IGTs to be tax-derived - all public funding regardless of its source should be eligible as the non-federal share of Medicaid expenditure.

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

Once an expenditure is approved under the State plan, any public expenditure - whether contractual or otherwise - either public CPE or IGT 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, and one way the local governmental entity can hold the provider accountable it through a contractual relationship and contractual obligations.

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

7. *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 documentation and approval process appears to be arbitrary. As noted above, any expenditure by a governmental entity to a provide should qualify as long as the provider is delivering Medicaid services as defined and approved in the state's plan.

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.

[6] Omnibus Budget Reconciliation Act of 1989, Pub. Law No. 101-239, 1989 U.S.C.C.A.N. (103 Stat.) 2106.

I. State and Local Tax Revenue

8. *State or local tax dollars not expressly generated for Medicaid purposes may be used as the permissible source of the non-Federal share of Medicaid expenditures.*

The Proposed Rule states that "[I]n order for state and/or local tax dollars to be eligible as the non-federal share of Medicaid expenditures, that tax revenue cannot be committed or earmarked for non-Medicaid activities."[7] By stating this in the negative it is unclear, what, if any or all, tax-derived funds may be used as match. In Florida, many local communities raise local tax dollars expressly for health care services, but not necessarily for Medicaid-only purposes (just as the state derives little or no direct tax dollars in express support of Medicaid), and these funds should be eligible as IGTs under the Medicaid program.

If a governmental entity is committed - contractually or otherwise - to pay a provider for health care services to underserved populations, those contractually obligated funds that ensure local access for uninsured and Medicaid populations should be eligible, appropriate IGTs.

Recommendation: CMS should not disqualify funds generated and used to support access to health care service. The Proposed Rule should clearly state that any and all unspecified tax revenues may be used as the non-Federal share of Medicaid expenditures.

9. *State and local appropriations by a unit of government made directly for the benefit of a health care provider - regardless of whether the provider is a unit of government or operated by a unit of government - 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 will be eligible IGTs. CMS should state that those appropriations will continue to be fully matchable under the new regulation, and that it will not disallow such taxpayer funding as an indirect provider donation.

For example, a public hospital authority without taxing authority and legally separate from the county which created it may, under current arrangements, receive a substantial sum (as an example, say $20 million) to care for the county's indigent patients. The

[7] 72 Fed. Reg. at 2239.

authority currently makes an IGT to the state using that $20 million to pay for the non-federal share of $40 million in DSH payments to support care provided by the authority's hospital to the uninsured. Under the Proposed Rule, the hospital authority would not be a unit of government because it does not have taxing authority and is not an integral part of a unit of government with taxing authority. Therefore, it would be prohibited from providing IGTs to the state. Although the county could certify the $20 million it pays to the hospital authority, the CPE would only yield $10 million in federal financial participation since a CPE represents 100 percent of a total computable Medicaid expenditure.[8] A better solution would be for the hospital authority to forgo receiving any payments for indigent care so that the county can directly make an IGT for payments that would benefit the hospital authority. However, the Preamble to the Proposed Rule states that "Health care providers that forego generally applicable tax revenue that has been contractually obligated for the provision of health care services to the indigent ... are making provider-related donations."[9] Thus, the hospital and the county may, in this example, be unable to use clearly governmental funds to support the hospital's provision of Medicaid-eligible services.

Another example is a county that is statutorily required to provide a fixed appropriation to a private hospital, and the statute expressly allows that appropriation to be used as IGT. However, it is unclear whether such appropriation would be considered an indirect provider donation or eligible IGT under the Proposed Rule.

A third example is a formerly public hospital that receives a state appropriation, which is currently used as an IGT; it is unclear if this appropriation can be used as an IGT under the Proposed Rule.

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.

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

SNHAF urges CMS to reconsider the dictate that funds contractually obligated by a governmental entity to a health care provider cannot be used as IGTs. Many communities in Florida have taken it upon themselves to enact special taxes and

[8] *Id.*
[9] *Id.*

assessments to support safety net providers that serve the uninsured and under-insured residents in a particular geographic location. These programs are usually intended to provide some reimbursement and managed delivery of cost-effective services to uninsured, underinsured and Medicaid eligible persons. To disallow the use of these funds, undermines the principals upon which Medicaid reform and the LIP program in Florida were founded. The failure to allow otherwise will adversely affect access for Medicaid patients.

Further, by contracting with governmental or non-governmental providers, the local government may ensure that critical access services are being provided to targeted populations. By eliminating contractually obligated funds from use as IGTs, CMS is removing an important layer of oversight and interfering in the often long-standing relationships between local governmental entities and their provider partners. Local communities depend upon their safety net providers, and those safety net providers are not always governmental entities or under the operation of a governmental entity, but those providers care for all persons in the community nonetheless.

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 IGTs.

II. Provisions of the Proposed Rule (the "Proposed Rule")

11. *The Proposed Rule states that it is applicable to all waiver states; however, since Florida's Section 1115 waiver creating the Low Income Pool ("LIP") was contingent on significant Medicaid Reform and CMS has already agreed to the Special Terms and Conditions of the waiver and thoroughly reviewed Florida's sources and uses of IGTs, Florida should be exempt from the Proposed Rule.*

Currently, a number of states including Florida have implemented demonstration programs under Section 1115 waiver authority. Florida's waiver program was negotiated in good faith and the program comports with the required budget-neutrality standard. Florida's demonstration waiver relies heavily on funds made available by eliminating certain above-cost payments to public providers; specifically, the Low Income Pool resulted in the elimination of certain supplemental, UPL payments. Florida's waiver was approved following significant and extensive discussions between Florida and CMS.

The Special Terms and Conditions of Florida's waiver require budget neutrality, which is to be recalculated in the event that a change in Federal law, regulation, or policy impacts

state Medicaid spending on program components included in the Demonstration. Throughout the Proposed Rule, CMS confirms that the proposed changes would apply to states that operate Section 1115 waiver programs but fails to discuss the extent to which the Proposed Rule would affect budget neutrality calculations under Medicaid waivers. It is not clear if CMS will recalculate budget neutrality applicable to Florida's waiver based on the new regulation. If that is not the case, it is not clear if Florida be able to continue its new initiatives beyond the term of the current demonstration project. It will be difficult for Florida to establish new programs under the waiver if it is going to be terminated within a few years.

Recommendation: CMS must clarify (i) whether current waiver states will be permitted to preserve their waivers, including safety net care pools and expanded coverage currently funded by the states' agreements to limit existing provider payments to cost and (ii) whether CMS plans to enforce requirements under waiver special terms and conditions (STCs) that budget neutrality agreements be renegotiated upon changes in federal law.

12. *Once a state is deemed to be exempt from the Proposed Rule, the state's Disproportionate Share Program ("DSH") and/or other components of the State plan should also be exempt.*

If any exemptions are granted, it is unclear what, if any, other components of the state's Medicaid program would be affected. If Florida's LIP program is exempt, Florida's DSH program and supplemental physician payments should likewise be exempt from the Proposed Rule, since the decision to create the LIP program was not made in isolation of other component provisions of the Medicaid program, including DSH and provider payments under the existing upper payment limit and Medicare reimbursement principals.

Recommendation: States with approved waiver programs should be totally exempt from the Proposed Rule.

13. *Since DSH payments recognize the costs of services provided to uninsured persons, the costs limits provided under proposed 42 CFR § 447.206 are not be applicable to DSH payments.*

The Proposed Rule states that the provisions of the Rule are applicable to all Medicaid payments. Therefore, the cost limits would be applicable to DSH payments contrary to existing statutes and rules, in contrast to current law. This is clearly outside CMS' authority.

Recommendation: Existing DSH statutes and regulations should stand.

II. Defining a Unit of Government (§ 433.50)

SNHAF urges CMS to reconsider its proposed new definition of a "unit of government" and the use of that definition to determine when a "health care provider is operated by a unit of government". This definition and qualification of providers usurps the traditional authority of states to identify their own subunits of government and far exceeds the authority provided in the Medicaid statute. The new definition and qualification of providers operated by such units of government undermines efforts to date by states to make units of government and providers more efficient and less reliant on public tax dollars.

14. *CMS does not have the statutory authority to restrict the definition of a "unit of government" or to subsequently use that definition to determine whether a health care provider is operated by a unit of government.*

CMS has exceeded its statutory authority in adopting a definition of a "unit of government" more restrictive than that established in Title XIX of the SSA. Section 1903(w)(7)(G) of the SSA[10] defines a "unit of local government," in the context of contributing to the non-federal share of Medicaid expenditures, as "a city, county, special purpose district, or other governmental unit in the State." The Proposed Rule narrows the definition of "a unit of government" to include, in addition to a state, "a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) *that has generally applicable taxing authority.*"[11] Congress never premised qualification as a unit of government on an entity's access to public tax dollars. Rather, the definition Congress has adopted for "other governmental units in the State," provides appropriate deference to the variety of governmental structures into which a state may organize itself. In narrowing this statutory definition, without instruction by Congress, CMS has unilaterally eliminated the deference to states underlying the statutory formulation.

Section 1903(w)(7)(G) is not the only section of Title XIX which evidences a Congressional intent to allow states to determine which entities are political subdivisions capable of participating in Medicaid financing. The absence of any requirement that units of government have taxing authority in order to contribute to the non-federal share

[10] 42 U.S.C. § 1396b(w)(7)(G).
[11] Proposed 42 C.F.R. § 433.50(a)(1)(i) (emphasis added).

of Medicaid expenditures is supported by the language elsewhere in the Medicaid statute. Section 1903(d)(1) requires states to submit quarterly reports for purposes of drawing down the federal share in which they must identify "the amount appropriated or made available by the State and its political subdivisions." The reference to the participation of political subdivisions in Medicaid funding does not include a requirement that the subdivisions have taxing authority.[12] In fact, funds made be made available through direct appropriation or through contract - and it is not limited funds paid to only those providers operated by governmental entities.

This violation of Congress' directives has been further compounded and compromised by using the definition to determine which providers might be afforded the benefits of "unit of government" status as "health care providers operated by units of government".

Recommendation: CMS must use the existing statutory definition of "unit of government."

15. *A federally-imposed restriction on state units of government violates Constitutional principals of federalism.*

In creating a new federal regulatory standard to determine which public entities within a state are considered to be "units of government" or operated by units of government, CMS is encroaching on a fundamental reserved right of states to organize their governmental structures as they see fit. This is an extraordinary step for the federal government to take, as the internal organization of a state into units of government has historically been an area in which, out of respect for federalism, the federal government has been loath to regulate. This federal intrusion into the operation and administration of state government violates the very basis of the Medicaid program -- the federal-state partnership and the federalism principles on which it rests.

Recommendation: CMS does not have the authority to deviate from the statutorily prescribed definition of "unit of government."

16. *CMS' restrictive definition of units of government and use of the definition to describe health care providers operated by units of government undermines marketplace incentives to operate public providers through independent governmental or private entities.*

[12] 42 U.S.C. § 1396b(d)(1).

More than a century ago, state and local governments began establishing public hospitals to provide health care services to their residents, including their most needy residents. As the health care system matured, commercial insurance evolved and the Medicare and Medicaid programs were established, public hospitals filled a unique role in serving the poor and uninsured in their communities -- patients who were often shunned by other providers. The public hospitals were typically operated as a department of the state or local government, with control over hospital operations in the hands of an elected legislative body, funding appropriated to plug deficits, surpluses reverting into the general fund of the government, public agency procurement requirements, civil service systems, and specific to Florida open government and public records laws. These unique public entity state laws are generally designed with the operations of traditional monopolistic governmental agencies such as libraries, police, fire and public schools in mind.

Over the past three decades, Florida has experienced a conversion of public hospitals. Local governments have been authorized to establish public hospitals as separate governmental entities and in some instances have leased the public facilities to private entities in recognition of the competitive market in which hospitals operate. State laws authorizing local governments to create hospital authorities, public hospital districts and similar independent governmental structures proliferated. Specific statutes were also enacted in Florida so that public hospitals could be leased to private entities, which still retained some of the public hospital's obligations for charity care and access without being bound by civil service and other uncompetitive governmental constraints.

As competition in the health care system intensified and state and local governments in Florida became less willing and able to provide open-ended taxpayer funding to ensure access to health care services, many government entities that had previously operated public hospitals as integrated governmental agencies began searching for new ways to organize and operate these enterprises. Typically the local government maintains their commitment to meeting the health care needs of their residents and without relaxing the accountability of these hospitals to the public for the services provided. Fueled by these demands and concerns, many state and local governments have restructured their public hospitals to provide them more autonomy and equip them to better control costs and compete in a managed care environment.

These restructurings have taken a wide variety of forms. Some local governments in Florida have created hospital authorities, with a separate governing board, appointed by elected officials and dedicated solely to governing the hospital. Other Florida public hospitals have elected boards, which are autonomous from the county or municipality.

And, some public hospitals have been sold or leased to private entities but retain obligations to provide services to the community for which the local government provides financial support.

The variations in these public and sometimes private structures are as numerous as the hospitals themselves - in Florida each has been unique to meet the local geographic needs. Theses changes in structure have been extremely successful in positioning public hospitals to reduce their reliance on public funding sources, to compete effectively with their private counterparts and to continuously enhance the quality of care and access they provide. The autonomy has allowed these hospitals to achieve these goals while still fulfilling their unique public mission of serving unmet needs in the community, providing access where the private market alone does not, and being responsive and accountable to the public.

Florida is a prime example of the numerous options that public hospitals have adopted. The following provides examples of the variety of structures in the state:

* Public Health Trust of Miami-Dade County is the umbrella organization which owns and operates Jackson Memorial Hospital, which is a public hospital under Florida law. Miami-Dade County imposes an optional sales for the benefit of the Trust and hospital; however, neither the trust nor the hospital has taxing authority, and so it is not clear if the Proposed Rule would allow those funds to be used as Medicaid match - particularly since the County does not operate the hospital or include the hospital in its consolidated financials.

* Both the North and South Broward Hospital Districts own and operate hospitals in Broward County, Florida and have taxing authority, and so they seem to meet the definition of "unit of government" as proposed.

* Lee Memorial Hospital is an independent special district with an elected board. The hospital is public; however, it does not have taxing authority. Under the Proposed Rule, Lee would not be public. Likewise, Bay Medical Center is a public hospital in Florida without taxing authority.

* Shands at the University of Florida is a formerly public hospital leased to private entity as is Tampa General Hospital. Many formerly public hospitals in Florida are leased to private entities for a number of reasons, and these facilities would be leery to be considered "public" for federal purposes while maintaining their private status under state laws. Shands receives a state appropriation which may qualify as IGT; Tampa General is

contractually obligated to fulfill the former public hospital's obligation to the uninsured in Hillsborough County and the hospital is also the statutory recipient of sales tax dollars raised in the County. The Proposed Rule appears to negate the funding for contractually obligated services, and it is unclear as to the treatment of the statutorily appropriated tax revenues.

The Proposed Rule's definition of a unit of government runs counter to this decades-long trend in government's obligation to provide access to health care. Under the Proposed Rule, only the most traditional of public hospitals would qualify as a governmental entity capable of contributing to the non-federal share of Medicaid funding. Most public hospitals and all of the formerly public hospitals leased to private entities appear to ineligible because they are an "integral part" of a unit of government with taxing authority under the strict criteria set forth in the Proposed Rule.

One very common feature of all of the restructurings that has occurred in Florida is to establish a separate and independent budget and accounting system for the hospital, in which revenues earned by the hospital are retained in a separate enterprise fund controlled by the governing board dedicated solely to the hospital rather than automatically reverting to the government's general fund. Such fiscal independence has been viewed as critical to establishing the necessary incentives and accountability for hospital administrators to operate efficiently, to maximize patient care revenues and to invest in new initiatives widely. Similarly, many restructured hospitals are not granted unlimited access to taxpayer support but are forced to manage within a fixed budget, which again has been viewed as furthering the goals of economy and efficiency. In short, the governmental entities that previously owned and operated these hospitals have restructured them deliberately to be both governmental and autonomous. They are governmental under state law and they remain fully accountable to the public. But they are autonomous governmental entities in that the local or state government with taxing authority is no longer legally responsible for their liabilities, expenses and deficits. For this reason, they likely would not meet CMS' new unit of government definition, even though they have retained several governmental attributes and may be considered governmental under the laws of the state.

The Proposed Rule would undermine the efforts of state and local governments to deliver public health care services more efficiently and effectively, and penalize those that have reduced their reliance on taxpayer support. Future restructurings will likely reflect CMS' narrow definition, undermining the important public policy goals achieved through the more flexible array of structures available under state law. CMS does not appear to have contemplated the perverse incentives its restrictive definition of units of government

would provide. For policy as well as legal reasons, the proposed definition should be rescinded.

In Florida, public hospitals have also been leased to non-governmental entities. These hospitals more often than not still retain the public hospitals' obligation to provide access to all comers, however, they would certainly be excluded under the Proposed Rule.

Recommendation: CMS should defer to states regarding the definition of a unit of government and the providers supported by such governmental units.

17. *CMS should leave the existing statutory definition of "unit of government" in place.*

CMS' restrictive definition of unit of government and the use of that definition to determine providers operated by a unit of government is fatally flawed and should be abandoned in favor of permitting state discretion. However, to the extent this element is included in the final regulation, CMS must clarify certain aspects.

The Proposed Rule would permit only units of government to participate in financing the non-federal share of Medicaid expenditures. The regulatory text then goes on to define a unit of government as "a State, a city, a county, a special purpose district or other governmental unit in the State (including Indian tribes) ***that has generally applicable taxing authority***."[13] A provider can only be considered to be a "unit of government" if it has taxing authority or it is an "***integral part of a unit of government with taxing authority***."[14] It is clear from this proposed definition that unless a provider has direct taxing authority, CMS will only consider it a "unit of government" if it is an integral part of a unit of government with taxing authority.

State courts, typically look beyond the presence of taxing authority to other indicia of public status to determine whether an entity is governmental.[15] For example, courts in Florida have looked to whether an entity enjoys sovereign immunity, to whether its employees are public employees, to whether it is governed by a publicly appointed board,

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

to whether it receives public funding, to whether its enabling statute declares it to be a political subdivision or a public entity, or to whether it is subject to specific state laws that govern public entities. There are a wide variety of factors that go into determining public status beyond whether the provider or the unit of government of which it is an integral part has taxing authority. SNHAF urges CMS to eliminate the caveat that units of government must have taxing authority and allow any governmental entity so designated under state law to be treated as public and capable of participating in Medicaid financing.

Recommendation: CMS should eliminate the requirement that units of government have taxing authority and defer to state law interpretations of public status.

18. *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 use of the term "public" appears in several different contexts throughout the Medicaid statute, and many states employ their own definitions of public status within their Medicaid state plans. For example, federal financial participation is available at the rate of 75 percent of the costs of skilled professional medical personnel of the state agency or "any other public agency."[16] A Medicaid managed care organization that is a "public entity" is exempt from certain otherwise applicable solvency standards.[17] "Public institutions" that provide inpatient hospital services for free or at nominal charges are not subject to the charge limit otherwise applicable to inpatient services.[18] The use of terms such as "public," "unit of government" and "governmental" in other areas of state and federal Medicaid law does not incorporate the restrictions CMS is seeking to impose through the Proposed Rule. CMS should clarify that these restrictive definitions are for purposes outlined in the Proposed Rule only.

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

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

[16] 42 U.S.C. § 1396b(a)(2)(A).
[17] 42 U.S.C. §1396b(m)(1)(C)(ii)(II).
[18] 42 U.S.C. §1396b(i)(3).

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

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

Rather than adopting a narrowly tailored solution to address identified concerns with inappropriate Medicaid financing practices, CMS proposes to impose a cost limit on governmental providers that is simply a straightforward funding cut of $932 million per year to hospitals in Florida. The limit purports to target Medicaid financing practices that CMS has publicly asserted are no longer a problem. Further, CMS recently completed a review of Florida's sources and uses of IGT and deemed them to be appropriate, and yet the Proposed Rule ignores the due diligence that has already been undertaken . To the extent abuses remain, the cost limit would not eliminate them; it would simply limit the net funding for governmental, safety net providers.

Recommendation: CMS should focus on the abuses with the sources and uses of IGT and rely upon established cost limits.

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

A payment limit based on Medicaid costs represents a sharp departure from CMS' efforts to bring cost-effective market principles into federal health programs. Prospective payment systems are structured to encourage health care providers to eliminate excess costs by allowing them to keep payments above costs as a reward for efficiency. As CMS considers new payment models, which would include incentives for providing high quality care as a means to better align payment and desired outcomes, it seems regressive to take steps that would cause all states to revert to a cost based system. The Proposed Rule would require a return to cost-based reporting and reimbursement that is inconsistent with efforts over the last twenty years by Congress and CMS to move away from cost-based methodologies.

Recommendation: CMS should proceed with the development of innovative ways to reimburse providers as opposed to reverting solely to cost based methodologies.

21. 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.

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

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

The upper payment limit methodology using aggregate classifications of providers, places the desired limits on the Medicaid program, while affording states the flexibility to meet the needs of diverse populations and geography.

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

22. Hospitals cannot survive without positive margins.

In any competitive marketplace, no business can survive simply by breaking even, earning revenues only sufficient to cover the direct and immediate costs of the services it provides. Any well-run business needs to achieve some margin in order to invest in the future, establish a prudent reserve fund, and achieve the stability which will allow them access to needed capital. Businesses that lose money on one line of business need to make up those losses on other lines in order to survive. These fundamental business concepts are equally applicable to the hospital industry - particularly to the safety net providers that serve a disproportionate share of uninsured, underinsured, and Medicaid patients.

The proposed cost limit would prohibit governmental hospitals from earning any margin on their largest line of business. Moreover, governmental hospitals, as compared to the hospital industry as a whole, are much more likely to have a line of business – care for the uninsured – in which they must absorb significant losses. Under the Proposed Rule, safety net providers may be able to earn a small margin on Medicare and perhaps a slightly larger margin on commercially insured patients, but these two revenue sources constitute less than half of average SNHAF net revenues. With self-pay patients comprising a significant portion of SNHAF members' patient populations, margins on Medicare and commercial insurance alone are not sufficient to keep these hospitals afloat if CMS denies any margin on Medicaid patients. CMS would not expect a private business to operate with revenues no greater than direct costs. It should not expect public hospitals, with their disproportionate share of uninsured patient populations, to survive and thrive under this limit.

Recommendation: CMS does not need to place a more restrictive cost limit on safety net providers.

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

It is unclear why CMS believes rates the agency would continue to allow states to pay private providers under the Proposed Rule are excessive with respect to government providers. The needs of governmental providers are often significantly greater than those of private providers as they typically provide a disproportionate share of care to the

uninsured and offer critical yet under-reimbursed community-wide services (such as trauma care, burn care, neonatal intensive care, first response services, standby readiness capabilities, etc.). For example, the members of SNHAF represent less than 10 percent of Florida's hospital but provide over half of the state's uncompensated hospital care. A report issued in December by the Congressional Budget Office confirmed that governmental hospitals provide significantly more Medicaid and uncompensated care and other community benefits than private hospitals.[19] Moreover, governmental providers' payer mix is markedly different from that of private providers, with greater reliance on Medicaid revenues to fund operations and a lower share of commercially insured patients on which uncompensated costs can be shifted. By cutting Medicaid reimbursement for governmental providers, the Proposed Rule would slash their primary funding source.

24. 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, SNHAF members 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, SNHAF members have invested millions of dollars in adopting electronic medical records and other new information systems that have a direct impact on quality of care, patient safety and long-term efficiency, all goals promoted by HHS and AHCA. Similarly, in the heightened security-conscious post-9/11 world, safety net hospitals - both public and private - have played a critical role in local emergency preparedness efforts, enhancing their readiness to combat both manmade and natural disasters and epidemics. HHS has focused on expanding access to primary and preventative services particularly for low-income Medicaid and uninsured patients and reducing inappropriate utilization of emergency departments. SNHAF members have been at the forefront of this effort, establishing elaborate networks of off-campus, neighborhood clinics with expanded hours, walk-in appointments, assigned primary care providers and access to appropriate follow-up and specialty care. In fact, it is SNHAF members that are spearheading the most innovative provider service networks under Florida's Medicaid reform initiative. HHS is striving to reduce the disparities in care provided to minority populations. With an extremely diverse patient population, SNHAF members are leaders in providing culturally sensitive and welcoming care, in providing access to translation

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

and interpretation services, and in adopting innovative approaches to treating the specific needs of different minority groups. All of these initiatives require substantial investments of resources. CMS does not appear to have considered the impact of the cut imposed by the cost limit on shared policy initiatives that HHS itself has established as key goals of America's complex health care system. 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.

25. The proposed cost limit violates federal law.

The proposed cost limit violates both section 1902(a)(30)(A) of the Social Security Act (SSA) and section 705(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).[20] CMS is therefore without legal authority to impose the limit by regulation.

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

> to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.[21]

Florida will be unable to meet the requirements of this provision given the restrictive limits imposed by CMS. By incentivizing providers to maximize costs in order to secure a higher reimbursement limit, the proposal clearly does not promote efficiency or economy. By removing tools to promote efficiency (such as through prospective payments systems that encourage providers to reduce costs), CMS has hampered states' ability to provide the assurances required by the statute. Similarly, the cost limit thwarts states' efforts to ensure quality of care by eliminating flexibility to provide targeted above-cost incentives to promote and reward high quality care, particularly for providers identified by the state as having particular needs or faced with unique challenges. Finally, to the extent that the cost regulation prohibits states from paying rates that they have determined are necessary to ensure access for Medicaid recipients, CMS's proposed regulation undermines the statutory requirement that states assure access to care and services at least equal to that available to the general population.

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[20] H.R. 5661, 106th Cong., enacted into law by reference in Pub. L. No. 106-554, § 1(a)(6) ("BIPA").
[21] 42 U.S.C. § 1396a(a)(30)(A).

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

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

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

Proposed 42 C.F.R. § 447.206(c)(1) provides that "[a]ll health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider's cost of providing ***covered Medicaid services to eligible Medicaid recipients***." By its terms, this provision would prohibit *any* Medicaid reimbursement to governmental providers for costs of care for patients who are *not* eligible Medicaid recipients, or for services that are not covered under the state Medicaid plan. Taken literally, states could no longer pay public hospitals for unreimbursed costs for uninsured patients or for non-covered services to Medicaid patients through the disproportionate share hospital program. Similarly, Florida's authority to make payments to public providers pursuant to expenditure authority received through its section 1115 demonstration projects to pay for otherwise unreimbursable costs to the uninsured, for infrastructure investments and for other purposes not covered under the state plan would be called into question. The cost limit could also extend to Medicaid reimbursement received by governmental providers from managed care organizations (despite CMS' disavowal of any such intent in the Preamble). The problem is exacerbated because the

regulation defines its scope as applying broadly to all "payments made to health care providers that are operated by units of government ...."[22] By contrast, the UPL regulations are carefully drafted to limit their scope to "rates set by the agency,"[23] and they include an explicit exemption for DSH payments.[24]

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

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

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

[22] Proposed 42 C.F.R. § 447.206(a)
[23] 42 C.F.R. § 447.272(a), § 447.321(a).
[24] 42 C.F.R. § 447.272(c)(2).

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

- costs incurred by the hospital for physician and other professional services (e.g. salaries for employed professionals, contractual payments to physician groups for services provided to hospitals, physician on-call and standby costs);
- capital costs necessary to maintain an adequate physical infrastructure;
- medical education costs incurred by teaching hospitals;
- investments in information technology systems critical to providing high quality, safe and efficient hospital care;
- investments in community-based clinics and other critical outpatient access points to ensure that Medicaid and uninsured patients have adequate access to primary care as well as specialty services;
- items unique to the provision of tertiary services, including but not limited to organ acquisition costs; and
- costs of a basic reserve fund critical to any prudently-operated business enterprise.

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

In addition, SNHAF strongly believes that allowable costs should also include Medicaid's share of costs for the uninsured (beyond costs directly reimbursable through the limited available DSH funding). Absent universal coverage or full reimbursement of uninsured costs, hospitals must continue to rely on cross-subsidization from other payers, including commercial payers, Medicare and Medicaid, to pay for this care. CMS should allow state Medicaid programs to shoulder their fair share of such costs rather than placing the full burden on Medicare and commercial payers. We therefore urge CMS to include uninsured costs among reimbursable Medicaid costs.

Recommendation: CMS should specify that any determination of Medicaid costs will include all costs necessary to operate a governmental facility including costs for the uninsured.

28. The costs associated with graduate medical education must be allowable costs.

The President's FY 2008 budget request includes an administrative proposal to eliminate Medicaid reimbursement for graduate medical education (GME) costs. Given the long-standing policy to permit GME payments (as of 2005, 47 states and the District of Columbia provided explicit GME payments to teaching hospitals, according to the Association of American Medical Colleges[25]) and the dozens of approved state plan provisions authorizing such payments, SNHAF, which represents Florida's teaching hospitals, was surprised to see this proposal described as an administrative rather than legislative initiative. We question CMS' authority to adopt such a policy change without statutory authorization. To the extent that CMS intends to change the policy administratively, however, we assume that the agency would undertake a full notice and comment rulemaking process. In particular, we assume that CMS will allow governmental providers to include all of the costs of their teaching programs in the cost limits under the Proposed Rule unless and until the law is changed to prohibit Medicaid payments for GME. Please confirm our understanding that full GME costs will be includable as reimbursable costs.

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

[25] Tim M. Henderson, *Direct and Indirect Graduate Medical Education Payments By State Medicaid Programs* (Association of American Medical Colleges), Nov. 2006, at 2.

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

The Proposed Rule applies the cost limit to "health care providers that are operated by units of government."[26] 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."[27] 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 professionals employed by governmental entities. CMS should clarify that it does not intend the regulation's reach to extend this far. Cost-based methodologies are particularly inappropriate for professional services. 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.

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.

30. 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.[28] There is an exception to this prohibition on direct provider payments for payments for graduate medical education, provided capitation rates have been adjusted accordingly. Given the extreme funding cuts that will be imposed on many governmental providers by the imposition of the cost limit, SNHAF urges CMS to reconsider the scope of the exception to the direct payment provision. SNHAF recommends that states be allowed to make direct Medicaid fee-for-service payments to governmental providers for all unreimbursed costs of care for Medicaid managed care patients (not just GME costs).

Because the payments would be based on costs pursuant to the new regulation, there would not be the danger of "excessive payments" that has concerned CMS in the current

[26] Proposed 42 C.F.R. § 447.206(a).
[27] Proposed 42 C.F.R. § 447.206(c)(4).
[28] 42 C.F.R. §438.60.

system. Moreover, to avoid double dipping, states could be required to similarly adjust capitation rates to account for the supplemental cost-based payments. If reimbursement to governmental providers is going to be restricted to cost, it should include costs for all Medicaid patients, not just those in the declining fee-for-service population. 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 governmental providers for unreimbursed costs of Medicaid managed care patients.

II. Retention of Payments (§ 447.207)

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

31. CMS should require states to pay all federal funding associated with provider-generated CPEs to the provider.

The retention provision requires providers to "receive and retain the full amount of the total computable payment provided to them."[29] We assume this requirement applies to all payments, whether financed through IGTs, CPEs, general state revenues or otherwise.

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

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

[29] Proposed 42 C.F.R. § 447.207(a).

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. SNHAF hospitals have a wide array of financial arrangements with state and local governments, with money flowing in both directions for a variety of reasons. We are concerned that CMS' new authority to examine "associated transactions" will jeopardize these arrangements, and that CMS may use its disallowance authority to pressure public providers to dismantle such arrangements. CMS' review and audit authority is limited to payments made under the Medicaid program. It does not have authority over providers' use of Medicaid payments received.

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

II. Conforming Changes to Reflect Upper Payment Limits for Governmental Providers (§ 447.272 and § 447.321)

While the proposed cost limit does not negate the upper payment limit provided under 42 CFR § 447.272 for providers that are not units of government or operated by units of government, the conforming change suggests that the aggregate limit based on the facility group will no longer be applicable.

> *33. If a provider that is a unit of government or operated by a unit of government is reimbursed is reimbursed their Medicaid costs, only the un-reimbursed costs associated with uninsured persons will be used to calculate its potential DSH payment.*

CMS does not have the authority to override policy established by Congress and arbitrarily undo the aggregate limits by type of facility as stated in the Proposed Rule.

Recommendation: CMS should maintain the current method of determining DSH payments.

II. Tool to Evaluate the Governmental Status of Providers

CMS has released a form entitled "Governmental Status of Health Care Provider" ("Tool")[30] that states can use to determine whether a health care provider satisfies the "unit of government" definition under the Proposed Rule. While SNHAF and national organizations like the National Association of Public Hospitals ("NAPH") appreciate CMS's efforts to assist providers in determining their governmental status under the regulation, we request that CMS revise the Tool in order to clarify precisely what results from the input of different responses into the form. We would be happy to work with you further to accomplish this clarification.

34. CMS should revise its "Tool to Evaluate Governmental Status of Providers."

A provider is not required to be included on the unit of government's consolidated financial report to be considered a "health care provider operated by a unit of government". However, it is not clear based on the Tool whether the comment above is true, which would be the interpretation based on a reading of the Proposed Rule, but not necessarily the conclusion one would draw using the Tool in its present form. Likewise, the unit of government is not required to be liable for a provider's operations, expenses, liabilities, and deficits in order for the provider to be considered a "health care provider operated by a unit of government. Again, it is unclear when reading the Proposed Rule and reviewing the Tool, what the outcome is. This will make it very difficult for states, governmental entities, and providers to interpret the impact of the Proposed Rule and create forming circumstances.

Recommendation: CMS should revise the form so that governmental entities and providers will recognize the result based on their responses.

In addition to the issue specific comments, if such a Proposed Rule is to move forward, SNHAF 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.

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[30] Proposed Rule at 2242. A copy of this form is available at: http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=2&sortOrder=descending&itemID=CMS1192476&intNumPerPage=10.

35. *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 the Safety Net Hospital Alliance of Florida.

Sincerely,

Anthony P. Carvalho

Anthony P. Carvalho
President

Submitter : Mr. Brock Nelson **Date:** 03/19/2007

Organization : Regions Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Thank you for this opportunity to comment on the Centers for Medicare & Medicaid Services'proposed rule entitled 'Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership.' 72 Fed. Reg. 2236 (January 18, 2007). As an entity that would be adversely affected by the proposed rule, we have significant concerns about the changes.

We respectfully request that the proposed rule be withdrawn. Its sweeping changes would seriously compromise an already fragile safety net system that ensures access and quality care for Medicaid beneficiaries and uninsured persons as well.

Regions Hospital is a leading, full-service hospital providing outstanding medical care, with special programs in heart, women's services, cancer, surgery, digestive care, seniors' services, behavioral health, burn, emergency and trauma. The health professionals at Regions Hospital are involved in teaching and research focused on improving health and medical care. As a safety net provider (we are a former county hospital) and second highest provider of charity care in Minnesota, stewardship and service are key components of our mission. In 2006, Regions provided over $41 million in uncompensated care to members of our community.

Major teaching hospitals such as Regions Hospital and their clinical physician faculty take seriously their commitment to treating the nation's poor by providing a disproportionate amount of health care to Medicaid recipients and uninsured patients while maintaining their core missions of education, research and innovative patient care. Approximately 15% of Regions patients last year were covered under Medicaid, along with our overall payer mix that included a total of 55% government program reimbursement. The proposed rule would seriously jeopardize our ability to continue providing medical services to everyone in our community, regardless of ability to pay.

The Medicaid program and teaching hospitals have a long history that has helped to ensure that poor and uninsured patients have access to high quality care. The proposed rule runs the grave risk of unraveling this fragile structure. We urge CMS 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.

Submitter : **Kenneth Raske** **Date: 03/19/2007**

Organization : **Greater New York Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment for comments.

CMS-2258-P-260-Attach-1.TXT

#260

GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA
Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

March
Nineteen
2007

VIA E-MAIL

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., 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 (Federal Register Vol. 72, No. 11), January 18, 2007

Dear Ms. Norwalk,

Greater New York Hospital Association (GNYHA) represents more than 100 public and private, not-for-profit hospitals in the greater New York metropolitan area. We appreciate the opportunity to comment on the captioned Centers for Medicare and Medicaid Services (CMS) proposed regulation. Included among our members are some of the most significant public health care provider systems in the country as well as smaller public providers. Together, they serve as safety net providers for millions of culturally and linguistically diverse Medicaid and uninsured patients through their provision of extensive inpatient, ambulatory, community-based, long term care, and other services.

CMS HAS UNDERESTIMATED THE POTENTIAL IMPACT OF THE PROPOSED RULE ON PUBLIC HOSPITAL FINANCIAL STABILITY AND, CONSEQUENTLY, THE NEGATIVE EFFECT OF THE RULE ON QUALITY AND ACCESS FOR MEDICAID PATIENTS

The proposed rule's provisions to impose a different Upper Payment Limit (UPL) on public providers based upon a facility-specific Medicaid cost limit, to narrowly define a "unit of government" for purposes of funding inter-governmental transfers (IGT), and to restrict what would qualify as a certified public expenditure (CPE) and IGT, could have a devastating impact on quality and access to care for the Medicaid and other indigent populations. CMS itself estimated that the proposed rule would result in a Federal savings of $3.9 billion over five years. This funding loss to the country's safety net could have a devastating and material impact on communities everywhere by worsening the already fragile financial condition of public hospitals and nursing homes. At the same time, CMS's savings estimate is suspected by many to be

understated because the new requirements and definitions in the regulation might very well affect many more public providers and their Medicaid revenues than CMS today anticipates, further devastating the health care safety net.

We do not believe CMS accurately assessed the negative impact of the proposed rule on public providers in its Regulatory Impact Analysis. For example, CMS expresses its belief that cost-based reimbursement would actually benefit public providers by "reduc[ing] inflated payments to those few governmental providers [that receive payments in excess of cost] and promote a more even distribution of funds among all governmental providers." There is no basis for CMS to believe that States would change the way they pay public providers to achieve this budget-neutral effect, particularly when those States would be grappling with the loss of at least $3.9 billion over five years in funding for the safety net. It is more likely that providers with payments above cost would experience funding cuts while those with payments below cost would remain where they are. CMS's assessment of the impact of the rule therefore fails to acknowledge the loss in funding, and subsequent consequences for health care delivery, access and quality, for Medicaid patients.

The proposed rule could also have an effect on already-approved State Plan Amendments (SPAs) and we are very concerned that they might require the recalculation of section 1115 waiver budget neutrality caps to reflect the new payment limits placed on public providers. These budget neutrality caps, which are established based upon what States would have spent in the absence of the waiver, allow States the flexibility to make changes in reimbursement and the delivery system and to reinvest any savings in coverage expansions, health care information technology, primary care, and infrastructure development. Changes from the proposed rule therefore could disrupt States' comprehensive efforts to expand coverage, access and quality for both Medicaid and uninsured residents.

CMS is proposing this sweeping regulation essentially to ensure the integrity of Federal medical assistance percentages (FMAP) by preventing States from drawing down more than they are entitled to through IGTs and CPEs. However, the preamble section to the rule notes that through careful regulatory scrutiny of proposed State Plan Amendments (SPAs), CMS has caught problems and required corrections many times. Given the apparent success of such ongoing regulatory efforts under existing regulations, it is difficult to see the need for this sweeping rule. We believe that such SPA reviews should continue to be the means of identifying and correcting problems to the extent they still exist and that any changes on this subject should be accomplished through legislation and not regulation. Indeed, many members of Congress have already indicated their agreement with this proposition. We endorse the comments of the American Hospital Association (AHA) and National Association of Public Hospitals (NAPH) and respectfully recommend that the regulation be permanently withdrawn.

We object to the following provisions in particular.

PROPOSED CHANGE IN UPPER PAYMENT LIMIT (UPL) FOR PUBLIC PROVIDERS (Sections 447.206, 447.271)

The proposed rule would change the UPL for governmental providers to one based upon the cost of treating Medicaid patients on a facility-specific basis. It would not change the UPL for non-public providers, which would continue to be set in the aggregate for the class of providers based upon Medicare payment policy.

Capping public providers at Medicaid cost. We believe that the proposed change to cap public providers at Medicaid cost would constitute a major step backwards for payment policy overall and further harm the health care safety net.

Cost-based reimbursement has largely been abandoned by all major payment systems, including Medicare, which in recent years has converted all of its payment systems – including those for inpatient, capital, outpatient, psychiatry, inpatient rehabilitation, home health, and skilled nursing facility – to prospective payment systems (PPS). PPS's are not capped at providers' costs but instead deliver a fixed amount of money for the care that is required. They are attractive because they provide incentives to providers to manage their costs within the fixed DRG payment with the promise that greater efficiency will produce more surplus at the end of the day to reinvest in the capital infrastructure, including critically important clinical information systems, as well as other needs. Cost-based reimbursement, on the other hand, simply rewards the highest cost providers, irrespective of quality or efficiency. New York's inpatient Medicaid system has relied upon DRGs since 1988 and this system applies equally to all hospitals, regardless of auspice.

Graduate Medical Education. The proposed rule does not define Medicaid costs. We are particularly concerned about the way that CMS would define the permissible costs of graduate medical education (GME) in light of the provision in the proposed Federal fiscal year 2008 budget that would completely eliminate Federal matching funds for GME programs. CMS should clarify that it would include all GME-related costs.

Inconsistency with Medicaid law. CMS's proposal is not consistent with Congress's 1997 elimination of the Boren Amendment's requirement that payments be reasonable and adequate to meet the costs of efficiently and economically operated facilities. Today, States must simply follow a public notice process to promulgate changes in payment methods.

It is also not consistent with section 1902(a)(30)(A) of the Social Security Act, which directs states to adopt payment methods that are economic and efficient and that promote quality and access. Medicaid programs are required:

> To assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. 42 USC section 1396a(a)(30)(A)

Cost-based reimbursement would deprive public providers of the benefits of a flexible reimbursement structure that has enabled them to be at the forefront in primary, preventive, and

community based care, as well as implementation of clinical information systems, comprehensive language access, and culturally sensitive care models. Capping payments on a facility-specific basis would compromise their ability to serve vulnerable populations as well as deprive them of needed surplus to reinvest in capital and other improvements. Public providers, which have a very high share of Medicaid, uninsured, and Medicare patients, cannot shift the costs of these essential reinvestments to the private sector by negotiating higher payment rates with commercial health plans. Because UPLs are calculated separately for inpatient and outpatient services, the proposed regulation could also lower inpatient payments at particular facilities without any opportunity to consider extremely below-cost payments for clinic and emergency room services. In New York, for example, Medicaid ambulatory payment rates only cover about half of cost. If it were applicable, the proposed rule could cut inpatient payments at particular facilities and, because it would have no impact on inadequate ambulatory care rates, significantly worsen the hospital's financial condition. It is not realistic to expect that States, facing the loss of at least $3.9 billion from safety net services, would make up these sorts of losses at an individual provider level. New York State has indicated the further concern that the administrative burdens alone imposed by the new regulation would result in providers such as school based health clinics dropping out of the Medicaid program.

The rule would also strip States of needed flexibility to fashion payment systems that achieve public policy goals, such as PPS's to encourage efficiency, payment for performance, incentives to train more primary care physicians, etc., and hamstring their ability to achieve efficiency and quality outcomes.

The proposed rule therefore would amount to a devastating funding cut to public providers that is totally inconsistent with the elimination of the Boren Amendment and the requirements of section 1902(a)(30)(A).

Two tiered system. We disagree with cost-based reimbursement for any provider. The proposed rule goes even further, however, by creating two tiers of providers, one public and subject to cost-based, facility-specific UPL caps, and the other non-public, subject to aggregate UPLs based upon Medicare payment principles. There is no justification for this differential treatment. New York's Medicaid payment structure does not distinguish between public and non-public providers, and neither does Medicare's. It would be a radical and historically unprecedented step for CMS to mandate differential treatment based upon governmental auspice, particularly because it seeks to do so to root out the possibility of impermissible IGT and CPE financing arrangements, which it already has ample current tools to do, and not to promote more accurate and progressive payment policies.

CMS's proposed rule would also create extensive administrative work for States and providers. The proposed rule would require hospitals and nursing homes to have their Medicaid costs determined through analysis of the Medicare cost report, which would require the State to analyze an additional cost report in addition to the State-specific document now completed by all hospitals. This would impose new and costly burdens on State agencies that are not addressed in the proposed rule.

Submitter : Mrs. Victoria Jones **Date:** 03/19/2007

Organization : Jackson Hospital and Clinic, Inc.

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-261-Attach-1.DOC

CMS-2258-P-261-Attach-2.DOC

#261

JACKSON
HOSPITAL

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, N0.11), January 18, 2006

Dear Ms. Norwalk:

This letter is being written to express our opposition to the above-referenced regulation and to express our specific concerns.

Under the proposed legislation, Alabama Medicaid Agency stands to lose as much as $1 billion in funding, or one fourth of its total budget. The loss of this funding could effectively shut down this Agency, and would have an adverse effect on already strapped Alabama hospitals.

At Jackson Hospital in Montgomery alone, this would mean a loss of $1.2 million per year...a loss we cannot absorb. Montgomery hospitals do not receive any local or county support, and there is no city/county hospital. Practically the entire brunt of indigent care is borne by local hospitals, and the loss of this revenue would further exacerbate an already dire situation.

We urge CMS to permanently withdraw this proposed rule as it will only further curtail the services available to Alabama's indigent population.

Yours truly,

Victoria W. Jones

Victoria W. Jones
Vice President – Operations

/vwj

More fundamentally, however, the Medicare cost report is not suitable for the purpose of determining Medicaid cost. While it has a section for hospitals to report Medicaid inpatient cost (which is not used for Medicare payment purposes), a review of as-filed Medicare cost reports demonstrates that there is extensive missing data for Medicaid, making reliance on the Medicare report to compute Medicaid cost highly inappropriate. The Medicare cost report furthermore lacks any information on outpatient costs and statistics. If Medicaid wishes to rely upon the Medicare cost report, Medicare would have to modify the instrument substantially. There are many problems with the proposed September 1, 2007 start date for the rule and the lack of data to determine Medicaid cost is one of them.

Use of a facility-specific, versus aggregate, cap. Both the AHA and NAPH have cited the proposed provision's inconsistency with section 705(a) of the Medicare, Medicaid, and SCHIP Beneficiary Improvement and Protection Act (BIPA) of 2000 (directing CMS to adopt an aggregate Medicare-related UPL); we agree with their analysis.

Moving from an aggregate to a facility-specific cap is not justified by the law and would deprive states of the flexibility to tailor payments to particular public hospitals based on their circumstances, financial need, desire to create incentive programs, populations served, and similar important State priorities.

As noted above, we strongly disagree with the use of Medicaid cost as the new UPL for public providers. On the specific issue of moving to facility-specific caps, however, CMS should at a minimum clarify that the term "facility" for which a facility-specific cap would be computed would still encompass in the aggregate all of the individual providers that may be operating divisions of one entity even though separately licensed with separate provider numbers.

We recommend that CMS abandon its proposal to change the UPL applied to public providers to a Medicaid cost-based, facility-specific cap and that it instead maintain an aggregate UPL cap based on Medicare payment policies for all providers.

DEFINITION OF "UNIT OF GOVERNMENT" AND SOURCES OF REVENUE QUALIFYING FOR FEDERAL MATCH (Sections 433.50, 433.51, 457.220, 457.628)

Proposed changes would restrict the health care providers considered to be "units of government" by requiring that they have generally applicable taxing authority or can access funding as an integral part of a unit of government with taxing authority that is legally obligated to pay for the provider's expenses, liabilities, and deficits. A contractual arrangement with the State or local government is not permitted to be the primary or sole basis for the health care provider to receive tax revenues, nor is an obligation to provide "limited support" by law (Preamble section p. 2240). The consequence of being found not to be a unit of government would be an inability to certify public expenditures or transfer funds to the state government to support the non-federal share of Medicaid and SCHIP expenditures.

The preamble section also states that the source of transferred funds should be State or local tax revenue, which must be supported by consistent treatment on the providers' financial records,

Submitter : Mr. Luke Standeffer **Date:** 03/19/2007

Organization : Northport Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2258-P-262-Attach-1.DOC

#262

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. Northport Medical Center alone will lose approximately 2.3 million in Medicaid funds.

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

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

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

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

Sincerely,

Luke Standeffer
Administrator
Northport Medical Center

Submitter : Mr. Steve Keil **Date: 03/19/2007**

Organization : California State Association of Counties

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

#263

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

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

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

Submitter : Ken Fleming **Date:** 03/19/2007

Organization : Sacramento Valley Family Services

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-264-Attach-1.DOC

#264

March 15, 2007

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

Re: Comments regarding the Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership.

The following are comments related to proposed additions to 42 CFR 447.207 in the January 18, 2007 Federal Register (Volume 72, No. 11, page 2236). Specifically, these comments are regarding current county government practices related to reimbursement procedures under California Short/Doyle Medi-Cal (Medicaid) and the conflict with the proposed rule which states "that providers received and retain the full amount of the total computable payment provided to them for services furnished under the approved state plan."

California has operated its mental health program under Centers for Medicare and Medicaid Services approved Medi-Cal specialty mental health services consolidated waiver since March 1995. Under the waiver program, each county government has the option to operate as the Mental Health Plan (MHP); all counties elected to be the MHP under the waiver.

The waiver document states, "The design of managed care for California's Medi-Cal mental health programs includes three steps, to be phased over several years. The Medi-Cal Psychiatric Inpatient Services Consolidation was the first phase, based on the authority granted by the freedom of choice waiver approved by CMS effective March 17, 1995. The second phase is Medi-Cal specialty mental health services consolidation based on the renewal, modification and renaming of the Medi-Cal psychiatric inpatient hospital services consolidation waiver which was approved by CMS, and has been in place continuously since September 5, 1997. The final plan phase would be the transfer of risk for federal financial participation (FFP) through capitation or other risk arrangement, to be phased in at a later date. Although the State continues to consider capitation or other risk arrangement, because of uncertain economic conditions, the State does not expect to move towards this phase during the fourth waiver renewal period". The fourth waiver renewal will expire on June 30, 2007.

The reimbursement procedures in the Consolidated Mental Health Waiver State Plan are included in this document as Attachment 1. Based on these reimbursement procedures, organizational providers are defined and reimbursed in the State Plan as a legal entity providing Short Doyle/Medi-Cal services. Fee-for-service Medi-Cal and psychiatric inpatient hospital services are reimbursed per Attachment 2. Organizational Providers are programs operated by the Mental Health Plans or under contract by private providers. They are required to submit a yearly cost report for final reconciliation of interim payments to allowed amounts as documented in the cost report. The oversight of compliance with the State Plan is the responsibility of the State Department of Health Services, the "Single State Agency", per 42 CFR 431.1. However under agreement, this responsibility has been delegated to the State Department of Mental Health.

Contracts between the State and the Mental Health Plans and between the MHP and private providers state that federal laws and regulations will take precedence if there is a conflict between local or state laws and the federal regulations. However it has been the experience of our organization, Sacramento Valley Family Services, that counties ignore federal regulation by withholding cost settlements from organizational providers when the costs are above the interim payment or by ignoring a Medi-Cal clients' right to treatment. Below are three examples experienced by our organization.

Sacramento Valley Family Services Inc. has been an organizational provider of Short/Doyle Medi-Cal services since 1999 specializing in services for children, particularly Therapeutic Behavioral Services. Our legal entity number is 00804. We have been closing down our organization over the past two years due to our inability to provide cost efficient, high-quality services within California's current management environment. We have finalized all outstanding cost reports with the counties we have served with the exception of two who have refused to even acknowledge acceptance of our cost report. In both cases the cost reports were submitted to the counties in a timely fashion per the requirements of our contracts, however, we have neither received cost settlement checks nor correspondence from either county indicating problems with our cost report. Telephone conversations with both counties suggest that they believe they do not have to meet federal and state Medicaid/Medi-Cal requirements for reimbursement of organizational providers of Therapeutic Behavioral Services. Specifically, they are unwilling to settle our cost report at the lower of cost, customary charges or the SMA.

After these telephone conversations I requested copies of the final cost reports submitted to the State Department of Mental Health by these counties for the services our organization provided to them during the years in question. I receive the requested information during a meeting with the State Department of Mental Health Services' Cost Reporting and Data Collection Section on April 25, 2006. During that meeting I was informed that the cost reports of one county for the years in question, FY 01/02 and FY 02/03, did not include a cost report for Sacramento Valley Family Services Inc. nor were we included as a legal entity utilized by the county. The cost reports we submitted to this county showed we had provided 569,844 units of service at a cost of 85 cents per unit for a total cost of $492,655 in FY 01/02 and 67,230 units of service at a cost of $1.46 per unit for the total cost of $97,937 in FY 02/03. There is an outstanding cost settlement from this county due us of $15,218.95 for FY 01/02 and $42,636.68 for FY 02/03.

The cost report that was submitted to the State Department of Mental Health by the second county for FY 02/03 contained a number of discrepancies including the following. The name of the person responsible for preparing the cost report was changed from that of our cost report consultant to a member of the county's staff. The legal entity number shown on the cost report submitted to DMH by the county was also changed. The cost report submitted by the county to the State shows a total of 13,135 units of service completed at a cost of $2.06 per unit for a gross cost of $27,038. The cost report we submitted to the county shows 33,595 units of service completed at a cost of $1.19 per unit for a gross cost of $39,979. There is an outstanding cost settlement due of $12,940.41. This county submitted a cost report to the State Department of Mental Health that showed less services had been provided at a higher per unit cost submitted under a legal entity number that I suspect belongs to the county's program. All of these changes were made without our knowledge or approval. It appears to me that this

practice calls into question the accuracy of all utilization and cost data within the State Department of Mental Health data system.

I suspect the first county (that did not submit our cost report to the state at all) may have altered the number and cost of our units of service in a manner similar to the second county but submitted the information to the State Department of Mental Health for reimbursement under their own provider name and legal entity number. I cannot imagine how these situations were not apparent to State Department of Mental Health Auditors.

Our organization also has experience with a third county that refused to reimburse us for services provided to children who were enrolled in the Medi-Cal program and who were also eligible for funding through the Victims of Crime Act (VOCA). The VOCA clearly states in 42 U.S.C. 10602 (e) that other federal programs or federally financed state or local programs will pay before victim compensation payments and they will make payments without regard to the victim compensation program. Medicaid programs, such as Medi-Cal, are specifically identified as such a funding source. The county argued that if "the child had been assessed and opened to County Mental Health before Victim Witness was applied for, then Medi-Cal would have been the source for billing services." Further, the county argued "that VCP will not require the claimant to change therapists in order to receive insurance or Medi-Cal payment. If this is the case the child did not need to become a county client to be eligible for VCP services. The eligibility follows the child, not the provider." The family chose to use up their VOCA allocation rather than utilize another organizational provider. This was unfortunate and unnecessary since we were contracted to provide EPSDT services by this county to the school in which these children were enrolled.

This county also required children to be transferred to other providers in order to continue receiving Medi-Cal services to avoid our program going over the contracted amount of services. This was typically the case towards the end of the contract year.

After providing mental health services to Medi-Cal recipients in 10 California counties over a five-year period, it is very clear to me that some Mental Health Plans are ignorant about the Medicaid regulations regarding payment to organizational providers and have not been provided the technical assistance or oversight from the Single State Agency necessary to correct problems such as those documented above. A colleague characterizes this behavior as "the county's behaving as if they were each a Single State Agency". Unfortunately this behavior, paradoxically, increases the cost of services within California as organizational providers have learned to keep their costs near the SMA as the only way to survive in this capricious business environment.

It appears that some confusion exists because some MHP may be under the impression they are administering a full capitated Medi-Cal system or that organizational providers are reimbursed based on the contract between the provider and the MHP rather than the approved state plan for Medi-Cal Services.

The intent of the proposed regulations is not directly related to the issues discussed above; however, I feel it important to point out that some California counties do not follow the reimbursement requirements of the approved state plan. If current procedures continue, the proposed regulation that providers are reimbursed based on the approved state plan will continue to be ignored.

Please feel free to contact me at the address and telephone number below if you have questions regarding the facts described above.

Ken Fleming

Director of Administration
Sacramento Valley Family Services
260 E. Sacramento Ave.
Chico, CA 95926
530-891-4053

Copies to:

Norman Black CDMH
Robin Mandela CDMH
Lupe Arce CDMH
Darlene Cheryl SVFS
Rusty Selix CCCMHA

Submitter : **Mr. A C Wharton** **Date: 03/19/2007**

Organization : **Shelby County Government**

Category : **Local Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-265-Attach-1.DOC

#265

March 12, 2007

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

Dear Administrator Norwalk:

I am writing on behalf of The Regional Medical Center at Memphis (The MED) which stands to suffer greatly from the proposed Medicaid regulation 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).

As the primary safety net hospital for the Mid-South region, The MED has been well established as a vital resource for our community especially within a 150 mile radius. In addition to the high percentage of Medicaid and uninsured patients the hospital serves, the MED is also highly visible and widely acclaimed for its Centers of Excellence – a high-risk obstetrics center, trauma and burn centers, and an historic, internationally benchmarked newborn center to name a few.

CMS-2258-P ("Proposed Rule") would seriously undermine much of the ongoing work at the MED, specifically its ability to serve as a safety net hospital for the region which continues as one of our nation's most financially distressed.

The enclosed document outlines the specific sections of the Proposed Rule that will have the most debilitating affect on the MED.

Thank you in advance for your attention to this matter. From physicians and hospital administrators to elected representatives in Congress and our state capitals, it is my hope that the strong voices of the stakeholders around the country who oppose these changes will be cause for reconsideration.

Please feel free to contact me at 901-545-4500 if I can be a source of any further information.

Sincerely,

A C Wharton
Mayor

COMMENTS RELATED TO SPECIFIC PROVISIONS

A. Cost Limit for Providers operated by Units of Government (Section 447.206)

The MED objects to the new cost limit on Medicaid payments to government providers under the Proposed Rule.

Congress has already determined that federal support is needed and that states may use their Medicaid programs to provide it. Above-cost Medicaid payments based on Medicare rates have been part of the Medicaid payment system for years. Congress has specifically rejected CMS's proposals to impose provider-specific cost-based payment limits during its budgetary deliberations in Fiscal Years 2005 and 2006.

The cost limits would prevent states from adopting payment methodologies that are economic and efficient and that promote quality and access in contravention of Section 1902(a)(30(A) of the Social Security Act (SSA). Second, it defies simplicity of administration and ignores the best interests of Medicaid recipients that states are required to safeguard pursuant to Section 1902(a)(19). Third, it would violate Section 705(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 by adopting upper payment limits that are not based on the proposed rule announced on October 5, 2000. And lastly, it would prohibit states from adopting prospective payment systems for their governmentally-operated federally qualified health centers and rural health clinics as required by Section 1902(b) of the SSA.

CMS should not modify the current upper payment limits.

B. Defining a Unit of Government (Section 433.50)

We urge you to reconsider the proposed definition of a "unit of government." This more restrictive definition would require a hospital to have *generally applicable taxing authority* in order to meet the new standard. Those healthcare facilities that fail to measure up to this highly prohibitive definition would be restricted from contributing to the non-federal share of Medicaid expenditures through intergovernmental transfers("IGTs") and certification of public expenditures ("CPEs").

The MED opposes this regulation and asks that states be allowed to continue to determine which entities qualify as units of government.

In creating a new federal regulatory standard to determine which public entities within a state are considered to be "units of government" and which are not, CMS is encroaching on a fundamental reserved right of states to organize their governmental structures as they see fit. This federal intrusion into the operation and administration of state government violates the very basis of the Medicaid program—the federal-state

partnership and the federalism principles on which it rests. Accordingly, The MED urges CMS to defer to states regarding the definition of a unit of government.

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

The MED opposes the restrictions related to the source of the public funds used for the state share of Medicaid funding.

Traditionally, states have been able to rely on the public funds contributed by governmental entities, regardless of the source of the public funds. The Proposed Rule rejects the idea that all funds held by a unit of government are governmental. Rather, the preamble to the proposed rule would establish a hierarchy of public funds, and only funding derived from taxes would be allowed to fund Medicaid expenditures while those derived from other governmental functions (such as providing patient care services through a public hospital) would be rejected. The preamble states that, with respect to intergovernmental transfers, "the source of the transferred funds (must be) State or local tax revenue (which must be supported by consistent treatment on the provider's financial records)." (72 Fed. Reg. at 2238).

While the proposed regulatory language itself refers only to "funds from units of government" without specifying the source of those funds, the preamble language clearly indicates CMS' intent to further restrict funding for state Medicaid programs by imposing the additional requirements that local funds be derived from tax revenues.

The combination of adopting a restrictive definition of a unit of government and then further restricting the source of funds that can be transferred by entities that meet the strict unit of government test will leave state Medicaid programs, including important supplemental payment programs that support the health care safety net, starved for resources. In imposing this new restriction on the source of IGTs, CMS is exceeding its Congressionally delegated authority. Section 1902(a)(2) of the SSA allows states to rely on "local sources" for up to 60 percent of the non-federal share of program expenditures. This provision does not limit the types of local sources that may be used. CMS is without legal authority to insist that local funding from units of government be limited to tax dollars only.

Therefore, The MED recommends that CMS allow all public funding regardless of its source to be used as the non-federal share of Medicaid expenditures.

Submitter : Mr. Charles Miller **Date:** 03/19/2007

Organization : Covington & Burling LLP

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2258-P-266-Attach-1.PDF

#266

BEFORE THE
DEPARTMENT OF HEALTH AND HUMAN 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	)
	)

JOINT COMMENTS OF THE STATES OF
ALASKA, CONNECTICUT, ILLINOIS, LOUISIANA, MAINE, MARYLAND, MICHIGAN, MISSOURI, NEW HAMPSHIRE, NEW JERSEY, NORTH CAROLINA, OKLAHOMA, PENNSYLVANIA, TENNESSEE, UTAH, WASHINGTON AND WISCONSIN

These comments on the above-captioned proposed rules are submitted on behalf of the agencies and officials responsible for administering the Medicaid program in the States of Alaska, Connecticut, Illinois, Louisiana, Maine, Maryland, Michigan, Missouri, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, Tennessee, Utah, Washington and Wisconsin ("Commenting States").

Before commenting on the specific "issue identifiers" covered by the proposed rules, the Commenting States cannot emphasize strongly enough that in their totality the proposals are not necessary to ensure the financial integrity of the program, are in derogation of the way that Medicaid has been operated since its inception, will seriously impair the ability of States to maintain their Medicaid programs, and will cause substantial financial injury to the hospitals and other health care businesses and professionals that provide essential health care

services to children, their families, the elderly, the disabled and other needy populations. CMS says that its proposals are consistent with and required by current law, but they go far beyond any reasonable construction of the agency's authority, disrupt long-standing practices, and impose new and onerous administrative and fiscal burdens on State and local governments, as well as all manner of public health care providers, including public schools.

Far from "ensur[ing] the integrity" of the "Federal-State Financial Partnership," the proposed rules seriously jeopardize it, by re-defining the types of public entities and sources of public funds that States have long relied on to serve Medicaid beneficiaries and help support the Medicaid program. There are numerous providers throughout the country that have traditionally earned federal matching funds either by certifying their expenditures in serving Medicaid patients or by transferring their funds to the State for use as the non-Federal share in Medicaid payments. Those providers are established under long-standing state laws, operate with substantial public oversight, and are dedicated to fulfilling an important public mission. Their willingness to contribute their own funds to pay for the non-federal share of serving Medicaid beneficiaries, thereby reducing the burden on state taxpayers, has been welcomed and should be applauded. Yet under the new rule many, if not most, of these providers would not qualify as "units of government" and their contributions would no longer be acceptable as a source of the non-Federal share. The denial of federal financial participation will eliminate a critical piece of funding for these providers and impose substantial new financing burdens on State Medicaid agencies tasked with preserving access to care.

Even if public providers meet the stringent "unit of government" test, the new rules would allow federal Medicaid payments only where the non-federal share of expenditures can be traced directly to an appropriation of tax dollars. Yet traditionally, the non-federal share

of expenditures by public entities has come not only from these sources but also from other unquestionably legitimate sources, such as foundation grants, earnings from other hospital operations (including ancillary lines of business like gift shops or parking lots) and charitable contributions. States have also used funds from such sources as tobacco payments, university tuitions, and other fees to pay for Medicaid services. The proposed rules would not only bar the use of these sources to pay for federally-matched services, but would even limit some categories of tax-based appropriations.

Limiting payments to cost would cripple states' ability to offer incentives to governmental providers to operate more efficiently. For governmental entities like schools, small clinics and other entities that provide critical front-line primary care services, and which have traditionally been paid on a fee basis, the cost limitation would impose on them massive accounting and reporting requirements way out of proportion to the scope of their operations. The cost limit is contrary to the direction of the Medicare program, which has replaced cost reimbursement systems for virtually all of its provider groups.

Finally, the proposal that governmental providers retain every penny of reimbursement, apart from being impossible to implement, fails to appreciate that these providers frequently are funded in full by state or county appropriations, so that the retention requirement would prevent return of the federal reimbursement to the account that put up the funds in the first place.

As set forth more fully below under the specific "issue identifiers," the proposals are in all key respects inconsistent with current law and are terrible public policy. The sources of funds that would no longer be the basis for federal support are a legitimate category of public money. Each of the entities that now certifies expenditures based on these sources is serving a

public mission, and by committing their resources (including those earned through their other business operations) to serving the Medicaid population they are advancing the purpose of the Medicaid program in exactly the way that the program contemplates. Preventing use of payment methods that offer the prospect of a reward for efficient operations insures that health care costs will continue to increase at unacceptable rates. And burdening providers with chimerical rules such as being required to retain all payments made for Medicaid services insures that program administration would be even more complicated and contentious than it is today.

I. Sources of State Share and Documentation of Certified Public Expenditures (Proposed § 433.51(b))

CMS proposes to revise 42 C.F.R. § 433.51(b) in order to change the funds that may be considered as the non-Federal share in Medicaid expenditures from "public funds" to "funds from units of government," which under the proposed amendment to 42 C.F.R. § 433.50(a)(1)(i) would be defined as funds from a "city, county, special purpose district, or other governmental unit in the State with generally applicable taxing authority." A health care provider will be considered to be a "unit of government" only if the provider itself has taxing authority or is a part of a unit of government with taxing authority that is legally obligated to fund the health care provider's expenses, liabilities and deficits. Proposed 433.50(a)(1)(ii). The preamble to the rule further states that State and/or local tax revenue paid to a provider cannot be considered the non-Federal share if the funds are committed or earmarked for non-Medicaid activities. 72 Fed. Reg. 2239. CMS asserts that its rule is required by The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1992, Pub. L. 102-234 ("Provider Tax Amendments").

Comment: The proposed rule embodies a radical curtailing of the types of public funds that have traditionally been used as the non-Federal share of Medicaid expenditures.

CMS's own past practices confirm that these changes do not flow from the fifteen-year-old Provider Tax Amendments but instead reflect a new and unjustifiably crabbed view of the federal government's role in contributing to public support of the Medicaid program.

The view that the federal government should only match expenditures financed through state and local tax revenues is not supported by Title XIX and runs contrary to decades of effort to make public providers less dependent on such revenues in carrying out their mission to serve the nation's most vulnerable citizens. We set forth below the relevant history that supports this conclusion. But it bears stressing at the outset that the approach now embraced by the proposed rules and their philosophical premise--that the non-federal share must derive from tax proceeds raised by governmental units--is, to use plain words, a bad idea. It limits the base of support for the Medicaid program by excluding worthy sources that can help to achieve the great and humane goal of assuring the widest availability of health care for the needy in our society. Nowhere in the preamble, or in its issuances or public statements on this subject over the past few years, has CMS or any of its representatives sought to justify the narrow view that underlies the proposed regulations as serving a public purpose or advancing the broad purposes of Medicaid. Why federal officials would want to adopt a view that limits the financial backing for such a critical and worthy program is hard to imagine.

The only justification ever offered by CMS is the assertion that the Medicaid program has always been predicated on state tax-funded contributions equal to the non-federal share of its costs. That is simply not the case. From its inception, Title XIX has contemplated that public entities not funded by state appropriations would contribute to the non-federal share of Medicaid expenditures. Section 1902(a)(2) permits 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 or 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."

Section 1903(d)(1) of the Act, which also has been a feature of Title XIX from the program's inception, makes explicit Congress' intention that the non-federal share may encompass public funds derived from "other sources" than the State and its political subdivisions. That subsection contains reporting requirements in order for a State to seek federal financial participation ("FFP") for Medicaid expenditures, including

> stating the amount appropriated or *made available* by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, *the source or sources from which the difference is expected to be derived*. . . .

42 U.S.C. § 1396b(d)(1) (emphasis added). This provision could not be more clear that sources of funds *in addition to* amounts appropriated by the State or its political subdivisions may supply the non-Federal match.

Those longstanding provisions are consistent with the fundamental purpose of Title XIX, in which Congress recognized that the "provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies" and crafted a program in which the federal role would be to "assist[ ] the States and localities in carrying this responsibility by participating in the cost of care provided." H.R. Rep. No. 89-213, at 63 (1965). The statute thus guaranteed that "local funds could continue to be utilized to meet the non-Federal share of expenditures under the plan." H.R. Rep. No. 89-682 (1965) (Conf. Rep.)

Consistent with this intent and the scope of the statutory provisions, CMS and its predecessor agencies have long permitted public funds to be considered as the non-federal share

in claiming federal financial participation if the funds are appropriated directly to the State or local agency, *or* transferred from other "public agencies" to the State or local Medicaid agency, *or* are "certified by the contributing public agency as representing expenditures eligible for FFP under this section." 42 C.F.R. § 433.51(b).

CMS now asserts 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" Section 1903(w)(6)(A), which was added to Title XIX as part of the Provider Tax Amendments of 1991. 72 Fed. Reg. at 2240. The Provider Tax Amendments do not dictate or even suggest the result that CMS now seeks to achieve. Section 1903(w)(6)(A) is not a limitation on the nature of public entities contributing to the non-federal share of financial participation but instead a limitation on CMS's authority to regulate in this area. It states that notwithstanding any other provision:

> 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 subchapter, regardless of whether the unit of government is also a health care provider. . . . .

The plain language of the provision ("the Secretary may not restrict . . .") makes clear that the Congress intended the provision merely to bar CMS from promulgating any regulation restricting States' use of the designated funds as participation in the non-federal share.

In its proposed rule, CMS takes the position that the restriction on the Secretary's authority to regulate certain funds means that only those funds are permissible sources of the state share and that all other funds are prohibited. Certain uncodified provisions of the 1992 Provider Tax Amendments rebut that interpretation. Section 5 of the 1992 law provides:

(a) *In general.* Subject to subsection (b), the Secretary of Health and Human Services shall issue such regulations (on an interim final or other basis) as may be necessary to implement this Act and the amendments made by this Act.

(b) *Regulations changing treatment of intergovernmental transfers.* The Secretary may not issue any interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act (as added by section 2(a) of this Act) that are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

(c) *Consultation with States.* The Secretary shall consult with the States before issuing any regulations under this Act.

Pub. L. 102-234 § 5.

Section 5(b) would have been irrelevant and unnecessary if CMS were correct that "public funds" other than state and local tax revenue referred to in Section 1903(w)(6) were prohibited by the statutory amendments. In subsection (a), Congress had already instructed the Secretary to issue regulations "on an interim final or other basis" to implement the Act, and then specifically prohibited "any interim final regulation that changes the treatment . . . of public funds as a source of State share of financial participation" (except as necessary to implement the Act). If the use of any public funds other than state and local tax revenue was an unlawful donation – the position taken in the draft rule – then Section 5(b) of the provider tax law would serve no purpose. The inclusion of Section 5(b) in the Provider Tax Amendments also confirms that even though the existing language at 42 C.F.R. § 433.51(b) reflects a broader scope of "public funds" than "funds . . . derived from State or local taxes" (the standard of Section

1903(w)(6)(A)), the regulation is nonetheless a lawful interpretation of the governing Social Security Act provision, Section 1902(a)(2).

The legislative history of the Provider Tax Amendments also validates that Congress did not intend, through Section 1903(w)(6)(A), to narrow the standards set forth in Section 1902(a)(2) or in its implementing regulation (then located at 42 C.F.R. § 433.45, now at 42 C.F.R. § 433.51) for acceptable sources of the non-federal share. The House Conference Report on the final version of the legislation states:

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

H.R. Conf. Rep. 102-409, at 18 (1991), *reprinted in* 1991 U.S.C.C.A.N. 1441, 1444 (emphasis added). No indication is given that the "current transfers" that continue to be permissible are only those derived from local tax revenue, as CMS asserts in the proposed rule.

CMS's own actions establish that the Provider Tax Amendments do not require it to limit acceptable "public funds" to those derived from tax revenue. In the regulations promulgated by the agency following the statute's enactment, the agency not only did not make the changes it now seeks to impose but expressly declined to do so, instead eliminating only the provision that had previously permitted private donations to be used toward the state share:

> Prior to the enactment of Public Law 102-234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a State's share of financial participation in the entire Medicaid program. As mentioned previously, **the statutory provisions of Public Law 102-234 do not include restrictions on the use of public funds** as the State share of financial participation. Therefore, the provisions of

> § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.

57 Fed. Reg. 55118, 55119 (November 24, 1992) (emphasis added). The agency concluded that "until the Secretary adopts regulations changing the treatment of intergovernmental transfers, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level)." *Id.*

The Provider Tax Amendments and the contemporary regulatory history indicate that CMS does have the authority to "chang[e] the treatment" of public funds considered for the non-Federal share beyond what the statute expressly prohibits. But in order to do so CMS would have to demonstrate that its actions are reasonable and consistent with the statute (including Section 1902(a)'s reference to funds from "local sources"), and it may not simply assert, as it does here, that such a result is required by the plain meaning of Section 1903(w)(6): it is not. To the extent that CMS had concluded that some sources apart from taxes reflect abusive funding practices, it should target its rules to ending those practices, not simply claim *ipse dixit* that state and local tax revenues are the only permissible source of public funds.

Finally, even if CMS were correct that Section 1903(w)(6) permits only state and local tax revenue to be sources of the state match, the preamble to the proposed rule indicates that CMS intends to apply the rule in a manner inconsistent with that section's prohibition on the Secretary's ability to restrict the use of funds derived from State or local taxes. The preamble sets forth the view that State and local tax revenue is not eligible for use if "committed or earmarked for non-Medicaid activities." 72 Fed. Reg. at 2239. As an example of such an impermissible source of non-federal funding, CMS cites "[t]ax revenue that is contractually

obligated between a unit of State or local government and health care providers to provide indigent care." *Id.* There is no basis for such a restriction, and Section 1903(w)(6) explicitly states that the Secretary may *not* restrict any transfers or certifications "where such funds are derived from State or local taxes." In attempting to dictate what kind of tax revenue passes muster, CMS proposes to do the very thing prohibited by § 1903(w)(6)(A): restrict the use of funds derived from State or local taxes.

II. Defining a Unit of Government (Proposed § 433.50)

CMS proposes two definitions of the "units of government" whose funds can be considered as making up the non-Federal share of Medicaid expenditures. The first 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." Proposed § 433.50(a)(1)(i). A health care provider will be considered to be a "unit of government" only if the provider itself has taxing authority or is "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." Proposed 42 C.F.R. § 433.50(a)(1)(ii)(A), (B). In the preamble, CMS asserts that a provider is likely not operated by a unit of government if an "independent entity [has] liability for the operation of the health care provider and will not have access to the unit of government's tax revenue without the express permission of the unit of government." 72 Fed. Reg. at 2240. Both aspects of the definition of "unit of government" are faulty and should not be adopted.

A. Comment on § 433.50(a)(1)(i)'s Requirement of "Generally Applicable Taxing Authority": Even assuming that CMS correctly asserts that under Section 1903(w)(6)(A) only "units of government" may participate in the non-federal share, it has defined "unit of

government" too narrowly. Section 1903(w)(7)(G) defines "unit of local government" as meaning "a State, a city, county, special purpose district, or other governmental unit in the State." CMS has added the requirement that, in order to be "governmental," the entity must have "generally applicable taxing authority." That requirement impermissibly narrows the "special purpose district" and "other governmental unit" components of the regulatory definition. CMS' rigid proposed definitions of "unit of government," and of what constitutes governmental "operation" of a provider, disregard States' inherent authority to create and to delegate functions to political subdivisions and agencies. In so doing, the proposed rules undercut the principle of federal-state cooperation embodied in the Medicaid program.

The requirement of taxing authority is not only an impermissible qualification to the definition in Section 1903(w)(7), but it is a qualification that is at odds with the recognition in Section 1903(w)(6) that a "unit of government" may be a "health care provider." Many, if not most, publicly owned or operated health care providers do not have taxing authority, and nonetheless have long been able to contribute to state Medicaid programs by using their funds as the non-federal share of Medicaid expenditures. Those contributions which have been used as acceptable "local sources" of funding would no longer be matchable under the proposed rule unless the State could establish that the provider was part of some other unit of government that had the requisite "generally applicable" taxing authority. That result not only eliminates a financial backbone of many public hospitals, but the attempt to have a federal agency define, in rulemaking, what constitutes a unit of state government flies in the face of the cooperative federalism on which the program is based.

By Executive Order binding on CMS, federal agencies must "closely examine the constitutional and statutory authority supporting any action that would limit the policymaking

discretion of the States and shall carefully assess the necessity for such action." Executive Order 13132, 64 Fed. Reg. at 43256 (August 4, 1999). Similarly, wherever feasible, agencies must "seek views of appropriate State, local and tribal officials before imposing regulatory requirements that might significantly or uniquely affect those governmental entities" and must "seek to minimize those burdens that uniquely or significantly affect such governmental entities, consistent with regulatory objectives." Executive Order 12866, Sec. 1(b)(9), as amended 58 Fed. Reg. 51735 (February 26, 2002). CMS has failed to respect those mandates here.

Few areas are as fundamental to the notion of state sovereignty as the ability to determine what constitutes a unit of government within the State. It is well established that "the state is supreme" in creating its political subdivisions and in defining their functions. *See Hunter v. City of Pittsburgh*, 207 U.S. 161, 179 (1907). States create political subdivisions, "counties, cities or whatever[,] . . . . 'as convenient agencies for exercising such of the governmental powers of the state as may be entrusted to them,' and the 'number, nature and duration of the powers conferred upon [political subdivisions] . . . rests in the absolute discretion of the state.'" *Reynolds v. Sims*, 377 U.S. 533, 575 (1964) (quoting *Hunter*, 207 U.S. at 178).

The power of taxation is only one of these powers. Taxing authority is not a precondition for an entity to be a unit of government. "Local government units do not have inherent power to tax because, in contrast to the state which creates them, they are viewed as subordinate units exercising only a delegated competence." JOHN MARTINEZ ET AL., LOCAL GOVERNMENT LAW § 23:2 (2006). Thus, while no one would doubt that a municipality is a unit of government, States frequently restrict, and may (absent State constitutional considerations) entirely suspend, municipalities' powers of taxation. CMS's requirement that a governmental entity must have "[g]enerally applicable taxing authority" in order to be considered a unit of

government whose funds may be used as the state share of Medicaid expenditures is thus adding a requirement that is not required by the Provider Tax Amendments and that fundamentally interferes with a State's own internal governmental structure.

The determination of what constitutes a "unit of government" is one that should be left to the States based on the broad definition in Section (w)(7) and CMS should omit taxing authority as a necessary precondition for unit of government status.[1]

B. Comment on § 433.50(a)(1)(ii)'s Definition of When a Health Care Provider is A Unit of Government. Section 1903(w)(6) recognizes that a "unit of government" can be a "health care provider" and yet CMS proposes a definition that is so limiting that some quintessentially public providers will be unable to meet it. According to the proposed rule, a provider must itself have "generally applicable taxing authority" or else demonstrate that it is an "integral part" of a governmental unit by showing that the government has an unconditional duty to fund the provider's operations expenses, losses, and deficits. If a provider does not meet this stringent definition it cannot certify its Medicaid expenditures for federal financial participation. This definition, too, imposes federal dictates on the organization of state government by administrative fiat, unsupported by the Provider Tax Amendments or any other provision of Title XIX.

Two classes of public providers would appear to be most adversely affected by the proposal. First, many public hospitals receive county, city, or State funding, but operate through autonomous hospital districts authorized by State law. Under these State laws, either the

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[1] For these reasons, the questionnaire developed by CMS and which was the subject of a Federal Register notice on January 19, 2007, should be discarded. Apart from its intrusiveness into the prerogative of states to determine the nature of their political subdivisions, the questionnaire is based on the same faulty premises as are the proposed rules.

city or county governing body, or voters, may authorize the creation of hospitals. The authorizing legislation invests the hospital with governmental status. State law typically empowers the city or county government, or the hospital district, to issue bonds or to impose special taxes to support the hospitals. State law frequently requires the governing board of the hospital to be elected by voters or appointed by government officials. State courts have held that these governing boards are public bodies, for example, subject to State open meeting requirements. *See Stegall v. Joint Twp. Dist. Memorial Hosp.*, 484 N.E.2d 1381, 1383 (Ohio App. 1985); *cf. Matagorda County Hosp. Dist. v. City of Palacios*, 47 S.W.3d 96, 100-101 (Tex. App. 2001) (city had standing to sue hospital district for failing to comply with open meeting requirements). Where (as frequently authorized by State law) a private entity manages the hospital, the government generally has the authority to terminate the lease or agreement for nonperformance.

While the municipal or county governments participating in a hospital district usually have some responsibility to provide financial support to the hospital, the municipality may, in order to encourage efficiency, provide a capped amount of financial support to the hospital, requiring it to absorb some losses and permitting it to enjoy profits. If the hospital authority administering the facility does not itself have "generally applicable taxing authority," then the operative question for public status, under the proposed rule, is whether the local government funds the hospital's expenses, losses, and deficits sufficiently for the hospital to be an "integral part" of local government. Hospitals operated under these systems have, until this rulemaking, been viewed as public hospitals. *See* 66 Fed. Reg. at 3154 (noting that facilities owned by "quasi-independent hospital districts" are non-State public hospitals).

Second, many public hospitals directly owned by States, cities, or State-chartered universities contract with private companies to manage some portion of the hospital business. CMS should not issue any rule that casts doubt on the ability of public hospitals to pursue this practice. Commonly, a State or local government or State university, while maintaining active involvement in the business operations of the hospital, may induce the contractor to improve efficiency by varying its payment to the contractor commensurate with the hospital's performance. In 2001, in response to comments, CMS's predecessor the Health Care Financing Administration ("HCFA") amended its proposed rule on upper payment limits ("UPL") in order to clarify in the final version that a hospital owned by a local government but managed by a private company was considered a non-State public facility. 66 Fed. Reg. at 3154. That approach is consistent with the Medicaid program history and purpose. CMS should continue to consider such a provider to be part of the unit of government as long as the governmental entity retains ultimate responsibility for the oversight and business operations of the provider.

There is no legal basis for CMS to require that the government fund all of a provider's losses, expenses, and liabilities, in order to acknowledge the provider as public. An analogy to State-local government relations demonstrates the flaw in this position: while no one questions that cities are governmental, State constitutional provisions frequently bar the State from lending its credit to a municipality, or at least limit the assistance the State may provide to the city. *See, e.g.,* N.Y. CONST. ART. 9, § 2(b)(2) (State may act in relation to property of a city government only by general law, by special request of two thirds of the legislature, or, except in the case of New York City, on a certificate of necessity issued by the Governor).

In the preamble to the proposed rule, CMS rejects the view that "an entity which is not governmental in nature but has a public-oriented mission (such as a not-for-profit hospital,

for example) may participate in the financing of the non-Federal share by CPEs." 72 Fed. Reg. at 2240. To the extent that the preamble indicates that not-for-profit status in and of itself is disqualifying as a unit of government (the rule is not clear on this point), the Commenting States disagree. Many traditional public providers are nonprofit corporations under Section 501(c)(3) of the Internal Revenue Code. These providers not only have a public-oriented mission but are subject to public oversight and receive substantial financial support from the communities in which they operate.

That an enterprise is organized in corporate form is not inconsistent with its being a public entity. Well-known examples of federal public entities that operate in corporate form include the Federal Deposit Insurance Corporation, the Tennessee Valley Authority, and the Communications Satellite Corporation. Frequently, State laws creating hospital districts allow the hospital to operate as a 501(c)(3) nonprofit corporation. Nonetheless, the authorizing legislation vests the hospital with governmental status. Hospitals operated under these hospital district laws have, until this rulemaking, been viewed as public hospitals. *See* 66 Fed. Reg. at 3154. Further, a CMS Medicare regulation governing whether a facility has provider-based status recognizes that a unit of State or local government may "formally grant[] governmental powers" to a health care provider organized as a public or nonprofit corporation. *See* 42 C.F.R. § 413.65(e)(3)(ii)(B).

Nonprofit corporations have many attributes of public entities. They are required to serve a "public interest," 26 C.F.R. § 1.501(c)(3)-1(d)(1)(ii). Unlike for-profit corporations, there are no shareholders, and no private persons can have any ownership interest in the nonprofit corporation. Nonprofit corporations can have "members" (though this is not required), but members have no ownership interest in the assets or business of the nonprofit corporation.

Further, when a nonprofit corporation terminates its operations, its assets must (depending on the applicable State law) be contributed either to another nonprofit or to the federal, State, or local government for a public purpose. In other words, once assets are committed to a benevolent purpose being carried out through a nonprofit corporation, those assets must remain available for a benevolent purpose.

Localities or hospital districts frequently choose to organize a hospital as a 501(c)(3) organization in order to ensure that the hospital will be able to accept private charitable donations. The Provider Tax Amendments do not bar a public provider or unit of government from receiving such donations, as long as the donor is not a provider. *See* 42 U.S.C. § 1396b(w)(2); *see also* 57 Fed. Reg. at 55120 (noting that States may continue to receive charitable donations from entities other than providers after the Provider Tax Amendments). The ability to receive private donations actually enhances the public mission of local hospitals, by strengthening their ability to fulfill their safety net function of treating the uninsured.

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There is another way in which the proposed rules undermine the sound financing of the Medicaid program. There are many public entities that would not meet the restrictive "unit of government" definition proposed by CMS but that nonetheless receive financial support from counties or other governmental bodies. It is normal for such entities to share with their funding agencies any revenue received for their services, from private and public payors. Yet under the proposed rules this return of funds advanced to finance operations pending receipt of revenue would be considered impermissible donations, resulting in a reduction of the FFP otherwise payable to the State for Medicaid services provided by the public entity. (Remarkably, the preamble to the proposed rules acknowledges this consequence, apparently without

awareness that it would inhibit normal return of advanced funds by public bodies. See 72 Fed. Reg. at 2238).

This perverse consequence is entirely unwarranted and demonstrates how far out of kilter the proposed regulations are with the structure and intent of the Medicaid program. The Provider Tax provisions were carefully crafted to fit with the existing Medicaid program structure. Specifically, the donation provisions were aimed to private contributions of the non-federal share. They were never intended to prevent the kind of fund transfers described above.

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

Proposed § 447.206(c)(1) provides that "[a]ll health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider's cost of providing covered Medicaid services to eligible Medicaid recipients." 72 Fed. Reg. 2246. Under proposed § 447.206(c)(2), the Secretary will determine "[r]easonable methods of identifying and allocating costs to Medicaid." *Id.* Proposed § 447.206(c)(3) and (c)(4) provide that for hospital and nursing facility (NF) services, "Medicaid costs must be supported using information based on the Medicare cost report," while for non-hospital and non-NF services, such costs "must be supported by auditable documentation in a form approved by the Secretary." *Id.* Under proposed § 447.206(d) and (e), each individual provider "must submit annually a cost report to the Medicaid agency that reflects [its] cost of serving Medicaid recipients during the year." *Id.* at 2246-47.

When States employ a cost-reimbursement methodology that is funded by certified public expenditures ("CPE"), they would be allowed to use the most recently filed cost reports to set interim rates and to trend these rates by a health-care-related index, and they would be required to perform interim and final reconciliations; as for payments made to providers operated by units of government that are not funded by CPEs, the Medicaid agency would have

to review each cost report "to determine that costs on the report were properly allocated to Medicaid," and it would have to "verify that Medicaid payments to the provider during the year did not exceed the provider's cost." *Id.* at 2247.

The proposed rule would eliminate existing § 447.271(b), which permits payments to "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." *Id.* Section 447.272, which applies to ratesetting for inpatient services provided by hospitals, nursing facilities, and ICFs/MR, would be changed to provide that the UPL for all government operated facilities is "the individual provider's cost," and to provide that Medicaid payments to these facilities "must not exceed the individual provider's cost." *Id.* The same changes would be made to § 447.321's UPL rules for ratesetting for outpatient hospital and clinic services. *Id.*

Comment: CMS lacks the statutory authority to impose a cost limit on governmental providers, to require cost reporting by individual providers in support of this limit, and to change the UPL rules in order to implement this limit. Congress has rejected cost-based reimbursement and provider-specific limits, and it has done so for all providers, including those operated by units of government. The proposed rule represents a significant and unjustified departure from CMS's own earlier, better understandings of congressional intent. And by deleting the exception for nominal charge hospitals the proposal places in jeopardy those hospitals that are most committed to serving the poor and the uninsured.

1. Congress Has Rejected Cost-Based Reimbursement Principles. The history of Section 1902(a)(13) of the Social Security Act ("Act") clearly shows congressional rejection of cost-based reimbursement. When Congress first created Medicaid, Section 1902(a)(13) required States to pay the "reasonable cost" of inpatient hospital services. Pub. L.

No. 89-97, § 121(a) (1965). Ever since then, Congress has consistently given States ever greater flexibility in the design of payment methods for providers, both public and private.

In 1972, Congress amended the Act to permit States to develop their own methods and standards for reimbursement for inpatient hospital services, although the "reasonable cost" principle was retained. Pub. L. No. 92-603, § 232(a) (1972). At the same time, Congress provided that States were to pay for skilled nursing facility (SNF) and intermediate care facility (ICF) services "on a reasonable cost related basis"; again, States were permitted to develop their own methods and standards. *Id.* § 249(a). In a 1976 rulemaking implementing these changes, HCFA stated that prospective ratesetting "involve[s] payment rates not subject to further adjustment on the basis of the actual costs of a particular provider," that "the inherent cost containment potential of such limits negates the need for an additional ceiling," and that "there is no single figure that is the reasonable cost, but rather a spectrum of figures within an acceptable range, any one of which is a reasonable cost." 41 Fed. Reg. 27300, 27302-03 (July 1, 1976), *quoted in Ill. Dept. of Pub. Aid*, DAB No. 467 (1983); *see also* 46 Fed. Reg. 47964 (Sept. 30, 1981) (describing existing policy as permitting "profit . . . to facilities that can keep their costs below a prospectively determined . . . rate").

In 1980, Congress enacted the Boren Amendment, which further increased State flexibility in the reimbursement of SNFs and ICFs by deleting the "reasonable cost related basis" requirement for these facilities. States were now to pay for these facilities' services through the use of rates that were "determined in accordance with methods and standards developed by the State" and "which the State finds, and makes assurances . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable" law. Pub. L. No. 96-499, § 962(a).

States were also required to "make[] further assurances . . . for the filing of uniform cost reports by each [SNF] or [ICF] and periodic audits by the State of such reports." *Id.* In 1981, Congress extended the Boren Amendment to hospitals. Pub. L. No. 97-35, § 2173 (1981).

It is plain from the legislative history of the Boren Amendment and its extension to hospitals that Congress intended States to have greater discretion in developing reimbursement mechanisms -- including the flexibility to set rates not subject to an actual cost limit and not subject to individual, provider-by-provider limits. There is no indication that this discretion was meant to be greater with respect to private providers than government providers. *See* H.R. Conf. Rep. No. 97-208, at 962 (1981); Sen. Rep. No. 97-139, at 744 (1981); H.R. Rep. No. 97-158, vol. II, at 292-93 (1981); H.R. Conf. Rep. No. 96-1479, at 154 (1980); Sen. Rep. No. 96-471, at 28-29 (1979). Moreover, in granting States greater rate-setting discretion, it is clear that Congress took a dim view of administrative overreaching in the form of unnecessary regulation and of paperwork requirements that overburdened States and facilities. *See* Sen. Rep. No. 97-139, at 744; Sen. Rep. No. 96-471, at 28-29.

In the preamble to interim final regulations implementing the Boren Amendment, HCFA recognized that "each State should be free to decide, in setting its payment rate, whether to allow facilities an opportunity for profit." 46 Fed. Reg. 47964 (Sept. 30, 1981). In a final rulemaking, HCFA further noted that Congress expected it to "develop regulations that would increase States' discretion in setting payment rates" and to "employ a Federal review process which would be less administratively burdensome." 48 Fed. Reg. 56046 (Dec. 19, 1983). HCFA declined to define the term "efficiently and economically operated facility," reasoning that doing so "would unnecessarily intrude upon the legislatively mandated flexibility provided to States." *Id.* HCFA also noted that the term "reasonable and adequate" is "not a precise

number, but rather a rate which falls within a range of what could be considered reasonable and adequate." *Id.*

In 1997, in response to court decision which had distorted the Congressional purpose by reading into the Boren Amendment cost based standards for rate setting and burdensome procedural prerequisites to state rate-setting, Congress repealed the Boren Amendment, eliminating the remaining constraints on State payment methods. In place of these limits Congress substituted only a public notice requirement. Pub. L. No. 105-33, Title IV, Subtitle H, Ch. 2, § 4711(a) (1997). Once again, Congress opted for broad state flexibility in establishing payment methods. *See* H.R. Conf. Rep. No. 105-217, at 867-68 (1997); H.R. Rep. No. 105-149, at 590-91 (1997); 143 Cong. Rec. S. 4000 (May 6, 1997). In sum, the history of Section 1902(a)(13), extending over a 32-year period, reflects a consistent movement by Congress away from cost-based limits provider reimbursement standards amounting to an affirmative rejection of a cost-based limit on payment rates.

2. Congress Has Rejected Provider-Specific Reimbursement Limits. The proposed rule ignores this history and purports to impose cost-based limits not only for institutional providers who would be subject to the provisions of Section 1902(a)(13) but all other providers as well, under the asserted authority of Section 1902(a)(30)(A) of the Act. That provision also does not supply the needed statutory authority for CMS's proposal. First, reading a cost limit into Section 1902(a)(30)(A) would be inconsistent with the congressional amendments to Section 1902(a)(13), which, as explained above, actually constitute a rejection of such a limit. Second, even if Section 1902(a)(30)(A) could be read in a vacuum, it could not fill the gap in statutory authority for imposing provider-specific limits on reimbursement. Contrary to the view expressed by CMS in the preamble to the proposed rule, 72 Fed. Reg. 2241, the

payment of prospective rates that are not adjusted to actual costs is wholly consistent with Section 1902(a)(30)(A)'s requirement that payments be consistent with efficiency and economy, and the history of that statutory provision as well reflects a movement away from provider-specific limits on reimbursement.

Section 1902(a)(30), like Section 1902(a)(13), has a history of congressional relaxation of constraints on State flexibility and of administrative recognition of that flexibility. Section 1902(a)(30), enacted in 1968, originally required States to "provide such methods and procedures relating to . . . the payment for . . . care and services available under the plan as may be necessary . . . to assure that payments . . . are not in excess of reasonable charges consistent with efficiency, economy, and quality of care." Pub. L. No. 90-248, § 237 (1968).

In 1981, as part of the same act in which the Boren Amendment was extended to hospitals under § 1902(a)(13), Congress amended § 1902(a)(30) by striking the original requirement that payment not be "in excess of reasonable charges." Pub. L. No. 97-35, § 2174 (1981). As a result, the provision simply required State Medicaid plans to provide methods ensuring that "payments are consistent with efficiency, economy, and quality of care."

This change was designed to "remove[] medicare reasonable charge levels as a ceiling on medicaid payments," thereby "remov[ing] the administrative burdens this requirement of current law imposes on the States and . . . provid[ing] States with the flexibility to create incentives to improve the availability and utilization of physician services under medicaid." H.R. Rep. No. 97-158, vol. II, at 312. Congress intended that States be permitted to "be more creative and offer incentives for improved delivery of care" and to "structure their physician payment levels to build in incentives or bonuses for physicians who provide care in more cost effective arrangements." *Id.* at 313. Congress also sought to "help simplify" State Medicaid

administration, and to ease "development of a Statewide medicaid fee schedule," both of which goals had been greatly hampered by the Medicare reasonable charge limit. *Id.* at 312-13.

In the preamble to interim final regulations implementing the 1981 amendment, HCFA noted that before the amendment, States had complained that "[t]he requirement for States to make and apply their own reasonable charge calculations and to obtain and use Medicare reasonable charge data imposed unjustified administrative costs and burdens on States," and that "[t]he Medicare reasonable charges vary from physician to physician, and from locality to locality," so that "[t]heir use as Medicaid payment limitations has resulted in the States being unable to apply a single payment rate Statewide unless that rate is set at or below the lowest Medicare reasonable charge level in the State." 46 Fed. Reg. 48556 (Oct. 1, 1981). HCFA recognized that Congress eliminated the reasonable charge limit "because it was aware of [these problems], and in recognition of States' need for flexibility in their Medicaid programs." *Id.* It noted that "*Congress expects the removal of the administrative burdens imposed on States by the prior law* to improve States' administration of their Medicaid programs and to provide States with the flexibility needed to create incentives to improve the availability and utilization of physicians services under Medicaid," and it responded by altering the regulations to "remove all references to reasonable charge limits for noninstitutional services under Medicaid." *Id.* (emphasis added).

After Congress eliminated the "reasonable charges" language of Section 1902(a)(30), the Medicare-based UPLs for institutional services were retained, but States were not required to apply the limit on a provider-by-provider basis. 46 Fed. Reg. 47964 (Sept. 30, 1981). States were free to apply the limit on an aggregate rather than facility-specific basis, "in keeping with the congressional intent that the calculation of the limit not be an administrative

burden on States"; they could proceed on the basis of estimates; and they were free to use prospective payment systems that employed "efficiency incentives or profit for providers to the extent they do not, or did not, incur costs in excess of the predetermined payment rate." 48 Fed. Reg. 56046 (Dec. 19, 1983).

Over time, concerns arose as to the level of payments to certain facilities, even though the overall aggregate UPL was not exceeded, *see* 51 Fed. Reg. 5728 (Feb. 18, 1986) (proposed rule), and in particular, that States were overpaying State-operated facilities, *see* 52 Fed. Reg. 28141 (July 28, 1987) (final rule). The regulations were refined so that the UPLs were to be calculated separately for State-operated facilities as well as for each group of facilities (hospitals, SNFs, ICFs, and ICFs/MR)as a whole. *Id.* A subsequent modification required that three categories of facilities -- State-owned or operated, non-State government-owned or operated, and privately owned and operated -- be considered separately. 66 Fed. Reg. 3148 (Jan. 12, 2001).

Importantly, however, the UPL rules continued to be easily applied: they were still based on estimates and still applied on an aggregate basis. 52 Fed. Reg. 28141. Indeed, HCFA expressly stated: "We considered facility-specific limitations as a possible remedy to the problem of excessive payments, but elected instead to refine our aggregate UPLs. We believe our approach provides an appropriate balance between the needs of States to have flexibility in rate setting and our objective to protect the integrity of the Medicaid program." 66 Fed. Reg. at 3152. HCFA stressed that it "want[ed] to curtail unnecessary spending in a way that results in the least amount of burden administratively on the States and the Federal government," 67 Fed. Reg. 2602, 2607 (Jan. 18, 2002), and it reiterated that it had considered and rejected facility-specific UPLs because of the administrative burdens of such a scheme, *id.* at 2610.

In light of this history, Section 1902(a)(30)(A) cannot support a rule barring all payments to government providers in excess of their individual, actual costs.

Decisions of the Departmental Appeals Board ("Board") additionally confirm the lack of authority for CMS to hold government providers to a different standard than the one to which it holds private providers, or to limit government providers to actual-cost reimbursement. The agency has tried to invoke OMB Circular A-87 as a basis for an actual-cost limit on payments to public providers, and the Board has rejected these efforts, holding that States may employ prospective payment systems without retroactive adjustment based on actual costs, even for public providers. The Board has explicitly held that "the cost principles [do] not impose an actual cost ceiling on claims for reimbursement for medical assistance provided by state-owned [facilities]," and that a State does not impermissibly profit where its claim for FFP is based on the cost it incurs in reimbursing facilities according to a prospective class rate. *Ill. Dept. of Pub. Aid*, DAB No. 467 (1983); *see also Alaska Dept. of Health & Soc. Servs.*, DAB No. 1452 (1993) (reiterating that "[a] distinguishing characteristic of prospective rate systems is that there needs to be no retrospective adjustment to reflect the actual costs of providing services during the rate period," and noting that under the "incentive theory" contemplated by the prospective payment regime, providers may retain profits designed to encourage cost-control or efficient operation).

The Board has stated, in a case concerning prospective payments made to State-operated ICFs/MR, that "the prospective rate is an estimate; the expectation is that it will not correspond precisely to the actual costs incurred during the rate year by any specific provider." *S.D. Dept. of Soc. Servs.*, DAB No. 934 (1988). The Board held that these rates were not subject to later adjustment based on actual costs, and it found no "unauthorized profit or windfall" where "the rates paid by the State met the Boren Amendment standard and . . . in all but one year costs

exceeded reimbursement." *Id.* The Board has also repeatedly distinguished the costs incurred by providers from the rates charged by providers to the State, and it has held that the latter are what form the basis of the State's claims for expenditures. *See Ala. Dept. of Human Res.*, DAB No. 1220 (1991); *N.J. Dept. of Human Servs.*, DAB No. 1016 (1989). It has also held that there can be an expenditure "even though the amount paid to the State-owned providers came back to the State treasury." *Fla. Dept. of Health and Rehab. Servs.*, DAB No. 884 (1987).

Finally, it bears mentioning that the present Administration has repeatedly asked Congress to impose a cost-limit on payments to public providers, putting CMS's new claim that it possesses the authority to do the same through its own regulatory initiative on shaky ground. That Congress has refused to legislate as requested highlights this lack of authority.

In addition to lacking a statutory basis, the proposed rule would create serious threats to the vitality of State programs for providing medical assistance. The proposed rule would remove the greatest incentive for cost savings by government providers. It would also drastically increase administrative burdens for both providers and the State -- burdens that threaten to cause many of the most important health care providers in the nation to cease participating in Medicaid altogether.

Limiting payments to each government provider's individual costs would eliminate these providers' incentive to keep costs below any prospectively set rate, since they would have to relinquish the difference. Indeed, a public provider, faced with a situation where it can never win and can only lose (when its costs exceed the prospectively set rate) is certain either to withdraw from providing Medicaid services or to demand that reimbursement at least be made more fair by reimbursing all actual costs, even if these costs exceed a prospectively set rate. The proposed rule will effectively force States to return to a system of retrospective cost

reimbursement -- precisely the "inherently inflationary" system whose lack of "incentives for efficient performance" motivated the Boren Amendment in the first place. Sen. Rep. No. 96-471, at 28 (1979). The return to cost-based reimbursement for public providers will permit them to break even at best, while permitting costs to spiral ever upwards, to the detriment of those who fund these costs -- States, the federal government, and taxpayers -- and those on whom these funds might otherwise have been spent.

Moreover, the proposed rule's cost reporting requirements dramatically increase the administrative burden on providers. Although some hospitals and NFs may already be accustomed to cost reporting, many other providers -- particularly those that are small or non-institutional -- are not. The effort and expense of keeping track of all the costs of providing Medicaid services, and especially of keeping track of time, will be enormously burdensome on many providers. The problem will be particularly acute with public schools, community mental health clinics, and other relatively small providers with very limited resources. These providers are generally paid on a fee-based system, which is relatively simply and cheaply administered. The cost-based recordkeeping and reporting required of these providers under the proposed rule would be difficult and in many cases impossible for them to manage. Indeed, many of these modestly sized but crucially important providers, when faced with the disproportionate administrative costs of the proposed rule, may simply find it no longer worthwhile or even possible to continue providing Medicaid services.

This will be particularly true of public schools, which are critical providers of health care services to children needing health care services related to their special education needs. The time studies and record keeping associated with proving the costs of providing health services may be outside the negotiated contracts of the therapists and other professionals who

work with children at risk, and the inability to prove costs may deprive schools of this needed source of funds.

Finally, the proposed rule will impose excessive administrative costs on the States. The requirements that States perform interim and final cost reconciliations and that they review and verify cost reports impose a staggering level of monitoring and paperwork on States. This sort of provider-by-provider review will overwhelm State Medicaid agencies' already overburdened staff and resources. By contrast, the current UPL calculations that the States perform are based on aggregate data and are relatively easy to do. The current UPL regime is straightforward and effective. It recognizes that payments should not be limitless -- a proposition that the Commenting States do not contest. There is no need, and no statutory authority, for the UPL rules to be stricter for government providers than for private ones, to be applied on a provider-specific basis, and for this basis to be actual cost.

In sum, the cost limit not only will not save money, it will waste it. State efforts to encourage cost-savings by public providers will be crippled by a return to cost-based reimbursement and inflated costs. Even if the cost limit could generate any savings on reimbursement, these savings would be offset by the massive administrative costs that will be incurred both by States and by those providers that continue to participate in the Medicaid system. And the Medicaid beneficiaries currently served by small providers unable to afford these administrative costs will be left with fewer -- or no -- sources of medical assistance.

3. The Nominal Charge Hospital Provision Should Be Retained

Current section 447.271 of the CMS regulations establishes a separate upper payment limit for inpatient hospital services at the level of the provider's "customary charges to the general public for the services." But it contains an exception for public providers that

provide services "free or at a nominal charge" to permit payment to the level that would be set "if the provider's charges were equal to or greater than its costs." The proposed changes would retain the general prohibition on payment above customary charges but would delete the exception for nominal charge hospitals.

The Commenting States urge that, whatever else is done, the nominal charge exception be retained. That exception recognizes that there are many hospitals that primarily serve the poor and uninsured that have established low charge levels for the benefit of those patients who are without coverage and would otherwise by hit with large bills for hospital services. A hospital ought not be prejudiced in its Medicaid reimbursement because it is willing to keep the cost of hospital care within reason for those who do not have coverage from insurance or public programs.

4. The Transition Provisions of the Current Regulations Should Be Retained

Current sections 447.272 and 447.321 of the CMS regulations embody the transition provisions mandated by Congress in the Medicare, Medicaid & SCHIP Benefit Improvement and Protection Act of 2000 ("BIPA"), Pub. L. 106-554, when it required CMS to amend its Upper Payment Limit rules to establish separate limits for three different categories of providers. The statutory provision provides for gradual reduction of the previous Upper Payment Limit over transition periods as long as eight years. The last of the transition periods will not expire until September 30, 2008.

There is no indication in the Preamble that CMS intended any interference with the transition provisions of BIPA that are still extant, and it could not by regulation affect the statutorily-prescribed periods. Nonetheless, to avoid confusion and to assure that the regulations

fully conform to the statute, any revision should retain the transition provisions at least until the longest of the transition periods has expired.

IV. Retention of Payments (Proposed § 447.207)

CMS proposes to add a new regulation at 42 C.F.R. § 447.207 that would require "all providers" to "receive and retain the full amount of the total computable payment provided to them," either as a state plan payment or under a waiver. To assure compliance, the Secretary would retain the right to examine "any associated transactions" related to the payment to ensure that the "claimed expenditure" is "equal to the State's net expenditure, and that the full amount of the non-Federal share of the payment has been satisfied." CMS justifies this proposed regulation as needed to "strengthen efforts to remove any potential for abuse involving the re-direction of Medicaid payments by IGTs." It states that compliance would be demonstrated by a showing that the funding source of an IGT is "clearly separated from the Medicaid payment" received by a provider, which would generally be the case if the IGT occurs before the payment and originates from an account funded by taxes that is separate from the account "in which the health care provider receives Medicaid payments."

Comment: This proposal promises to be a continuing source of mischief, and is a paradigm example of overkill, for it proposes to cope with a perceived problem that has been largely if not completely eliminated already with an intrusive new federal rule that will likely prove to be as difficult to apply as it is for the agency to define.

To begin with, the proposed rule amounts to a weapon directed at a non-existent problem. CMS justifies the proposal as necessary to deal with what it refers to as "redirection" of Medicaid payments, or what it has more commonly come to describe as "recycling." While there is no specific definition of this term, and it has been employed loosely in recent times to cover various practices, some of which are entirely appropriate, the rationale of the preamble

appears to be focused on situations where payments are made to public providers that are substantially beyond their needs and which are accompanied by transfers of all or most of the payment amount back to the state. CMS has addressed, and effectively eliminated that potential over the past several years, through amendment to its Upper Payment Rules in 2001 to require separate limits for state government owned and operated, non-state government owned and operated, and private owned and operated providers, and by policies employed in the state plan approval process that withhold approval for payments to providers in which more than the non-federal share is proposed to be transferred back to the state. By using the plan approval process to deal with perceived "recycling" issues, CMS has been able to distinguish between benign transfers that do not present issues of concern, and those that CMS believes present problems.

The proposed regulation, by contrast, is a blunderbuss approach that would strike at unobjectionable transfers that raise no "recycling" issues, but rather represent normal dealings between different entities within a state. For example, it is common for states, or their political subdivisions, to provide full funding to their health care providers, in the expectation of receiving the federal portion back from the provider when it has been reimbursed for serving Medicaid patients (just as the provider remits payment from other payors to its funding agency). Transfers from the provider to the funding agency out of Medicaid payments in such situations are not inappropriate; yet, the proposed rule would prohibit them.

As written, the rule is so absolute that it literally would prevent a provider from using Medicaid payments to pay normal operating expenses, such as taxes, fees, and costs of government-provided goods and services. While presumably this is not the intent of the rule, the fact that it has this effect demonstrates both that it is ill-conceived and that any attempt of this

kind to regulate how providers use their Medicaid reimbursement will create far more problems than it will solve.

There is no legal justification for the proposed payment retention regulation. The only authority cited in the preamble is section 1903(a)(1), which provides for the payment of FFP in state expenditures, and the provisions of Circular A-87 relating to "applicable credits." From these sources the preamble draws the conclusion that "failure by the provider to retain the full amount of reimbursement is inappropriate and inconsistent with statutory construction that the Federal government pay only its proportional cost for the delivery of Medicaid services" and that where the provider transfers a portion of the payment to another governmental entity the "net expenditure" is reduced so that FFP in the claimed expenditure results in the federal government paying more than the FMAP rate calculated in accordance with the statute. 72 Fed. Reg. at 2238.

Yet the same preamble discussion says that only where the governmental-operated provider transfer to the State "more than the non-Federal share" is there a situation where the net payment is "necessarily reduced." Id. This justification is not consistent with the provisions of the proposed rule that would preclude *any* transfer to the State from the payment received by the provider.

This inconsistency in rationale points up the absence of legal authority for the proposed regulation, for whether the prohibition is meant to apply to any portion of the Medicaid payment or only to the federal portion, it lacks a basis in the statute. No provider retains the entirety of a reimbursement payment. Given the reimbursement nature of Medicaid FFP, there could not be a valid prohibition on the provider returning to the original source of its outlays the portion of the payment so advanced. And if at the end of an accounting period a governmental

provider has experienced a surplus, its arrangement with a sponsoring governmental authority likely would require that the surplus be transferred to that authority. Nothing in the law would authorize CMS to proscribe any such transfers; yet that is what its proposed rule would do.

The proposed retention rule manages to sweep far too broadly while at the same time being unnecessary to deal with the one narrow situation that CMS says is the reason for the rule. The proposal should be withdrawn in its entirety.

V. Effect of the Proposed Rules on Demonstration Waivers (Preamble, page 2240)

The Preamble to the proposed rules states that "the provisions of this regulation" apply to all Medicaid payments (including disproportionate share hospital payments) "made under the authority of the State plan and under Medicaid waiver and demonstration authorities."[2]

Comment: Special mention is required of the preamble statement that the regulations will apply to demonstration waivers (including those under section 1115 of the Act), in light of assurances that have been provided to some state officials that the proposed rules would not affect their currently-outstanding 1115 waiver programs. Those assurances have appeared to be inconsistent not only with the preamble statement referred to above, but also with the terms and conditions of the waivers, which generally provide that the waiver program will be modified to conform to changes in applicable law and regulations.

The proposed regulations, were they to be adopted, promise to be very disruptive of existing waiver programs. Several states have made major commitments to funding arrangements authorized by 1115 waivers that rely, for example, on certification of expenditures by public entities that may not satisfy the extremely restrictive definitions in the proposed rules

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[2] There is an exception for the cost limit provision for Medicaid managed care organizations and SCHIP providers.

of those entitled to certify expenditures. Many utilize payment methodologies for providers, including public providers, that are not necessarily confined to the providers' costs. There are approved waiver programs that embody expected transfers by providers of portions of the payments received. And it is common for these programs, as for Medicaid programs generally, to rely on sources other than state and local taxes to provide the non-federal share of expenditures.

Thus, were the proposed rules to be adopted, they would seriously impair the viability of 1115 waiver programs currently in place. Moreover, because these programs are all subject to time-limited authorizations, requiring periodic renewal, states with such waivers would have no assurance that they would obtain renewal of their programs, no matter how successful, without complying with the proposed regulations, which could well undermine the entire basis for the waiver program.

Demonstration waivers have proved themselves to be a vital and worthwhile aspect of the Medicaid program, and have been a prime source for testing new ways for delivering services and financing the program. The continued success of this avenue for innovation depends on opportunity to escape from programmatic requirements that can stifle initiative and block improvements. Nothing would more undermine the effectiveness of this excellent means of implementing program change than to impose new and restrictive financing rules on projects after they have been developed, reviewed, approved and initiated.

While the Commenting States firmly believe that the entire rulemaking proposal is ill-conceived and should be abandoned, at the very least the rules should expressly be made inapplicable to any currently-operating demonstration program under section 1115, for as long as that program remains in effect, including through subsequent renewal periods.

Conclusion

The proposed rules are not necessary to deal with any perceived imperfections in or unanticipated effects of the current method of financing the Medicaid program throughout the states. Rather, they represent a reversal of the way in which Medicaid has been financed from the time of the program's inception through repeated Congressional review and amendment over the past 40 years. If adopted, they would force substantial disruption of the program and would surely lead to a reduction in resources available to support the delivery of basic health care to those the Medicaid program was intended to serve.

A proposal with these characteristics is not worthy of serious consideration. The Commenting States urge CMS to abandon it, and to disavow the unsupportable premises on which it is predicated.

Respectfully submitted,

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On behalf of the States of Alaska, Connecticut, Illinois, Louisiana, Maine, Maryland, Michigan, Missouri, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, Tennessee, Utah, Washington and Wisconsin

March 19, 2007

Submitter : Mr. George Miller **Date:** 03/19/2007

Organization : National Rural Health Association

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-267-Attach-1.PDF

#267

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March 19, 2007

Leslie Norwalk, Esq., Acting Administrator
Centers for Medicare & Medicaid Services
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Delivered Via On-Line Form: *http://www.cms.hhs.gov/eRulemaking*

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

Dear Administrator Norwalk:

The National Rural Health Association (NRHA) appreciates the opportunity to comment on the impact of the Centers for Medicare and Medicaid Services' above referenced Proposed Rule on the nation's health system and the Medicaid program. We look forward to working with you on our mutual goals of improving access and quality of health care for all rural Americans, while making sure that the Proposed Rule does not have a negative impact on the unique circumstances of rural public health providers.

The NRHA is a national nonprofit membership organization with over 11,000 members that provides leadership on rural health issues. The Association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

The NRHA endorses CMS' stated goal of ensuring accountability and protecting the fiscal integrity of the Medicaid program. Rural Americans tend to be older, poorer, and have higher incidences of disabilities and long-term health problems such as diabetes. It is therefore no surprise that rural America disproportionately relies on the Medicaid program, which provides health coverage for fifteen percent of rural Americans compared to eleven percent of urban Americans. An accountable and fiscally strong Medicaid program is essential for health coverage of rural Americans.

However, the NRHA has serious concerns that the Proposed Rule will have a very serious affect on the ability of rural safety net providers to serve Medicaid patients and the uninsured while also providing many essential, community-wide services. The harm that may be inflicted on the rural health safety net by this rule could also inflict fiscal crises on many states and increase the

numbers of uninsured, at a time when we should be searching for ways to improve access and coverage.

In addition, the NRHA is not convinced that the Proposed Rule is necessary to fix the stated goal of ensuring accountability and fiscal integrity of the Medicaid program. Over the years, Congress and CMS have taken a series of steps to advance these goals with respect to both provider payments and nonfederal share financing. These efforts have included restrictions on provider taxes and donations, statewide and hospital-specific limitations on Disproportionate Share Hospital (DSH) payments and a series of modifications to regulatory upper payment limits. Over the last three years, CMS has significantly increased its oversight of payment methodologies and financing arrangements in state Medicaid programs, working with states to restructure their programs as necessary to eliminate inappropriate federal matching arrangements. Officials from the Department of Health and Human Services (HHS) have repeatedly claimed success from this initiative, stating that they have largely eliminated "recycling" from those programs under scrutiny. Indeed, since the publication of the Proposed Rule, it is our understanding that CMS provided to Members of Congress data indicating that there are only three states about which CMS has any remaining concerns of recycling intergovernmental transfers (IGTs).

Clearly the steps taken by Congress and CMS to date have addressed the concerns CMS has raised about state financing mechanisms and it is unclear why CMS feels the need to proceed with this rulemaking. It seems to the NRHA that this goal can be accomplished by working with the three remaining states to make sure that they are appropriately using Federal funding in their system. Nor does the agency explain how the restrictive policies in the Proposed Rule will further its stated goals. Instead, the Proposed Rule imposes payment and financing policies that go far beyond merely institutionalizing the oversight procedures CMS has used successfully to date. These policies would cut deep into the heart of Medicaid as a safety net support program with no measurable increase in fiscal integrity.

In its Regulatory Impact Analysis, CMS asserts that the Proposed Rule will not have a significant impact on providers and projects "this rule's effect on actual patient services to be minimal." It estimates $3.9 billion in federal savings from the Proposed Rule over five years, but provides no detail on how it derived this estimate. From a National Association of Public Hospitals' survey, it is clear that CMS has significantly understated the impact of the Proposed Rule on providers, on patients and on total federal Medicaid funding provided to states. For example, the estimated statewide loss of federal dollars for public hospitals is at least $932 million in Florida, $253 million in Georgia, $350 million in New York and $374 million in Texas. This is disconcerting to the NRHA, as our own analysis has shown that two-thirds of government hospitals nationwide (either with a hospital district, hospital authority, or county governance) are in non-metropolitan areas. Many of these hospitals already are at a very small margin and elimination of these funds could have a devastating effect on their ability to continue to provide care for small rural communities.

In addition to these general concerns about the necessity of the Proposed Rule and its negative effect on rural safety net providers, we have specific concerns about the (1) cost limit on Medicaid payments to governmental providers, (2) the new and restrictive redefinition of a "unit of government" and (3) the restrictions on sources of non-federal share funding. After

addressing each of these concerns, the NRHA makes suggestions to CMS on how to move forward with the Proposed Rule.

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

The NRHA is concerned by the new cost limit for providers operated by units of government from the Medicaid system. Rather than adopting a narrowly tailored solution to identified concerns with inappropriate Medicaid financing practices, CMS proposes to impose a cost limit on governmental providers that is simply a funding cut. As previously stated, according to CMS' own data, it has largely eliminated the "recycling" that the cost limit purports to address. Even if recycling were occurring, however, a cost limit would not eliminate it; it would simply limit the net funding for governmental providers.

In proposing the new cost limit, and asserting that it is necessary to ensure economy and efficiency in the program, CMS is effectively stating that the current limit, based on Medicare rates, is unreasonable. This statement is surprising since CMS and Congress have put substantial effort into creating the Medicare payment system. At the same time, this claim is contradicted by CMS allowing the very same limit in the Medicaid system for private providers. Yet, government run facilities are much more likely (government facilities make up 2 percent of all hospitals in the nation but provide 25 percent of the uncompensated care) to provide care for Medicaid and uninsured patients.

The NRHA is concerned that this payment cut will hinder the ability of rural governmental hospitals to continue to operate. In some areas these organizations are in competitive marketplaces, where they cannot simply survive by breaking even. These hospitals need revenue to invest in the future, establish a reserve fund, and access capital. Other rural governmental hospitals are already running at a negative margin. Loss of these funds may be the proverbial last straw or at the very least put further strain on rural communities to provide funding. This comes as the administration calls on providers to improve quality and access and to invest in important new technology. Now is not the time to impose unnecessary funding cuts on rural governmental providers.

Recommendation: CMS should withdraw the cost limit for governmental providers and allow upper payment limits based on Medicare payment principles for all categories of providers.

New and Restrictive Redefinition of a "Unit of Government" (§ 433.50)

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

As cost in the health care system has grown, state and local governments have become less willing and able to provide open-ended taxpayer funding to ensure access to health care services. Many local governments that had previously operated public hospitals as integrated governmental agencies began searching for new ways to organize and operate these entities. In doing so, they did not want to diminish their commitment to meeting the health care needs of their residents. Many state and local governments restructured their public hospitals to provide them more autonomy and equip them to better control costs and compete in a managed care environment while remaining responsive to the local government.

The Proposed Rule's definition of a unit of government runs exactly counter to this decades-long trend in the provision of governmental health care. Under the Proposed Rule, only the most traditional of public hospitals would qualify as a governmental entity capable of contributing to the non-federal share of Medicaid funding. Others simply would not be deemed an "integral part" of a unit of government with taxing authority under the strict criteria set forth in the Proposed Rule. The rule would undermine the efforts of state and local governments to deliver public health care services more efficiently and effectively, and penalize those that have reduced their reliance on taxpayer support. Perversely, facilities that have been forced to operate efficiently would be punished, while hospitals with unlimited taxpayer support would be unharmed by this Proposed Rule.

In addition, we question CMS' authority to redefine a "unit of government." Title XIX of the Social Security Act, Section 1903(w)(7)(G) defines a "unit of local government," in the context of contributing to the non-federal share of Medicaid expenditures, as "a city, county, special purpose district, or other governmental unit in the State." Congress never qualified a unit of government on an entity's access to public tax dollars. Rather, Congress' formulation, which includes an "other governmental unit in the State," provides appropriate deference to the variety of governmental structures into which a state may organize itself. In narrowing this statutory definition, without instruction by Congress, CMS has eliminated the deference to states underlying the statutory formulation. In addition to ignoring federal law, CMS is violating the very basis of the Medicaid system, a federal-state partnership, which is vital in maintaining access to rural health care services.

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

Restrictions on Sources of Non-Federal Share Funding (§ 433.51 (b))

Traditionally, states have been able to rely on public funds contributed by governmental entities, regardless of the source of the public funds. As long as funds were contributed by a governmental entity, they were considered to be public and a legitimate source of Medicaid funding.

The Proposed Rule rejects the idea that all funds held by a public entity are public, notwithstanding a large body of state law to the contrary. Rather, the regulation would establish a hierarchy of public funds, and only funding from taxes would be allowed to fund Medicaid

expenditures while those derived from other governmental functions (such as providing patient care services through a public hospital) would be rejected.

In imposing this new restriction on the source of IGTs, CMS is again exceeding its Congressionally delegated authority. Section 1902(a)(2) of the SSA allows states to rely on "local sources" for up to 60 percent of the non-federal share of program expenditures. This provision does not limit the types of local sources that may be used. When Congress has intended to restrict such local sources, it has rejected CMS' attempts to impose limits by regulation and has insisted on legislating the limits itself. For example, in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Congress adopted significant restrictions on sources of local funding, but did so by statute after imposing a series of moratoria on HHS' attempts to restrict local sources of funding administratively. CMS is without legal authority to insist that local funding from units of government be limited to tax dollars only.

The combination of adopting a restrictive definition of a unit of government and then further restricting the source of funds that can be transferred by entities that meet the strict unit of government test will leave state Medicaid programs, including important supplemental payment programs that support the health care safety net, starved for resources, especially in rural communities that have less of an ability to make up these funds than larger urban settings.

Recommendation: CMS should allow all public funding to be used as the non-federal share of Medicaid expenditures.

Conclusions

The NRHA believes that CMS should reevaluate the necessity of the Proposed Rule and reconsider CMS' estimate of the impact of the Proposed Rule. Based on CMS' stated intentions of ensuring accountability and fiscal strength within the Medicaid system, the NRHA does not see the necessity of this Proposed Rule when only three states remain on CMS' list of those with problematic recycling practices. It seems that CMS should be able to work with the remaining states to reform their systems without this Proposed Rule as this can have large negative effects on rural governmental providers. It is our belief that the Proposed Rule should be withdrawn.

If, however, CMS moves forward with the Proposed Rule, we strongly urge that CMS delay implementation and begin a dialogue with state governments and the governors now to implement the Proposed Rule with less hardship. The September 1, 2007 effective date for the new cost limit is not achievable for a successful implementation. An effective date for other portions of the regulation is not provided but we are concerned that many states will need to overhaul their provider payment systems and plug large budgetary gaps from the required changes in non-federal share financing. State plan amendments will need to be developed, vetted with the public, submitted to CMS and approved, which has historically taken at least 180 days. By the time a final rule is published, states will have long finalized budgets and funding levels through, in some cases, the end of FY 2008. Making it more difficult, some states will not be in

session before the implementation date. Taken together, the September 1, 2007 effective date will not be achievable.

Thank you for your consideration of these comments. We look forward to continuing our work together to mutual goals of improving access and quality of health care for all rural Americans. If you would like additional information, please contact Amy Elizondo, Vice President of Program Services, or Tim Fry, Government Affairs Manager, at 703-519-7910.

Sincerely,

George Miller
President

Submitter : Raymond Scheppach **Date:** 03/19/2007

Organization : National Governors Association

Category : Other Association

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

"See Attachment"

GENERAL

GENERAL

"See Attachment"

CMS-2258-P-268-Attach-1.PDF

#268

NATIONAL GOVERNORS ASSOCIATION

Janet Napolitano
Governor of Arizona
Chair

Tim Pawlenty
Governor of Minnesota
Vice Chair

Raymond C. Scheppach
Executive Director

March 19, 2007

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

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:

On behalf of the nation's governors, we request that you withdraw proposed rule CMS-2258-P, which was published on January 18, 2007. Governors recognize the importance of a strong state-federal partnership in the Medicaid program. However, the Medicaid administrative changes contained in the proposed rule [CMS-2258-P] are a significant cost shift to states that governors strongly oppose. The proposed policies represent a significant Medicaid policy change that will result in cuts of approximately $5 billion in federal Medicaid spending over five years and will have a significant impact on state funding for Medicaid.

The proposed rule includes imposing a cost limit for public health care providers and altering the definition of "public" status. These fundamental policy changes would diminish long-standing, legitimate state funding mechanisms that the Centers for Medicare and Medicaid Services (CMS) has previously approved. Such changes in state plans would also impose a huge administrative burden on states, providers and school-based health clinics. In addition, the proposals overstep statutory authority by defining what subunits of state government may contribute to and what financing sources states may utilize in financing the non-federal share of Medicaid - discretion that has been left to state governments since Medicaid was created in 1965. These proposals would further impede our progress in implementing reform options and expanding affordable health insurance coverage.

Last year, the governors, in addition to 300 bipartisan members of Congress and 55 Senators sent letters to Secretary Leavitt urging that he not move forward via the regulatory process with the proposed cuts. Despite these objections, we are now faced with a proposed rule, which is slated to go into effect on September 1, 2007. Therefore, governors urge you to withdraw the proposed rule.

Sincerely,

Raymond C. Scheppach

Hall of the States · 444 North Capitol Street · Suite 267 · Washington, D.C. 20001-1512
Telephone (202) 624-5300 · Fax (202) 624-5313 · www.nga.org

Submitter : Ms. Sally Smith **Date:** 03/19/2007

Organization : National Indian Health Board

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-269-Attach-1.PDF

#269

NATIONAL INDIAN HEALTH BOARD

101 Constitution Ave. N.W., Suite 8-B02 • Washington, DC 20001
Phone: (202) 742-4262 • Fax: (202) 742-4285
Website: www.nihb.org

March 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

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

Dear Ms. Norwalk:

As Chairman and on behalf of the National Indian Health Board (NIHB), I 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.

Established in 1972, the NIHB serves all Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments by advocating for the improvement of health care delivery to AI/ANs, as well as upholding the Federal government's trust responsibility to AI/AN Tribal governments. We appreciate the opportunity to comments on these rules.

Statements made by the Acting Administrator, Deputy Administrator and other CMS officials during the most recent meeting of the Tribal Technical Advisory Group (TTAG) 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 (SMD) 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 the Indian Health Service (IHS) resulting in an October 18, 2005, 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 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 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:

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[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, SMD 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").

(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 SMD 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. 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 IHS 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,

H. Sally Smith, Chairman
National Indian Health Board

Cc: NIHB Board Members
Area Health Boards
Tribal Technical Advisory Group (TTAG)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #05-004

October 18, 2005

Dear State Medicaid Director:

A number of States and Tribal organizations have asked whether expenditures that are certified by Tribal organizations can be used to fulfill State matching requirements for administrative activities under the Medicaid program. In considering this question, the Centers for Medicare & Medicaid Services (CMS) took into account the fact that Tribal organizations may have governmental responsibilities when operating on behalf of Tribal governments. Additionally, CMS considered the possible occurrence of duplicate payment when the same entity is paid under an agreement to perform Medicaid State administrative activities and as a provider for Medicaid services. This letter describes CMS' policy regarding the conditions under which Tribal organizations can certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services directly provided by such entities.

Pursuant to Federal law, the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, as amended, permits Indian Tribes to directly operate health programs that furnish covered Medicaid services under a contract or compact with the Indian Health Service (IHS). Several States have contracted with Tribes to perform certain allowable Medicaid administrative functions and, as units of government, the Tribes certify actual expenditures related to these activities to the State. The activities performed include, among other things, outreach and application assistance for Medicaid enrollment and activities that ensure appropriate utilization of Medicaid services by Medicaid beneficiaries. The contract language ensures that expenditures certified for administrative costs do not duplicate, in whole or in part, claims made for the costs of direct patient care. The State uses the certified expenditures in its Federal financial participation (FFP) claims for State Medicaid administration activities.[1]

Section 1903(w)(6)(A) of the Social Security Act (the Act) specifies that the Secretary may not restrict a State's use of funds where such funds are derived from State or local taxes (or funds appropriated to State teaching hospitals) transferred from, or certified by, units of government within a State as the non-Federal share of Medicaid expenditures, regardless of whether the unit of government is also a health care provider under the State plan, unless the transferred funds are derived from donations or taxes that would not otherwise be recognized as the non-Federal share. Under this provision, only certified public expenditures from units of government are protected.

[1] Federal funds may not be used to meet State matching requirements, except as authorized by Federal law. Although Federal IHS funds awarded under ISDEAA may be used to meet Tribal matching requirements, that authority does not include State matching requirements. As a result, Tribal expenditures certified for this purpose must be funded through non-ISDEAA sources.

Regulations at 42 CFR section 433.51 permit certified public expenditures from public agencies, specifically including Indian Tribes, to be used as the non-Federal share of expenditures. However, these regulations do not address Tribal organizations.

It is not the intent of this letter to expand the scope of transactions protected under section 1903(w)(6)(A) of the Act or the regulations at 42 CFR section 433.51. However, it is CMS' position that when federally recognized Indian Tribes coalesce for a common purpose, that collective effort should be afforded the same rights, privileges, protections, and exemptions as the individual Tribes themselves.[2] This status extends to Tribal organizations formed solely by, wholly owned by or comprised of, and exclusively controlled by Indian Tribes, as currently defined in section 4(e) of ISDEAA. This section defines "Indian Tribe" to mean any Indian Tribe, band, nation, or other organized group or community, including any Alaska Native village or a regional or village corporation as defined in, or established pursuant to, the Alaska Native Claims Settlement Act, which are recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Some Indian Tribes, either alone or jointly with other Indian Tribes, operate health programs indirectly through separate Tribal organizations. The organizational structure of the Tribal organizations, as well as the designation of authority and responsibilities by the Tribes to the Tribal organizations, varies among Tribes and Tribal organizations. When the IHS enters into an ISDEAA contract or compact with a Tribal organization, the IHS engages in a detailed process of certifying that the Tribal organization meets the ISDEAA statutory requirements. The governing body of the Tribal organization must be composed solely of members of Indian Tribes. Each Tribe represented by the Tribal organization must have passed a resolution authorizing the Tribal organization to act on its behalf. ISDEAA requires that the contracting or compacting Tribal organization compute its costs in accordance with the cost principles for State, local, and Indian Tribal governments contained in the Office of Management and Budget (OMB) Circular A-87. Additionally, ISDEAA requires that the Tribal organization comply with the provisions of the Single Audit Act (31 U.S.C., Chapter 75). Therefore, reliance on the IHS certification process for approval of ISDEAA contracts and compacts will prevent duplication of some of the efforts necessary to determine—by CMS standards—whether an entity is a unit of government.

Some Tribal organizations that receive IHS funding do not operate solely on behalf of Tribal governments. A Tribal organization that is not formed wholly by Indian Tribes, as discussed above, may be authorized to act on behalf of Tribal governments, may receive IHS grant funds on behalf of such governments, and may be accorded the rights of such governments for many purposes. However, unless a Tribal organization is either the recognized governing body of an Indian Tribe, or an entity which is formed solely by, wholly owned by or comprised of, and

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[2] See Dille v. Council of Energy Resource Tribes, 801 F.2d 373 (10th Cir. 1986).

exclusively controlled by Indian Tribes, as defined above, it is not a unit of government for Medicaid purposes.

Because of the variations in the organization, nature, function, responsibilities, and fiscal arrangements between Tribes and Tribal organizations, CMS has developed a set of criteria for use in analyzing whether a Tribal organization is acting as a unit of government and incurs expenditures of State plan administration that are eligible for Federal matching funds. All of these criteria must be met for recognition of certified public expenditures for administration of the State plan by a Tribal organization. If you choose to enter into a contractual arrangement for certification of expenditures for Medicaid administrative activities by a Tribal organization which meets the criteria set forth below, please ensure that your agreements are structured such that you do not contract out any Medicaid administrative functions that Federal or State law and regulations require that the State government itself perform. Assure that the activities covered by the contract are not already being offered or provided by other entities or through other programs and will not otherwise be paid for as a Medicaid administrative cost. In addition, if the Tribal organization is also a direct provider of health care services, the contract language must ensure that activities that are integral parts or extensions of direct medical services, such as patient follow-up, patient assessment, patient education, or counseling, are not included in the claims for Medicaid administration. Finally, the costs of any subcontracts by the Tribal organization to non-governmental entities are not to be included in the FFP claims for which certification is made.

CRITERIA FOR RECOGNITION OF TRIBAL ORGANIZATION EXPENDITURES AS THE NON-FEDERAL SHARE OF MEDICAID ADMINISTRATION CLAIMS:

1. The Tribal organization is 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 IHS pursuant to the ISDEAA (P.L. 93-638), as amended.

2. The Tribal organization is either the recognized governing body of an Indian Tribe, or an entity which is formed solely by, wholly owned by or comprised of, and exclusively controlled by Indian Tribes, as defined in Section 4 of the ISDEAA (P.L. 93-638), as amended.

3. The Tribal organization has contracted with the State Medicaid agency to perform specified State Medicaid administrative activities and certify as public expenditures only its actual costs (computed in accordance with applicable provisions of OMB Circular A-87) of allowable administrative activities performed pursuant to its contract with the State Medicaid agency.

4. The expenditures for allowable administrative activities which are certified by the Tribal organization are made with Tribal sources of revenue other than Medicaid revenues or ISDEAA funds.

Attached is a list of Tribal organizations with current ISDEAA Title I contracts or Title V compacts that have been identified by IHS as meeting the criteria listed above (Attachment A). This list is subject to change as new Tribal organizations contract or compact with IHS on a yearly basis. In addition to the attached list of Tribal organizations, for those Tribal organizations which are the recognized governing body of an Indian Tribe, please refer to the Department of the Interior's list of federally Recognized Tribes. The most recent listing, a copy of which is attached (Attachment B), was published on December 5, 2003, in the *Federal Register* (67 *Fed. Reg.* 68180). Proof of current ISDEAA contractor status should be included in the agreement approval process established by each State.

Prior to claiming FFP for expenditures for which a Tribal organization certifies the funds, the State must submit a written statement to the jurisdictional CMS regional office, certifying that the State reviewed the organization and that it meets all of the criteria specified in this letter. Please note that the source of funds used by Tribal organizations to represent expenditures eligible for FFP must be documented to CMS upon its request.

If you have questions regarding this matter, please contact Mr. Ed Gendron at (410) 786-1064.

Sincerely,

/s/

Dennis G. Smith
Director

Attachments

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Sandy Bourne
Legislative Director
American Legislative Exchange Council

Lynne Flynn
Director for Health Policy
Council of State Governments

Dr. Charles W. Grim, D.D.S., M.H.S.A.
Director
Indian Health Service

H. Sally Smith
Chairperson
National Indian Health Board

Valerie Davidson
Chairperson
CMS Tribal Technical Advisory Group

Attachment A

Title I Contractors
Tribal Organizations

Title I Tribal Organizations*

Alamo Navajo School Board, Inc.
Albuquerque Area Indian Health Board
All Indian Pueblo Council, Inc.
California Rural Indian Health Board (CRIHB)
Central Valley Indian Health, Inc.
Chapa-De Indian Health Program, Inc.
Consolidated Tribal Health Project, Inc.
Cook Inlet Tribal Council, Inc.
Eight Northern Indian Pueblo Council
Fairbanks Native Association
Feather River Tribal Health, Inc.
Great Lakes Inter-Tribal Council
Healing Lodge of Seven Nations
Indian Health Council
Lake County Tribal Health Consortium, Inc.
Mariposa, Amador, Calaveras, Tuolumne (MACT)
Indian Health Board, Inc.
Northern Valley Indian Health
NW Portland Area Indian Health Board
Ramah Navajo School Board, Inc.
Sierra Tribal Consortium
Sonoma County Indian Health
Southern Indian Health Council
South Puget Intertribal Planning Agency
Toiyabe Indian Health Project
Ukpeagvik Inupiat Corporation
United Indian Health Services
United South and Eastern Tribes, Inc.
United Tribes Technical College
Valdez Native Tribe

*** This list will be updated periodically.**

Title V Compactors
Tribal Organizations

Title V Tribal Organizations*

Alaska Native Tribal Health Consortium (ANTHC)
Aleutian Pribilof Islands Association, Inc.
Arctic Slope Native Association, Ltd.
Bristol Bay Area Health Corporation
Chugachmiut
Copper River Native Association
Council of Athabascan Tribal Governments
Eastern Aleutian Tribes, Inc.
Ketchikan Indian Community
Kodiak Area Native Association
Maniilaq Association
Metlakatla Indian Community
Miami Health Consortium
Mount Sanford Tribal Consortium
Native Village of Eklutna
Northeastern Tribal Health System
Norton Sound Health Corporation
Riverside-San Bernadino County Indian Health, Inc.
Seldovia Village Tribe
Southcentral Foundation
SouthEast Alaska Regional Health Consortium (SEARHC)
Tanana Chiefs Conference, Inc.
Yakutat Tlingit Tribe
Yukon-Kuskokwim Health Corporation

* This list is updated periodically.

Federal Register

Friday,
December 5, 2003

Part III

Department of the Interior

Bureau of Indian Affairs

Indian Entities Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs; Notice

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Indian Entities Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: Notice is hereby given of the current list of 562 tribal entities recognized and eligible for funding and services from the Bureau of Indian Affairs by virtue of their status as Indian tribes. This notice is published pursuant to section 104 of the Act of November 2, 1994 (Pub. L. 103–454; 108 Stat. 4791, 4792).

FOR FURTHER INFORMATION CONTACT: Daisy West, Bureau of Indian Affairs, Division of Tribal Government Services, MS–320-MIB, 1849 C Street, NW., Washington, DC 20240. Telephone number: (202) 513–7641.

SUPPLEMENTARY INFORMATION: This notice is published in exercise of authority delegated to the Assistant Secretary—Indian Affairs under 25 U.S.C. 2 and 9 and 209 DM 8.

Published below is a list of federally acknowledged tribes in the contiguous 48 states and in Alaska. The list is updated from the notice published on July 12, 2002 (67 FR 46328).

Several tribes have made changes to their tribal name. To aid in identifying tribal name changes, the tribe's former name is included with the new tribal name. We will continue to list the tribe's former name for several years before dropping the former name from the list. We have also made several corrections. To aid in identifying corrections, the tribe's previously listed name is included with the tribal name.

The listed entities are acknowledged to have the immunities and privileges available to other federally acknowledged Indian tribes by virtue of their government-to-government relationship with the United States as well as the responsibilities, powers, limitations and obligations of such tribes. We have continued the practice of listing the Alaska Native entities separately solely for the purpose of facilitating identification of them and reference to them given the large number of complex Native names.

Dated: November 21, 2003.

Aurene M. Martin,

Principal Deputy Assistant Secretary—Indian Affairs.

Indian Tribal Entities Within the Contiguous 48 States Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs

Absentee-Shawnee Tribe of Indians of Oklahoma
Agua Caliente Band of Cahuilla Indians of the Agua Caliente Indian Reservation, California
Ak Chin Indian Community of the Maricopa (Ak Chin) Indian Reservation, Arizona
Alabama-Coushatta Tribes of Texas
Alabama-Quassarte Tribal Town, Oklahoma
Alturas Indian Rancheria, California
Apache Tribe of Oklahoma
Arapahoe Tribe of the Wind River Reservation, Wyoming
Aroostook Band of Micmac Indians of Maine
Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana
Augustine Band of Cahuilla Mission Indians of the Augustine Reservation, California
Bad River Band of the Lake Superior Tribe of Chippewa Indians of the Bad River Reservation, Wisconsin
Bay Mills Indian Community, Michigan
Bear River Band of the Rohnerville Rancheria, California
Berry Creek Rancheria of Maidu Indians of California
Big Lagoon Rancheria, California
Big Pine Band of Owens Valley Paiute Shoshone Indians of the Big Pine Reservation, California
Big Sandy Rancheria of Mono Indians of California
Big Valley Band of Pomo Indians of the Big Valley Rancheria, California
Blackfeet Tribe of the Blackfeet Indian Reservation of Montana
Blue Lake Rancheria, California
Bridgeport Paiute Indian Colony of California
Buena Vista Rancheria of Me-Wuk Indians of California
Burns Paiute Tribe of the Burns Paiute Indian Colony of Oregon
Cabazon Band of Mission Indians, California (previously listed as the Cabazon Band of Cahuilla Mission Indians of the Cabazon Reservation)
Cachil DeHe Band of Wintun Indians of the Colusa Indian Community of the Colusa Rancheria, California
Caddo Nation of Oklahoma (formerly the Caddo Indian Tribe of Oklahoma)
Cahuilla Band of Mission Indians of the Cahuilla Reservation, California
Cahto Indian Tribe of the Laytonville Rancheria, California
California Valley Miwok Tribe, California (formerly the Sheep Ranch Rancheria of Me-Wuk Indians of California)
Campo Band of Diegueno Mission Indians of the Campo Indian Reservation, California
Capitan Grande Band of Diegueno Mission Indians of California:
Barona Group of Capitan Grande Band of Mission Indians of the Barona Reservation, California
Viejas (Baron Long) Group of Capitan Grande Band of Mission Indians of the Viejas Reservation, California
Catawba Indian Nation (aka Catawba Tribe of South Carolina)
Cayuga Nation of New York
Cedarville Rancheria, California
Chemehuevi Indian Tribe of the Chemehuevi Reservation, California
Cher-Ae Heights Indian Community of the Trinidad Rancheria, California
Cherokee Nation, Oklahoma
Cheyenne-Arapaho Tribes of Oklahoma
Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota
Chickasaw Nation, Oklahoma
Chicken Ranch Rancheria of Me-Wuk Indians of California
Chippewa-Cree Indians of the Rocky Boy's Reservation, Montana
Chitimacha Tribe of Louisiana
Choctaw Nation of Oklahoma
Citizen Potawatomi Nation, Oklahoma
Cloverdale Rancheria of Pomo Indians of California
Cocopah Tribe of Arizona
Coeur D'Alene Tribe of the Coeur D'Alene Reservation, Idaho
Cold Springs Rancheria of Mono Indians of California
Colorado River Indian Tribes of the Colorado River Indian Reservation, Arizona and California
Comanche Nation, Oklahoma (formerly the Comanche Indian Tribe)
Confederated Salish & Kootenai Tribes of the Flathead Reservation, Montana
Confederated Tribes of the Chehalis Reservation, Washington
Confederated Tribes of the Colville Reservation, Washington
Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians of Oregon
Confederated Tribes of the Goshute Reservation, Nevada and Utah
Confederated Tribes of the Grand Ronde Community of Oregon
Confederated Tribes of the Siletz Reservation, Oregon
Confederated Tribes of the Umatilla Reservation, Oregon
Confederated Tribes of the Warm Springs Reservation of Oregon
Confederated Tribes and Bands of the Yakama Nation, Washington (formerly

the Confederated Tribes and Bands of the Yakama Indian Nation of the Yakama Reservation)
Coquille Tribe of Oregon
Cortina Indian Rancheria of Wintun Indians of California
Coushatta Tribe of Louisiana
Cow Creek Band of Umpqua Indians of Oregon
Cowlitz Indian Tribe, Washington
Coyote Valley Band of Pomo Indians of California
Crow Tribe of Montana
Crow Creek Sioux Tribe of the Crow Creek Reservation, South Dakota
Death Valley Timbi-Sha Shoshone Band of California
Delaware Nation, Oklahoma (formerly the Delaware Tribe of Western Oklahoma)
Delaware Tribe of Indians, Oklahoma
Dry Creek Rancheria of Pomo Indians of California
Duckwater Shoshone Tribe of the Duckwater Reservation, Nevada
Eastern Band of Cherokee Indians of North Carolina
Eastern Shawnee Tribe of Oklahoma
Elem Indian Colony of Pomo Indians of the Sulphur Bank Rancheria, California
Elk Valley Rancheria, California
Ely Shoshone Tribe of Nevada
Enterprise Rancheria of Maidu Indians of California
Ewiiaapaayp Band of Kumeyaay Indians, California (formerly the Cuyapaipe Community of Diegueno Mission Indians of the Cuyapaipe Reservation)
Federated Indians of Graton Rancheria, California (formerly the Graton Rancheria)
Flandreau Santee Sioux Tribe of South Dakota
Forest County Potawatomi Community, Wisconsin
Fort Belknap Indian Community of the Fort Belknap Reservation of Montana
Fort Bidwell Indian Community of the Fort Bidwell Reservation of California
Fort Independence Indian Community of Paiute Indians of the Fort Independence Reservation, California
Fort McDermitt Paiute and Shoshone Tribes of the Fort McDermitt Indian Reservation, Nevada and Oregon
Fort McDowell Yavapai Nation, Arizona (formerly the Fort McDowell Mohave-Apache Community of the Fort McDowell Indian Reservation)
Fort Mojave Indian Tribe of Arizona, California & Nevada
Fort Sill Apache Tribe of Oklahoma
Gila River Indian Community of the Gila River Indian Reservation, Arizona
Grand Traverse Band of Ottawa and Chippewa Indians, Michigan
Greenville Rancheria of Maidu Indians of California
Grindstone Indian Rancheria of Wintun-Wailaki Indians of California
Guidiville Rancheria of California
Hannahville Indian Community, Michigan
Havasupai Tribe of the Havasupai Reservation, Arizona
Ho-Chunk Nation of Wisconsin (formerly the Wisconsin Winnebago Tribe)
Hoh Indian Tribe of the Hoh Indian Reservation, Washington
Hoopa Valley Tribe, California
Hopi Tribe of Arizona
Hopland Band of Pomo Indians of the Hopland Rancheria, California
Houlton Band of Maliseet Indians of Maine
Hualapai Indian Tribe of the Hualapai Indian Reservation, Arizona
Huron Potawatomi, Inc., Michigan
Inaja Band of Diegueno Mission Indians of the Inaja and Cosmit Reservation, California
Ione Band of Miwok Indians of California
Iowa Tribe of Kansas and Nebraska
Iowa Tribe of Oklahoma
Jackson Rancheria of Me-Wuk Indians of California
Jamestown S'Klallam Tribe of Washington
Jamul Indian Village of California
Jena Band of Choctaw Indians, Louisiana
Jicarilla Apache Nation, New Mexico (formerly the Jicarilla Apache Tribe of the Jicarilla Apache Indian Reservation)
Kaibab Band of Paiute Indians of the Kaibab Indian Reservation, Arizona
Kalispel Indian Community of the Kalispel Reservation, Washington
Karuk Tribe of California
Kashia Band of Pomo Indians of the Stewarts Point Rancheria, California
Kaw Nation, Oklahoma
Keweenaw Bay Indian Community, Michigan
Kialegee Tribal Town, Oklahoma
Kickapoo Tribe of Indians of the Kickapoo Reservation in Kansas
Kickapoo Tribe of Oklahoma
Kickapoo Traditional Tribe of Texas
Kiowa Indian Tribe of Oklahoma
Klamath Indian Tribe of Oregon
Kootenai Tribe of Idaho
La Jolla Band of Luiseno Mission Indians of the La Jolla Reservation, California
La Posta Band of Diegueno Mission Indians of the La Posta Indian Reservation, California
Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wisconsin
Lac du Flambeau Band of Lake Superior Chippewa Indians of the Lac du Flambeau Reservation of Wisconsin
Lac Vieux Desert Band of Lake Superior Chippewa Indians, Michigan
Las Vegas Tribe of Paiute Indians of the Las Vegas Indian Colony, Nevada
Little River Band of Ottawa Indians, Michigan
Little Traverse Bay Bands of Odawa Indians, Michigan
Lower Lake Rancheria, California
Los Coyotes Band of Cahuilla & Cupeno Indians of the Los Coyotes Reservation, California (formerly the Los Coyotes Band of Cahuilla Mission Indians of the Los Coyotes Reservation)
Lovelock Paiute Tribe of the Lovelock Indian Colony, Nevada
Lower Brule Sioux Tribe of the Lower Brule Reservation, South Dakota
Lower Elwha Tribal Community of the Lower Elwha Reservation, Washington
Lower Sioux Indian Community in the State of Minnesota
Lummi Tribe of the Lummi Reservation, Washington
Lytton Rancheria of California
Makah Indian Tribe of the Makah Indian Reservation, Washington
Manchester Band of Pomo Indians of the Manchester-Point Arena Rancheria, California
Manzanita Band of Diegueno Mission Indians of the Manzanita Reservation, California
Mashantucket Pequot Tribe of Connecticut
Match-e-be-nash-she-wish Band of Pottawatomi Indians of Michigan
Mechoopda Indian Tribe of Chico Rancheria, California
Menominee Indian Tribe of Wisconsin
Mesa Grande Band of Diegueno Mission Indians of the Mesa Grande Reservation, California
Mescalero Apache Tribe of the Mescalero Reservation, New Mexico
Miami Tribe of Oklahoma
Miccosukee Tribe of Indians of Florida
Middletown Rancheria of Pomo Indians of California
Minnesota Chippewa Tribe, Minnesota (Six component reservations: Bois Forte Band (Nett Lake); Fond du Lac Band; Grand Portage Band; Leech Lake Band; Mille Lacs Band; White Earth Band)
Mississippi Band of Choctaw Indians, Mississippi
Moapa Band of Paiute Indians of the Moapa River Indian Reservation, Nevada
Modoc Tribe of Oklahoma
Mohegan Indian Tribe of Connecticut
Mooretown Rancheria of Maidu Indians of California
Morongo Band of Cahuilla Mission Indians of the Morongo Reservation, California

Muckleshoot Indian Tribe of the Muckleshoot Reservation, Washington
Muscogee (Creek) Nation, Oklahoma
Narragansett Indian Tribe of Rhode Island
Navajo Nation, Arizona, New Mexico & Utah
Nez Perce Tribe of Idaho
Nisqually Indian Tribe of the Nisqually Reservation, Washington
Nooksack Indian Tribe of Washington
Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, Montana
Northfork Rancheria of Mono Indians of California
Northwestern Band of Shoshoni Nation of Utah (Washakie)
Oglala Sioux Tribe of the Pine Ridge Reservation, South Dakota
Omaha Tribe of Nebraska
Oneida Nation of New York
Oneida Tribe of Indians of Wisconsin
Onondaga Nation of New York
Osage Tribe, Oklahoma
Ottawa Tribe of Oklahoma
Otoe-Missouria Tribe of Indians, Oklahoma
Paiute Indian Tribe of Utah (Cedar City Band of Paiutes, Kanosh Band of Paiutes, Koosharem Band of Paiutes, Indian Peaks Band of Paiutes, and Shivwits Band of Paiutes)
Paiute-Shoshone Indians of the Bishop Community of the Bishop Colony, California
Paiute-Shoshone Tribe of the Fallon Reservation and Colony, Nevada
Paiute-Shoshone Indians of the Lone Pine Community of the Lone Pine Reservation, California
Pala Band of Luiseno Mission Indians of the Pala Reservation, California
Pascua Yaqui Tribe of Arizona
Paskenta Band of Nomlaki Indians of California
Passamaquoddy Tribe of Maine
Pauma Band of Luiseno Mission Indians of the Pauma & Yuima Reservation, California
Pawnee Nation of Oklahoma
Pechanga Band of Luiseno Mission Indians of the Pechanga Reservation, California
Penobscot Tribe of Maine
Peoria Tribe of Indians of Oklahoma
Picayune Rancheria of Chukchansi Indians of California
Pinoleville Rancheria of Pomo Indians of California
Pit River Tribe, California (includes XL Ranch, Big Bend, Likely, Lookout, Montgomery Creek and Roaring Creek Rancherias)
Poarch Band of Creek Indians of Alabama
Pokagon Band of Potawatomi Indians, Michigan and Indiana
Ponca Tribe of Indians of Oklahoma
Ponca Tribe of Nebraska
Port Gamble Indian Community of the Port Gamble Reservation, Washington
Potter Valley Rancheria of Pomo Indians of California
Prairie Band of Potawatomi Nation, Kansas (formerly the Prairie Band of Potawatomi Indians)
Prairie Island Indian Community in the State of Minnesota
Pueblo of Acoma, New Mexico
Pueblo of Cochiti, New Mexico
Pueblo of Jemez, New Mexico
Pueblo of Isleta, New Mexico
Pueblo of Laguna, New Mexico
Pueblo of Nambe, New Mexico
Pueblo of Picuris, New Mexico
Pueblo of Pojoaque, New Mexico
Pueblo of San Felipe, New Mexico
Pueblo of San Juan, New Mexico
Pueblo of San Ildefonso, New Mexico
Pueblo of Sandia, New Mexico
Pueblo of Santa Ana, New Mexico
Pueblo of Santa Clara, New Mexico
Pueblo of Santo Domingo, New Mexico
Pueblo of Taos, New Mexico
Pueblo of Tesuque, New Mexico
Pueblo of Zia, New Mexico
Puyallup Tribe of the Puyallup Reservation, Washington
Pyramid Lake Paiute Tribe of the Pyramid Lake Reservation, Nevada
Quapaw Tribe of Indians, Oklahoma
Quartz Valley Indian Community of the Quartz Valley Reservation of California
Quechan Tribe of the Fort Yuma Indian Reservation, California & Arizona
Quileute Tribe of the Quileute Reservation, Washington
Quinault Tribe of the Quinault Reservation, Washington
Ramona Band or Village of Cahuilla Mission Indians of California
Red Cliff Band of Lake Superior Chippewa Indians of Wisconsin
Red Lake Band of Chippewa Indians, Minnesota
Redding Rancheria, California
Redwood Valley Rancheria of Pomo Indians of California
Reno-Sparks Indian Colony, Nevada
Resighini Rancheria, California (formerly the Coast Indian Community of Yurok Indians of the Resighini Rancheria)
Rincon Band of Luiseno Mission Indians of the Rincon Reservation, California
Robinson Rancheria of Pomo Indians of California
Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota
Round Valley Indian Tribes of the Round Valley Reservation, California (formerly the Covelo Indian Community)
Rumsey Indian Rancheria of Wintun Indians of California
Sac & Fox Tribe of the Mississippi in Iowa
Sac & Fox Nation of Missouri in Kansas and Nebraska
Sac & Fox Nation, Oklahoma
Saginaw Chippewa Indian Tribe of Michigan
St. Croix Chippewa Indians of Wisconsin
St. Regis Band of Mohawk Indians of New York
Salt River Pima-Maricopa Indian Community of the Salt River Reservation, Arizona
Samish Indian Tribe, Washington
San Carlos Apache Tribe of the San Carlos Reservation, Arizona
San Juan Southern Paiute Tribe of Arizona
San Manual Band of Serrano Mission Indians of the San Manual Reservation, California
San Pasqual Band of Diegueno Mission Indians of California
Santa Rosa Indian Community of the Santa Rosa Rancheria, California
Santa Rosa Band of Cahuilla Mission Indians of the Santa Rosa Reservation, California
Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation, California
Santa Ysabel Band of Diegueno Mission Indians of the Santa Ysabel Reservation, California
Santee Sioux Nation, Nebraska (formerly the Santee Sioux Tribe of the Santee Reservation of Nebraska)
Sauk-Suiattle Indian Tribe of Washington
Sault Ste. Marie Tribe of Chippewa Indians of Michigan
Scotts Valley Band of Pomo Indians of California
Seminole Nation of Oklahoma
Seminole Tribe of Florida, Dania, Big Cypress, Brighton, Hollywood & Tampa Reservations
Seneca Nation of New York
Seneca-Cayuga Tribe of Oklahoma
Shakopee Mdewakanton Sioux Community of Minnesota
Shawnee Tribe, Oklahoma
Sherwood Valley Rancheria of Pomo Indians of California
Shingle Springs Band of Miwok Indians, Shingle Springs Rancheria (Verona Tract), California
Shoalwater Bay Tribe of the Shoalwater Bay Indian Reservation, Washington
Shoshone Tribe of the Wind River Reservation, Wyoming
Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho
Shoshone-Paiute Tribes of the Duck Valley Reservation, Nevada
Sisseton-Wahpeton Oyate of the Lake Traverse Reservation, South Dakota (formerly the Sisseton-Wahpeton

Sioux Tribe of the Lake Traverse Reservation)
Skokomish Indian Tribe of the Skokomish Reservation, Washington
Skull Valley Band of Goshute Indians of Utah
Smith River Rancheria, California
Snoqualmie Tribe, Washington
Soboba Band of Luiseno Indians, California (formerly the Soboba Band of Luiseno Mission Indians of the Soboba Reservation)
Sokaogon Chippewa Community, Wisconsin
Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado
Spirit Lake Tribe, North Dakota
Spokane Tribe of the Spokane Reservation, Washington
Squaxin Island Tribe of the Squaxin Island Reservation, Washington
Standing Rock Sioux Tribe of North & South Dakota
Stockbridge Munsee Community, Wisconsin
Stillaguamish Tribe of Washington
Summit Lake Paiute Tribe of Nevada
Suquamish Indian Tribe of the Port Madison Reservation, Washington
Susanville Indian Rancheria, California
Swinomish Indians of the Swinomish Reservation, Washington
Sycuan Band of Diegueno Mission Indians of California
Table Bluff Reservation—Wiyot Tribe, California
Table Mountain Rancheria of California
Te-Moak Tribe of Western Shoshone Indians of Nevada (Four constituent bands: Battle Mountain Band; Elko Band; South Fork Band and Wells Band)
Thlopthlocco Tribal Town, Oklahoma
Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota
Tohono O'odham Nation of Arizona
Tonawanda Band of Seneca Indians of New York
Tonkawa Tribe of Indians of Oklahoma
Tonto Apache Tribe of Arizona
Torres-Martinez Band of Cahuilla Mission Indians of California
Tule River Indian Tribe of the Tule River Reservation, California
Tulalip Tribes of the Tulalip Reservation, Washington
Tunica-Biloxi Indian Tribe of Louisiana
Tuolumne Band of Me-Wuk Indians of the Tuolumne Rancheria of California
Turtle Mountain Band of Chippewa Indians of North Dakota
Tuscarora Nation of New York
Twenty-Nine Palms Band of Mission Indians of California
United Auburn Indian Community of the Auburn Rancheria of California
United Keetoowah Band of Cherokee Indians in Oklahoma
Upper Lake Band of Pomo Indians of Upper Lake Rancheria of California
Upper Sioux Community, Minnesota
Upper Skagit Indian Tribe of Washington
Ute Indian Tribe of the Uintah & Ouray Reservation, Utah
Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah
Utu Utu Gwaitu Paiute Tribe of the Benton Paiute Reservation, California
Walker River Paiute Tribe of the Walker River Reservation, Nevada
Wampanoag Tribe of Gay Head (Aquinnah) of Massachusetts
Washoe Tribe of Nevada & California (Carson Colony, Dresslerville Colony, Woodfords Community, Stewart Community, & Washoe Ranches)
White Mountain Apache Tribe of the Fort Apache Reservation, Arizona
Wichita and Affiliated Tribes (Wichita, Keechi, Waco & Tawakonie), Oklahoma
Winnebago Tribe of Nebraska
Winnemucca Indian Colony of Nevada
Wyandotte Nation, Oklahoma (formerly the Wyandotte Tribe of Oklahoma)
Yankton Sioux Tribe of South Dakota
Yavapai-Apache Nation of the Camp Verde Indian Reservation, Arizona
Yavapai-Prescott Tribe of the Yavapai Reservation, Arizona
Yerington Paiute Tribe of the Yerington Colony & Campbell Ranch, Nevada
Yomba Shoshone Tribe of the Yomba Reservation, Nevada
Ysleta Del Sur Pueblo of Texas
Yurok Tribe of the Yurok Reservation, California
Zuni Tribe of the Zuni Reservation, New Mexico

Native Entities Within the State of Alaska Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs

Native Village of Afognak (formerly the Village of Afognak)
Agdaagux Tribe of King Cove
Native Village of Akhiok
Akiachak Native Community
Akiak Native Community
Native Village of Akutan
Village of Alakanuk
Alatna Village
Native Village of Aleknagik
Algaaciq Native Village (St. Mary's)
Allakaket Village
Native Village of Ambler
Village of Anaktuvuk Pass
Yupiit of Andreafski
Angoon Community Association
Village of Aniak
Anvik Village
Arctic Village (See Native Village of Venetie Tribal Government)
Asa'carsarmiut Tribe (formerly the Native Village of Mountain Village)
Native Village of Atka
Village of Atmautluak
Atqasuk Village (Atkasook)
Native Village of Barrow Inupiat Traditional Government
Beaver Village
Native Village of Belkofski
Village of Bill Moore's Slough
Birch Creek Tribe
Native Village of Brevig Mission
Native Village of Buckland
Native Village of Cantwell
Native Village of Chanega (aka Chenega)
Chalkyitsik Village
Cheesh-Na Tribe (formerly the Native Village of Chistochina)
Village of Chefornak
Chevak Native Village
Chickaloon Native Village
Native Village of Chignik
Native Village of Chignik Lagoon
Chignik Lake Village
Chilkat Indian Village (Klukwan)
Chilkoot Indian Association (Haines)
Chinik Eskimo Community (Golovin)
Native Village of Chitina
Native Village of Chuathbaluk (Russian Mission, Kuskokwim)
Chuloonawick Native Village
Circle Native Community
Village of Clarks Point
Native Village of Council
Craig Community Association
Village of Crooked Creek
Curyung Tribal Council (formerly the Native Village of Dillingham)
Native Village of Deering
Native Village of Diomede (aka Inalik)
Village of Dot Lake
Douglas Indian Association
Native Village of Eagle
Native Village of Eek
Egegik Village
Eklutna Native Village
Native Village of Ekuk
Ekwok Village
Native Village of Elim
Emmonak Village
Evansville Village (aka Bettles Field)
Native Village of Eyak (Cordova)
Native Village of False Pass
Native Village of Fort Yukon
Native Village of Gakona
Galena Village (aka Louden Village)
Native Village of Gambell
Native Village of Georgetown
Native Village of Goodnews Bay
Organized Village of Grayling (aka Holikachuk)
Gulkana Village
Native Village of Hamilton
Healy Lake Village
Holy Cross Village
Hoonah Indian Association
Native Village of Hooper Bay
Hughes Village
Huslia Village
Hydaburg Cooperative Association
Igiugig Village
Village of Iliamna

Inupiat Community of the Arctic Slope
Iqurmuit Traditional Council (formerly the Native Village of Russian Mission)
Ivanoff Bay Village
Kaguyak Village
Organized Village of Kake
Kaktovik Village (aka Barter Island)
Village of Kalskag
Village of Kaltag
Native Village of Kanatak
Native Village of Karluk
Organized Village of Kasaan
Native Village of Kasigluk
Kenaitze Indian Tribe
Ketchikan Indian Corporation
Native Village of Kiana
King Island Native Community
King Salmon Tribe
Native Village of Kipnuk
Native Village of Kivalina
Klawock Cooperative Association
Native Village of Kluti Kaah (aka Copper Center)
Knik Tribe
Native Village of Kobuk
Kokhanok Village
Native Village of Kongiganak
Village of Kotlik
Native Village of Kotzebue
Native Village of Koyuk
Koyukuk Native Village
Organized Village of Kwethluk
Native Village of Kwigillingok
Native Village of Kwinhagak (aka Quinhagak)
Native Village of Larsen Bay
Levelock Village
Lesnoi Village (aka Woody Island)
Lime Village
Village of Lower Kalskag
Manley Hot Springs Village
Manokotak Village
Native Village of Marshall (aka Fortuna Ledge)
Native Village of Mary's Igloo
McGrath Native Village
Native Village of Mekoryuk
Mentasta Traditional Council
Metlakatla Indian Community, Annette Island Reserve
Native Village of Minto
Naknek Native Village
Native Village of Nanwalek (aka English Bay)
Native Village of Napaimute
Native Village of Napakiak
Native Village of Napaskiak
Native Village of Nelson Lagoon
Nenana Native Association
New Koliganek Village Council (formerly the Koliganek Village)
New Stuyahok Village
Newhalen Village
Newtok Village
Native Village of Nightmute
Nikolai Village
Native Village of Nikolski
Ninilchik Village
Native Village of Noatak
Nome Eskimo Community
Nondalton Village
Noorvik Native Community
Northway Village
Native Village of Nuiqsut (aka Nooiksut)
Nulato Village
Nunakauyarmiut Tribe (formerly the Native Village of Toksook Bay)
Native Village of Nunapitchuk
Village of Ohogamiut
Village of Old Harbor
Orutsararmuit Native Village (aka Bethel)
Oscarville Traditional Village
Native Village of Ouzinkie
Native Village of Paimiut
Pauloff Harbor Village
Pedro Bay Village
Native Village of Perryville
Petersburg Indian Association
Native Village of Pilot Point
Pilot Station Traditional Village
Native Village of Pitka's Point
Platinum Traditional Village
Native Village of Point Hope
Native Village of Point Lay
Native Village of Port Graham
Native Village of Port Heiden
Native Village of Port Lions
Portage Creek Village (aka Ohgsenakale)
Pribilof Islands Aleut Communities of St. Paul & St. George Islands
Qagan Tayagungin Tribe of Sand Point Village
Qawalangin Tribe of Unalaska
Rampart Village
Village of Red Devil
Native Village of Ruby
Saint George Island (See Pribilof Islands Aleut Communities of St. Paul & St. George Islands)
Native Village of Saint Michael
Saint Paul Island (See Pribilof Islands Aleut Communities of St. Paul & St. George Islands)
Village of Salamatoff
Native Village of Savoonga
Organized Village of Saxman
Native Village of Scammon Bay
Native Village of Selawik
Seldovia Village Tribe
Shageluk Native Village
Native Village of Shaktoolik
Native Village of Sheldon's Point
Native Village of Shishmaref
Shoonaq' Tribe of Kodiak
Native Village of Shungnak
Sitka Tribe of Alaska
Skagway Village
Village of Sleetmute
Village of Solomon
South Naknek Village
Stebbins Community Association
Native Village of Stevens
Village of Stony River
Takotna Village
Native Village of Tanacross
Native Village of Tanana
Native Village of Tatitlek
Native Village of Tazlina
Telida Village
Native Village of Teller
Native Village of Tetlin
Central Council of the Tlingit & Haida Indian Tribes
Traditional Village of Togiak
Tuluksak Native Community
Native Village of Tuntutuliak
Native Village of Tununak
Twin Hills Village
Native Village of Tyonek
Ugashik Village
Umkumiute Native Village
Native Village of Unalakleet
Native Village of Unga
Village of Venetie (See Native Village of Venetie Tribal Government)
Native Village of Venetie Tribal Government (Arctic Village and Village of Venetie)
Village of Wainwright
Native Village of Wales
Native Village of White Mountain
Wrangell Cooperative Association
Yakutat Tlingit Tribe

[FR Doc. 03–30244 Filed 12–4–03; 8:45 am]
BILLING CODE 4310–4J–P

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

June 9, 2006 **SMDL#06-014**

Dear State Medicaid Director:

On October 18, 2005 The Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director (SMD) letter containing guidance for participation by Tribal organizations in arrangements that use certified public expenditures by a "unit of government" to fulfill the non- federal matching requirements for administrative activities under the Medicaid program. The letter set forth criteria under which a Tribal organization may be considered as a unit of government that can certify expenditures as the non-Federal share of Medicaid administration claims. The letter contained the following footnote:

"Federal funds may not be used to meet State matching requirements, except as authorized by Federal law. Although Federal HHS funds awarded under ISDEAA [the Indian Self-Determination and Education Assistance Act, or Pub.L. 93-638] may be used to meet Tribal matching requirements, that authority does not include State matching requirements. As a result, Tribal expenditures certified for this purpose must be funded through non-ISDEAA sources."

Although the footnote correctly states the applicable principles of law, after further review, we have determined that the conclusion in the last sentence would not apply when the full financial benefit and responsibility has been assigned to the tribal organization. The Indian Health Service (IHS) and CMS are issuing this joint SMD letter to clarify that footnote.

When a State assigns to a tribal organization the full right to the federal matching share, without any diminution, along with the full responsibility for establishing the non-federal share through certified public expenditures, the State effectively drops out of the financial equation. What remains is a funding arrangement under which federal matching funds are directly available to the tribal organization based on the tribal organization's expenditures. This is effectively a tribal matching obligation, rather than a contribution to a larger State matching obligation.

Based on this analysis that such an arrangement effectively results in a tribal matching obligation, the Indian Health Service (HIS) has determined that ISDEAA funds may be used for certified public expenditures under such an arrangement to obtain federal Medicaid matching funding. The net required contribution by the Tribal organization cannot exceed the non-Federal share of such expenditures; thus the State must pass through to the Tribal organization the full amount of Federal Medicaid matching funding received based on the certified expenditures.

It is important to note that ISDEAA funds may only be used to fund activities permissible under the ISDEAA. This includes activities authorized under the Snyder Act, 25 U.S.C. 13, and the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. §1601 et seq. Thus, any Medicaid administrative activities that are funded with ISDEAA funds must also be permissible activities under the Snyder Act or the IHCIA.

The October 18, 2005 State Medicaid Director letter also contained four criteria for recognition of Tribal organization expenditures as the non-Federal share of Medicaid administration claims. The fourth criterion, stating that expenditures for allowable administrative activities which are certified by the Tribal organizations must be made with Tribal sources of revenue other than Medicaid revenues or ISDEAA funds is amended to delete the reference to ISDEAA funds, which may now be used as outlined in this letter. Additionally, a fifth criterion is hereby added. The fourth and fifth criteria now read as follows:

4. Expenditures for allowable Medicaid administrative activities which are certified by the Tribal organization are made with funds derived from Tribal sources of revenue other than Medicaid revenues.

5. Expenditures made with funds derived from ISDEAA agreements may be certified by the Tribal organization only to the extent that the State passes the entire amount of Federal Medicaid matching funding to the Tribal organization.

Tribes, as well as Tribal organizations, which certify Medicaid administration expenditures made with funds derived from ISDEAA agreements, must receive the full amount of Federal Medicaid matching funding.

If you have questions regarding this matter, please contact Ed Gendron at CMS on 410-786-1064 or Carl Harper at HIS on 301-443-3216.

Sincerely,

/s/
Dr. Charles Grim, D.D.S.,M.H.S.A.
Director
Indian Health Service

/s/
Dennis G. Smith
Director
Center for Medicaid and State Operations

Cc:

CMS Regional Administrators

CMS Associate Regional Administrators
For Medicaid and State Operations

Martha Roberty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
Director of Policy and Programs
Association of State and Territorial Health Officials

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Lynne Flynn
Director for Health Policy
Council of State Governments

H. Sally Smith
Chairperson
National Indian Health Board

Valerie Davidson
Chairperson
CMS Tribal Technical Advisory Group

HIS Area Directors

Submitter : Mr. Steve Keil **Date:** 03/19/2007

Organization : California State Association of Counties

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2258-P-270-Attach-1.DOC

#270

California State Association of Counties
1100 K Street, Suite 101
Sacramento, CA 95814

March 19, 2007

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

Re: Comments on Proposed Rule CMS 2258-P

Dear Acting Administrator Norwalk:

The California State Association of Counties (CSAC) urges the Centers for Medicare and Medicaid Services (CMS) to withdraw its proposed rule CMS-2258-P published on January 18, 2007 in the Federal Register. The proposed rule would restrict severely the ability of states and counties to finance health systems serving their most vulnerable populations.

While California's 58 counties – ranging from Alpine with less than 1,200 people to Los Angeles with nearly 10 million – are diverse, many common issues exist. CSAC's long-term objective is to significantly improve the fiscal health of all California counties so they can adequately meet the demand for vital public programs and services. California's counties are ultimately responsible for the health care of the lowest-income uninsured and, in some counties, Medicaid populations. County public hospitals serve as a foundation of this support. Given counties' service responsibilities and local financial contributions to the safety net, any reduction in federal support will shift costs to states and localities and place further stress on our systems of care.

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

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

Our specific comments follow.

Section 433.50: Basis, Scope and Applicability

Comment: The proposed rule would re-define a "unit of government." CMS does not have the authority to do so and should leave to states the authority to define such entities. The use of the term 'generally applicable taxing authority' as a key determinant in qualifying payments as match, disregards and undermines those long-standing arrangements.

The proposed definition would eliminate the use of University of California teaching appropriations as match as well as the contributions of the Alameda County Medical Center, since neither system has independent taxing authority. Moreover, counties receive funds from a variety of sources, including tobacco settlement funds, individual donations, and revenues from property and other operations. Strictly interpreted, none of these funds would qualify. Requiring counties to comply with this requirement is impossible, given the how various revenues are intermingled in a county general fund.

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

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

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

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

Recommendation: CMS should continue to allow states and localities to determine the sources of public funding, within Congressionally-proscribed parameters enacted into law. CMS should clarify that non-federal sources of revenue are not limited to tax revenue.

Section 447.206 Cost Limit for Providers Operated by Units of Government

Comment: The proposed rule provides that "[a]ll health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider's cost of providing covered Medicaid services to eligible Medicaid recipients."

CMS again is intruding into long-standing authority given to states to establish inpatient payment methods. Over the years, Congress has been clear on preserving this authority. The State of California and its counties are much better able to determine how to pay providers within the State, given regional and other differences in the provision of care.

Recommendation: CMS must clarify that calculating Medicaid "costs" includes all costs necessary to operate a governmental facility, including costs associated with the uninsured.

The Proposed Rule's Applicability to the State's Medi-Cal Waivers

Comment: California's Medi-Cal program has a number of demonstration waiver agreements with CMS, including a Hospital Waiver that created a Safety Net Care Pool providing $766 million annually to match state and local expenditures on care provided to the uninsured. The preamble of the regulation asserts that state waivers are subject to all of the proposed rule's provisions. Given that assertion, applying the rule to California's Hospital Waiver will undercut a substantial portion of the support provided.

Recommendation: If indeed CMS believes that the proposed rule does not apply to California, an explicit statement to that effect must be made. Short of that, the rule should be withdrawn.

Section 447.206(g): Compliance Dates

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

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

On behalf of California's counties, thank you for considering our views.

Sincerely,
/s/
Steve Keil
Interim Executive Director

Submitter : Mrs. Kim Duggan **Date:** 03/19/2007

Organization : Missouri Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-271-Attach-1.DOC

MISSOURI HOSPITAL ASSOCIATION #271

Marc D. Smith, Ph.D., President

March 19, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., 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

Dear Ms. Norwalk:

On behalf of the Missouri Hospital Association and the 141 hospitals that comprise the membership, the following comments are offered for your consideration on the Centers for Medicare & Medicaid Services' 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. In Missouri, the new rules will seriously impair the state's ability to maintain its current program and impede the state's planned transformation of the current Medicaid program. If finalized, the new rules could derail the state's efforts to cover more uninsured through the "Missouri Health Improvement Act of 2007," which follows the president's proposal of shifting federal funding to help the uninsured buy private insurance and take ownership of their healthcare, by further cutting federal funding to an already financially strapped program.

THE PROPOSED DEFINITION OF "UNIT OF GOVERNMENT" ELIMINATES CRITICAL SOURCES OF FUNDING

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. Our greatest concern is that the CMS regulation, without justification, will curtail the public entities and sources of public funds that Missouri has long relied on to serve Medicaid beneficiaries. Missouri has historically used certification of expenditures from its public hospitals and nursing facilities for purposes of claiming federal financial participation. This will eliminate the ability of many providers to certify their expenditures and thus will decrease the amount of federal funds available to the state and its public providers.

P.O. Box 60 Jefferson City, MO 65102-0060 Phone: 573/893-3700 Fax: 573/893-2809 *www.mhanet.com*

Truman Medical Center

The Missouri hospital that will be chiefly affected is Truman Medical Center (TMC), which is the primary health care safety-net entity for the Kansas City metropolitan area, including Kansas City, Missouri, and Jackson County. Its two hospitals, Hospital Hill and Lakewood, serve as the principal teaching hospitals for the University of Missouri-Kansas City School of Medicine. The hospitals are critical providers of services to Medicaid and other low-income patients.

TMC was formed through cooperative agreements between TMC and both Jackson County and Kansas City as part of an effort to replace old city and county hospitals. Under those agreements, the county retained ownership of the two new hospitals and TMC agreed to retain its predecessor public institutions' obligations to serve the medically indigent population in Kansas City and Jackson County.

Though in corporate form a not-for-profit corporation, TMC looks and acts like a public entity in at least the following ways: it has assumed the obligations of Jackson County and Kansas City to provide services to medically indigent ill citizens of the county and city; the standards for controlling the admission of patients at the facilities are those established by the county; three members of the TMC Board of Directors are appointed by the county, three by Kansas City, and two by the state's University of Missouri-Kansas City; the county owns the land and buildings of both hospitals; TMC has the responsibility to operate the County Health Department, health services at the County Jail, and transportation of the medically indigent to health facilities; TMC construction and equipment have been financed by over $76 million in Jackson County special obligation bonds since 2001 alone; and TMC directly draws from city and county property tax levies imposed by the respective governments specifically to support TMC, their hospital to provide indigent medical care.

On the basis of these facts, Missouri sought confirmation from CMS in 2001 that TMC should be treated as a "non-state government-owned or operated" facility and CMS agreed that it was. As a result, TMC certifies over $150 million annually in total expenditures for services provided to Medicaid patients and the uninsured, and those expenditures have earned a federal match. TMC also makes an intergovernmental transfer of funds (approximately $1 million) to be used as the state share for increased payments to the physicians who practice in its hospitals.

The recognition of TMC as a governmental entity is an important component in supporting the provision of hospital care to Medicaid patients and the uninsured in the Kansas City area. However, because it does not have independent taxing authority (and is not a formal part of another governmental entity with taxing authority), TMC would not be considered a unit of government under the new rules and its expenditures and transfers would no longer be eligible for federal financial participation. This will be a devastating blow to a critical Missouri provider.

TMC has direct access to tax funds through its interdependent relationship with Kansas City and Jackson County. TMC today receives approximately $25 million from the Kansas City health levy tax, which was first imposed in 1989. The ballot question at that time was specifically whether to authorize "an increase in the tax levy for ... Truman Medical Center ... and other

public health programs and facilities." A further health tax levy increase was funneled to TMC again in 2005. The ballot question in 2005 was whether the City could act "by increasing the existing tax levy by 22 cents per $100 assessed valuation [distributing] ... the revenue derived from 15 cents of the levy to Truman Medical Center." In other words, TMC has an absolute right to specified revenues from the city tax.

While TMC does receive subsidies from Jackson County and Kansas City that can be certified as expenditures by the county and city under the new rules, that is not sufficient to support the mission of TMC to serve the citizens of western Missouri. TMC not only is supported by subsidies from Jackson County and Kansas City, but also by grants, operating revenue, and revenue from other operations. These funds have traditionally become public funds once expended by TMC, and CMS and its predecessor agency knowingly have authorized the state to count these expenditures toward the state share of Missouri Medicaid costs. There is no reason in law, and the state sees no valid reason in policy, for not allowing this to continue.

Other Public Hospitals Without Taxing Authority

While TMC is most negatively impacted by the proposed regulations, there are 33 additional public hospitals in Missouri that have certified over $73 million in annual expenditures for services provided to Medicaid and the uninsured. These hospitals are established pursuant to state statute which provides for establishment of hospital districts by voters of the jurisdiction in question: Revised Statutes of Missouri (RSMo), Chapter 205 (authorizing the establishment of county hospitals – 19 hospitals); chapter 206 RSMo (providing for the establishment of hospital districts – nine hospitals); chapter 96 RSMo (providing for the establishment of city hospitals – five hospitals). The hospitals' governing boards are elected by the voters. The boards may contract with other entities for operation of the hospitals but retain power over major expenditures and personnel and retain the power to cancel the contracts at any time. The boards have the power to issue bonds. Hospitals established under Chapters 96, 205 and 206, do have taxing authority. However, taxes are not the sole source of the revenue that supports the expenditures that are certified. It is not clear from the proposed rule whether the expenditures of these public hospitals would continue to be eligible for federal financial participation or whether all such certifications will be limited to the tax revenue collected under the proposed rule.

LIMITING PAYMENTS TO GOVERNMENT PROVIDERS

We also object to the proposal that all payments to public providers be limited to cost. Missouri pays some of its public hospital providers up to the amount that Medicare would pay for the same services, as calculated under the current upper payment limit rules, even if those amounts exceed the hospital's costs in serving Medicaid patients. These payments help offset some of the hospitals' other uncompensated costs – including non-allowable costs, physician staffing, costs of serving indigent patients, bad debt, etc. – coverage of which helps ensure that the hospital will remain open and available to Medicaid patients.

Depending on which hospitals meet CMS's new "unit of government test" the new cost-based cap will eliminate $16 to $38 million in UPL payments to Missouri hospitals. There is no basis for CMS's position that a State Medicaid program cannot pay at the same level that Medicare pays but must instead cap all payments at cost. These restrictions would jeopardize the progress that Missouri has made on covering the uninsured. In addition, this approach effectively precludes any facility from conserving its resources to invest in its future.

INSUFFICENT 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.

For the past several years, Missouri has been operating under a Partnership Plan with CMS under which CMS reviews all of the state's funding sources in advance of each state fiscal year to ensure consistency with federal requirements. CMS is aware of and has worked with the State on each of the reimbursement programs described above and has concluded that they are consistent with its rules and regulations – yet all are thrown into jeopardy by the new proposals, which taken together will impose huge new administrative burdens on the State and its public providers, and could take hundreds of millions of federal funds out of the Missouri Medicaid program. There is no justification for that result. The proposed restrictions would result in fewer dollars available to pay for needed care for the nation's most vulnerable people.

For these reasons, we urge that the proposal be rejected in its entirety.

The Missouri Hospital Association appreciates the opportunity to submit comments on the proposed Rule on Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership. We welcome any questions or comments you may have.

Sincerely,

Kim Duggan

Kim Duggan
Vice President of Medicaid and FRA

kd/kh

Submitter : David P. Driscoll **Date:** 03/19/2007

Organization : Massachusetts Dept. of Education

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2258-P-272-Attach-1.DOC

#272

The Commonwealth of Massachusetts
Department of Education

350 Main Street, Malden, Massachusetts 02148-5023

Telephone: (781) 338-3000
TTY: N.E.T. Relay 1-800-439-2370

David P. Driscoll
Commissioner of Education

March 19, 2007

By Electronic and Regular Mail

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

RE: CMS-2258-P – Comments on Proposed Rule Changes for Medicaid

To Whom it May Concern:

The Massachusetts Department of Education ("MADOE") submits the following comments on the proposed rule changes for Medicaid published in the Federal Register on January 18, 2007. These comments are in addition to the comments submitted by the Executive Office of Health and Human Services of Massachusetts. The proposed rule changes would affect significantly the school-based Medicaid program as it operates in Massachusetts and make it more difficult for public schools to meet the needs of their students.

MADOE is particularly concerned regarding three issues in the proposed rule changes. These issues are the unclear definition of a unit of government, the unduly burdensome cost reporting requirements, and the timeframe for implementing these proposed rule changes.

First, with respect to the definition of a unit of government, MADOE seeks clarification regarding whether all 389 school districts in Massachusetts fall within the proposed definition. See 42 CFR 433.50 (proposed). School districts in Massachusetts include 84 regional school districts, 51 Commonwealth charter schools, and numerous municipal districts that currently qualify for and receive federal reimbursement for providing school-based Medicaid services.

Second, with respect to cost reporting, the proposed rule changes would impose significant new administrative burdens on providers of school-based Medicaid services. See 42 CFR 447.206, 447.271, 447.272, and 447.321 (proposed). In Massachusetts, there

are almost 400 school districts and providers of school-based Medicaid services. Every provider will need cost accounting documentation that provides specific detail for the costs associated with the provided service. It is difficult for MADOE to assess fully the burden of these cost reporting requirements because there are currently no standardized tools for schools to use in reporting their Medicaid costs.

Lastly, MADOE is very concerned about the timeframe for implementing these proposed rule changes. We urge the Centers for Medicare & Medicaid Services to consider grandfathering existing arrangements and gradually phasing-in cost reporting requirements according to a schedule that assures that school-based Medicaid providers can comply with these new requirements. Because the majority of the Medicaid claims submitted by public schools are for students with disabilities, increased paperwork is a real concern. The procedural requirements of special education are already extensive. Requiring individual cost accounting, in addition to documentation already required for Medicaid participation, places a significant burden on school districts that are struggling with increasing educational paperwork requirements under the federal special education law and the No Child Left Behind Act.

Thank you for allowing us the opportunity to comment. MADOE urges modification of the proposed rules to enable public schools and districts to meet the needs of their most needy students in an efficient and uncomplicated manner.

Sincerely,

/s

David P. Driscoll
Commissioner of Education

C: Senator Edward Kennedy
Thomas Dehner, Acting Medicaid Director, Massachusetts
Kristen Reasoner Apgar, General Counsel, Executive Office of Health and Human Services, Massachusetts
Marcia Mittnacht, State Director of Special Education, Massachusetts

Submitter : Ms. Valerie Davidson **Date:** 03/19/2007

Organization : CMS Tribal Technical Advisory Group

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-273-Attach-1.PDF

#273

Tribal Technical Advisory Group

to the Centers for Medicare and Medicaid Services

National Indian Health Board 101 Constitution Ave NW, #6B02 Washington, DC 20001 (202) 742-4262 (202) 742-4285 fax www.nihb.org

March 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

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

Dear Ms. Norwalk:

As Chair and on behalf of the Tribal Technical Advisory Group (TTAG), I 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 TTAG 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 (SMD) 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 the Indian Health Service (IHS) resulting in an October 18, 2005, 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 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

[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, SMD 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").

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 SMD 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. 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.

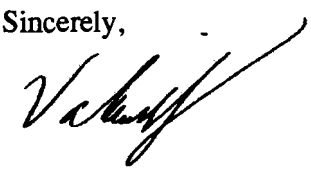
The caveat to paragraph (2) above regarding the source of payments was added to expressly address a new limitation that CMS proposed on February 23, 2007, with regard to approving the Washington State Medicaid Administrative Match Implementation Plan to exclude any "638 clinics that are reimbursed at 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 IHS 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,



Valerie Davidson, Chair
Tribal Technical Advisory Group

Cc: Herb Kuhn
Dr. Charles Grim
CMS Tribal Affairs Staff
Aaron Blight

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #05-004

October 18, 2005

Dear State Medicaid Director:

A number of States and Tribal organizations have asked whether expenditures that are certified by Tribal organizations can be used to fulfill State matching requirements for administrative activities under the Medicaid program. In considering this question, the Centers for Medicare & Medicaid Services (CMS) took into account the fact that Tribal organizations may have governmental responsibilities when operating on behalf of Tribal governments. Additionally, CMS considered the possible occurrence of duplicate payment when the same entity is paid under an agreement to perform Medicaid State administrative activities and as a provider for Medicaid services. This letter describes CMS' policy regarding the conditions under which Tribal organizations can certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services directly provided by such entities.

Pursuant to Federal law, the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, as amended, permits Indian Tribes to directly operate health programs that furnish covered Medicaid services under a contract or compact with the Indian Health Service (IHS). Several States have contracted with Tribes to perform certain allowable Medicaid administrative functions and, as units of government, the Tribes certify actual expenditures related to these activities to the State. The activities performed include, among other things, outreach and application assistance for Medicaid enrollment and activities that ensure appropriate utilization of Medicaid services by Medicaid beneficiaries. The contract language ensures that expenditures certified for administrative costs do not duplicate, in whole or in part, claims made for the costs of direct patient care. The State uses the certified expenditures in its Federal financial participation (FFP) claims for State Medicaid administration activities.[1]

Section 1903(w)(6)(A) of the Social Security Act (the Act) specifies that the Secretary may not restrict a State's use of funds where such funds are derived from State or local taxes (or funds appropriated to State teaching hospitals) transferred from, or certified by, units of government within a State as the non-Federal share of Medicaid expenditures, regardless of whether the unit of government is also a health care provider under the State plan, unless the transferred funds are derived from donations or taxes that would not otherwise be recognized as the non-Federal share. Under this provision, only certified public expenditures from units of government are protected.

[1] Federal funds may not be used to meet State matching requirements, except as authorized by Federal law. Although Federal IHS funds awarded under ISDEAA may be used to meet Tribal matching requirements, that authority does not include State matching requirements. As a result, Tribal expenditures certified for this purpose must be funded through non-ISDEAA sources.

Regulations at 42 CFR section 433.51 permit certified public expenditures from public agencies, specifically including Indian Tribes, to be used as the non-Federal share of expenditures. However, these regulations do not address Tribal organizations.

It is not the intent of this letter to expand the scope of transactions protected under section 1903(w)(6)(A) of the Act or the regulations at 42 CFR section 433.51. However, it is CMS' position that when federally recognized Indian Tribes coalesce for a common purpose, that collective effort should be afforded the same rights, privileges, protections, and exemptions as the individual Tribes themselves.[2] This status extends to Tribal organizations formed solely by, wholly owned by or comprised of, and exclusively controlled by Indian Tribes, as currently defined in section 4(e) of ISDEAA. This section defines "Indian Tribe" to mean any Indian Tribe, band, nation, or other organized group or community, including any Alaska Native village or a regional or village corporation as defined in, or established pursuant to, the Alaska Native Claims Settlement Act, which are recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Some Indian Tribes, either alone or jointly with other Indian Tribes, operate health programs indirectly through separate Tribal organizations. The organizational structure of the Tribal organizations, as well as the designation of authority and responsibilities by the Tribes to the Tribal organizations, varies among Tribes and Tribal organizations. When the IHS enters into an ISDEAA contract or compact with a Tribal organization, the IHS engages in a detailed process of certifying that the Tribal organization meets the ISDEAA statutory requirements. The governing body of the Tribal organization must be composed solely of members of Indian Tribes. Each Tribe represented by the Tribal organization must have passed a resolution authorizing the Tribal organization to act on its behalf. ISDEAA requires that the contracting or compacting Tribal organization compute its costs in accordance with the cost principles for State, local, and Indian Tribal governments contained in the Office of Management and Budget (OMB) Circular A-87. Additionally, ISDEAA requires that the Tribal organization comply with the provisions of the Single Audit Act (31 U.S.C., Chapter 75). Therefore, reliance on the IHS certification process for approval of ISDEAA contracts and compacts will prevent duplication of some of the efforts necessary to determine—by CMS standards—whether an entity is a unit of government.

Some Tribal organizations that receive IHS funding do not operate solely on behalf of Tribal governments. A Tribal organization that is not formed wholly by Indian Tribes, as discussed above, may be authorized to act on behalf of Tribal governments, may receive IHS grant funds on behalf of such governments, and may be accorded the rights of such governments for many purposes. However, unless a Tribal organization is either the recognized governing body of an Indian Tribe, or an entity which is formed solely by, wholly owned by or comprised of, and

[2] See Dille v. Council of Energy Resource Tribes, 801 F.2d 373 (10th Cir. 1986).

exclusively controlled by Indian Tribes, as defined above, it is not a unit of government for Medicaid purposes.

Because of the variations in the organization, nature, function, responsibilities, and fiscal arrangements between Tribes and Tribal organizations, CMS has developed a set of criteria for use in analyzing whether a Tribal organization is acting as a unit of government and incurs expenditures of State plan administration that are eligible for Federal matching funds. All of these criteria must be met for recognition of certified public expenditures for administration of the State plan by a Tribal organization. If you choose to enter into a contractual arrangement for certification of expenditures for Medicaid administrative activities by a Tribal organization which meets the criteria set forth below, please ensure that your agreements are structured such that you do not contract out any Medicaid administrative functions that Federal or State law and regulations require that the State government itself perform. Assure that the activities covered by the contract are not already being offered or provided by other entities or through other programs and will not otherwise be paid for as a Medicaid administrative cost. In addition, if the Tribal organization is also a direct provider of health care services, the contract language must ensure that activities that are integral parts or extensions of direct medical services, such as patient follow-up, patient assessment, patient education, or counseling, are not included in the claims for Medicaid administration. Finally, the costs of any subcontracts by the Tribal organization to non-governmental entities are not to be included in the FFP claims for which certification is made.

CRITERIA FOR RECOGNITION OF TRIBAL ORGANIZATION EXPENDITURES AS THE NON-FEDERAL SHARE OF MEDICAID ADMINISTRATION CLAIMS:

1. The Tribal organization is 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 IHS pursuant to the ISDEAA (P.L. 93-638), as amended.

2. The Tribal organization is either the recognized governing body of an Indian Tribe, or an entity which is formed solely by, wholly owned by or comprised of, and exclusively controlled by Indian Tribes, as defined in Section 4 of the ISDEAA (P.L. 93-638), as amended.

3. The Tribal organization has contracted with the State Medicaid agency to perform specified State Medicaid administrative activities and certify as public expenditures only its actual costs (computed in accordance with applicable provisions of OMB Circular A-87) of allowable administrative activities performed pursuant to its contract with the State Medicaid agency.

4. The expenditures for allowable administrative activities which are certified by the Tribal organization are made with Tribal sources of revenue other than Medicaid revenues or ISDEAA funds.

Attached is a list of Tribal organizations with current ISDEAA Title I contracts or Title V compacts that have been identified by IHS as meeting the criteria listed above (Attachment A). This list is subject to change as new Tribal organizations contract or compact with IHS on a yearly basis. In addition to the attached list of Tribal organizations, for those Tribal organizations which are the recognized governing body of an Indian Tribe, please refer to the Department of the Interior's list of federally Recognized Tribes. The most recent listing, a copy of which is attached (Attachment B), was published on December 5, 2003, in the *Federal Register* (67 *Fed. Reg.* 68180). Proof of current ISDEAA contractor status should be included in the agreement approval process established by each State.

Prior to claiming FFP for expenditures for which a Tribal organization certifies the funds, the State must submit a written statement to the jurisdictional CMS regional office, certifying that the State reviewed the organization and that it meets all of the criteria specified in this letter. Please note that the source of funds used by Tribal organizations to represent expenditures eligible for FFP must be documented to CMS upon its request.

If you have questions regarding this matter, please contact Mr. Ed Gendron at (410) 786-1064.

Sincerely,

/s/

Dennis G. Smith
Director

Attachments

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Sandy Bourne
Legislative Director
American Legislative Exchange Council

Lynne Flynn
Director for Health Policy
Council of State Governments

Dr. Charles W. Grim, D.D.S., M.H.S.A.
Director
Indian Health Service

H. Sally Smith
Chairperson
National Indian Health Board

Valerie Davidson
Chairperson
CMS Tribal Technical Advisory Group

Attachment A

Title I Contractors
Tribal Organizations

Title I Tribal Organizations*

Alamo Navajo School Board, Inc.
Albuquerque Area Indian Health Board
All Indian Pueblo Council, Inc.
California Rural Indian Health Board (CRIHB)
Central Valley Indian Health, Inc.
Chapa-De Indian Health Program, Inc.
Consolidated Tribal Health Project, Inc.
Cook Inlet Tribal Council, Inc.
Eight Northern Indian Pueblo Council
Fairbanks Native Association
Feather River Tribal Health, Inc.
Great Lakes Inter-Tribal Council
Healing Lodge of Seven Nations
Indian Health Council
Lake County Tribal Health Consortium, Inc.
Mariposa, Amador, Calaveras, Tuolumne (MACT)
Indian Health Board, Inc.
Northern Valley Indian Health
NW Portland Area Indian Health Board
Ramah Navajo School Board, Inc.
Sierra Tribal Consortium
Sonoma County Indian Health
Southern Indian Health Council
South Puget Intertribal Planning Agency
Toiyabe Indian Health Project
Ukpeagvik Inupiat Corporation
United Indian Health Services
United South and Eastern Tribes, Inc.
United Tribes Technical College
Valdez Native Tribe

*** This list will be updated periodically.**

Title V Compactors
Tribal Organizations

Title V Tribal Organizations*

Alaska Native Tribal Health Consortium (ANTHC)
Aleutian Pribilof Islands Association, Inc.
Arctic Slope Native Association, Ltd.
Bristol Bay Area Health Corporation
Chugachmiut
Copper River Native Association
Council of Athabascan Tribal Governments
Eastern Aleutian Tribes, Inc.
Ketchikan Indian Community
Kodiak Area Native Association
Maniilaq Association
Metlakatla Indian Community
Miami Health Consortium
Mount Sanford Tribal Consortium
Native Village of Eklutna
Northeastern Tribal Health System
Norton Sound Health Corporation
Riverside-San Bernadino County Indian Health, Inc.
Seldovia Village Tribe
Southcentral Foundation
SouthEast Alaska Regional Health Consortium (SEARHC)
Tanana Chiefs Conference, Inc.
Yakutat Tlingit Tribe
Yukon-Kuskokwim Health Corporation

* This list is updated periodically.

Federal Register

Friday,
December 5, 2003

Part III

Department of the Interior

Bureau of Indian Affairs

Indian Entities Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs; Notice

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Indian Entities Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: Notice is hereby given of the current list of 562 tribal entities recognized and eligible for funding and services from the Bureau of Indian Affairs by virtue of their status as Indian tribes. This notice is published pursuant to section 104 of the Act of November 2, 1994 (Pub. L. 103–454; 108 Stat. 4791, 4792).

FOR FURTHER INFORMATION CONTACT: Daisy West, Bureau of Indian Affairs, Division of Tribal Government Services, MS–320-MIB, 1849 C Street, NW., Washington, DC 20240. Telephone number: (202) 513–7641.

SUPPLEMENTARY INFORMATION: This notice is published in exercise of authority delegated to the Assistant Secretary—Indian Affairs under 25 U.S.C. 2 and 9 and 209 DM 8.

Published below is a list of federally acknowledged tribes in the contiguous 48 states and in Alaska. The list is updated from the notice published on July 12, 2002 (67 FR 46328).

Several tribes have made changes to their tribal name. To aid in identifying tribal name changes, the tribe's former name is included with the new tribal name. We will continue to list the tribe's former name for several years before dropping the former name from the list. We have also made several corrections. To aid in identifying corrections, the tribe's previously listed name is included with the tribal name.

The listed entities are acknowledged to have the immunities and privileges available to other federally acknowledged Indian tribes by virtue of their government-to-government relationship with the United States as well as the responsibilities, powers, limitations and obligations of such tribes. We have continued the practice of listing the Alaska Native entities separately solely for the purpose of facilitating identification of them and reference to them given the large number of complex Native names.

Dated: November 21, 2003.

Aurene M. Martin,

Principal Deputy Assistant Secretary—Indian Affairs.

Indian Tribal Entities Within the Contiguous 48 States Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs

Absentee-Shawnee Tribe of Indians of Oklahoma
Agua Caliente Band of Cahuilla Indians of the Agua Caliente Indian Reservation, California
Ak Chin Indian Community of the Maricopa (Ak Chin) Indian Reservation, Arizona
Alabama-Coushatta Tribes of Texas
Alabama-Quassarte Tribal Town, Oklahoma
Alturas Indian Rancheria, California
Apache Tribe of Oklahoma
Arapahoe Tribe of the Wind River Reservation, Wyoming
Aroostook Band of Micmac Indians of Maine
Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana
Augustine Band of Cahuilla Mission Indians of the Augustine Reservation, California
Bad River Band of the Lake Superior Tribe of Chippewa Indians of the Bad River Reservation, Wisconsin
Bay Mills Indian Community, Michigan
Bear River Band of the Rohnerville Rancheria, California
Berry Creek Rancheria of Maidu Indians of California
Big Lagoon Rancheria, California
Big Pine Band of Owens Valley Paiute Shoshone Indians of the Big Pine Reservation, California
Big Sandy Rancheria of Mono Indians of California
Big Valley Band of Pomo Indians of the Big Valley Rancheria, California
Blackfeet Tribe of the Blackfeet Indian Reservation of Montana
Blue Lake Rancheria, California
Bridgeport Paiute Indian Colony of California
Buena Vista Rancheria of Me-Wuk Indians of California
Burns Paiute Tribe of the Burns Paiute Indian Colony of Oregon
Cabazon Band of Mission Indians, California (previously listed as the Cabazon Band of Cahuilla Mission Indians of the Cabazon Reservation)
Cachil DeHe Band of Wintun Indians of the Colusa Indian Community of the Colusa Rancheria, California
Caddo Nation of Oklahoma (formerly the Caddo Indian Tribe of Oklahoma)
Cahuilla Band of Mission Indians of the Cahuilla Reservation, California
Cahto Indian Tribe of the Laytonville Rancheria, California
California Valley Miwok Tribe, California (formerly the Sheep Ranch Rancheria of Me-Wuk Indians of California)
Campo Band of Diegueno Mission Indians of the Campo Indian Reservation, California
Capitan Grande Band of Diegueno Mission Indians of California:
Barona Group of Capitan Grande Band of Mission Indians of the Barona Reservation, California
Viejas (Baron Long) Group of Capitan Grande Band of Mission Indians of the Viejas Reservation, California
Catawba Indian Nation (aka Catawba Tribe of South Carolina)
Cayuga Nation of New York
Cedarville Rancheria, California
Chemehuevi Indian Tribe of the Chemehuevi Reservation, California
Cher-Ae Heights Indian Community of the Trinidad Rancheria, California
Cherokee Nation, Oklahoma
Cheyenne-Arapaho Tribes of Oklahoma
Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota
Chickasaw Nation, Oklahoma
Chicken Ranch Rancheria of Me-Wuk Indians of California
Chippewa-Cree Indians of the Rocky Boy's Reservation, Montana
Chitimacha Tribe of Louisiana
Choctaw Nation of Oklahoma
Citizen Potawatomi Nation, Oklahoma
Cloverdale Rancheria of Pomo Indians of California
Cocopah Tribe of Arizona
Coeur D'Alene Tribe of the Coeur D'Alene Reservation, Idaho
Cold Springs Rancheria of Mono Indians of California
Colorado River Indian Tribes of the Colorado River Indian Reservation, Arizona and California
Comanche Nation, Oklahoma (formerly the Comanche Indian Tribe)
Confederated Salish & Kootenai Tribes of the Flathead Reservation, Montana
Confederated Tribes of the Chehalis Reservation, Washington
Confederated Tribes of the Colville Reservation, Washington
Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians of Oregon
Confederated Tribes of the Goshute Reservation, Nevada and Utah
Confederated Tribes of the Grand Ronde Community of Oregon
Confederated Tribes of the Siletz Reservation, Oregon
Confederated Tribes of the Umatilla Reservation, Oregon
Confederated Tribes of the Warm Springs Reservation of Oregon
Confederated Tribes and Bands of the Yakama Nation, Washington (formerly

the Confederated Tribes and Bands of the Yakama Indian Nation of the Yakama Reservation)
Coquille Tribe of Oregon
Cortina Indian Rancheria of Wintun Indians of California
Coushatta Tribe of Louisiana
Cow Creek Band of Umpqua Indians of Oregon
Cowlitz Indian Tribe, Washington
Coyote Valley Band of Pomo Indians of California
Crow Tribe of Montana
Crow Creek Sioux Tribe of the Crow Creek Reservation, South Dakota
Death Valley Timbi-Sha Shoshone Band of California
Delaware Nation, Oklahoma (formerly the Delaware Tribe of Western Oklahoma)
Delaware Tribe of Indians, Oklahoma
Dry Creek Rancheria of Pomo Indians of California
Duckwater Shoshone Tribe of the Duckwater Reservation, Nevada
Eastern Band of Cherokee Indians of North Carolina
Eastern Shawnee Tribe of Oklahoma
Elem Indian Colony of Pomo Indians of the Sulphur Bank Rancheria, California
Elk Valley Rancheria, California
Ely Shoshone Tribe of Nevada
Enterprise Rancheria of Maidu Indians of California
Ewiiaapaayp Band of Kumeyaay Indians, California (formerly the Cuyapaipe Community of Diegueno Mission Indians of the Cuyapaipe Reservation)
Federated Indians of Graton Rancheria, California (formerly the Graton Rancheria)
Flandreau Santee Sioux Tribe of South Dakota
Forest County Potawatomi Community, Wisconsin
Fort Belknap Indian Community of the Fort Belknap Reservation of Montana
Fort Bidwell Indian Community of the Fort Bidwell Reservation of California
Fort Independence Indian Community of Paiute Indians of the Fort Independence Reservation, California
Fort McDermitt Paiute and Shoshone Tribes of the Fort McDermitt Indian Reservation, Nevada and Oregon
Fort McDowell Yavapai Nation, Arizona (formerly the Fort McDowell Mohave-Apache Community of the Fort McDowell Indian Reservation)
Fort Mojave Indian Tribe of Arizona, California & Nevada
Fort Sill Apache Tribe of Oklahoma
Gila River Indian Community of the Gila River Indian Reservation, Arizona
Grand Traverse Band of Ottawa and Chippewa Indians, Michigan
Greenville Rancheria of Maidu Indians of California
Grindstone Indian Rancheria of Wintun-Wailaki Indians of California
Guidiville Rancheria of California
Hannahville Indian Community, Michigan
Havasupai Tribe of the Havasupai Reservation, Arizona
Ho-Chunk Nation of Wisconsin (formerly the Wisconsin Winnebago Tribe)
Hoh Indian Tribe of the Hoh Indian Reservation, Washington
Hoopa Valley Tribe, California
Hopi Tribe of Arizona
Hopland Band of Pomo Indians of the Hopland Rancheria, California
Houlton Band of Maliseet Indians of Maine
Hualapai Indian Tribe of the Hualapai Indian Reservation, Arizona
Huron Potawatomi, Inc., Michigan
Inaja Band of Diegueno Mission Indians of the Inaja and Cosmit Reservation, California
Ione Band of Miwok Indians of California
Iowa Tribe of Kansas and Nebraska
Iowa Tribe of Oklahoma
Jackson Rancheria of Me-Wuk Indians of California
Jamestown S'Klallam Tribe of Washington
Jamul Indian Village of California
Jena Band of Choctaw Indians, Louisiana
Jicarilla Apache Nation, New Mexico (formerly the Jicarilla Apache Tribe of the Jicarilla Apache Indian Reservation)
Kaibab Band of Paiute Indians of the Kaibab Indian Reservation, Arizona
Kalispel Indian Community of the Kalispel Reservation, Washington
Karuk Tribe of California
Kashia Band of Pomo Indians of the Stewarts Point Rancheria, California
Kaw Nation, Oklahoma
Keweenaw Bay Indian Community, Michigan
Kialegee Tribal Town, Oklahoma
Kickapoo Tribe of Indians of the Kickapoo Reservation in Kansas
Kickapoo Tribe of Oklahoma
Kickapoo Traditional Tribe of Texas
Kiowa Indian Tribe of Oklahoma
Klamath Indian Tribe of Oregon
Kootenai Tribe of Idaho
La Jolla Band of Luiseno Mission Indians of the La Jolla Reservation, California
La Posta Band of Diegueno Mission Indians of the La Posta Indian Reservation, California
Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wisconsin
Lac du Flambeau Band of Lake Superior Chippewa Indians of the Lac du Flambeau Reservation of Wisconsin
Lac Vieux Desert Band of Lake Superior Chippewa Indians, Michigan
Las Vegas Tribe of Paiute Indians of the Las Vegas Indian Colony, Nevada
Little River Band of Ottawa Indians, Michigan
Little Traverse Bay Bands of Odawa Indians, Michigan
Lower Lake Rancheria, California
Los Coyotes Band of Cahuilla & Cupeno Indians of the Los Coyotes Reservation, California (formerly the Los Coyotes Band of Cahuilla Mission Indians of the Los Coyotes Reservation)
Lovelock Paiute Tribe of the Lovelock Indian Colony, Nevada
Lower Brule Sioux Tribe of the Lower Brule Reservation, South Dakota
Lower Elwha Tribal Community of the Lower Elwha Reservation, Washington
Lower Sioux Indian Community in the State of Minnesota
Lummi Tribe of the Lummi Reservation, Washington
Lytton Rancheria of California
Makah Indian Tribe of the Makah Indian Reservation, Washington
Manchester Band of Pomo Indians of the Manchester-Point Arena Rancheria, California
Manzanita Band of Diegueno Mission Indians of the Manzanita Reservation, California
Mashantucket Pequot Tribe of Connecticut
Match-e-be-nash-she-wish Band of Pottawatomi Indians of Michigan
Mechoopda Indian Tribe of Chico Rancheria, California
Menominee Indian Tribe of Wisconsin
Mesa Grande Band of Diegueno Mission Indians of the Mesa Grande Reservation, California
Mescalero Apache Tribe of the Mescalero Reservation, New Mexico
Miami Tribe of Oklahoma
Miccosukee Tribe of Indians of Florida
Middletown Rancheria of Pomo Indians of California
Minnesota Chippewa Tribe, Minnesota (Six component reservations: Bois Forte Band (Nett Lake); Fond du Lac Band; Grand Portage Band; Leech Lake Band; Mille Lacs Band; White Earth Band)
Mississippi Band of Choctaw Indians, Mississippi
Moapa Band of Paiute Indians of the Moapa River Indian Reservation, Nevada
Modoc Tribe of Oklahoma
Mohegan Indian Tribe of Connecticut
Mooretown Rancheria of Maidu Indians of California
Morongo Band of Cahuilla Mission Indians of the Morongo Reservation, California

Muckleshoot Indian Tribe of the Muckleshoot Reservation, Washington
Muscogee (Creek) Nation, Oklahoma
Narragansett Indian Tribe of Rhode Island
Navajo Nation, Arizona, New Mexico & Utah
Nez Perce Tribe of Idaho
Nisqually Indian Tribe of the Nisqually Reservation, Washington
Nooksack Indian Tribe of Washington
Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, Montana
Northfork Rancheria of Mono Indians of California
Northwestern Band of Shoshoni Nation of Utah (Washakie)
Oglala Sioux Tribe of the Pine Ridge Reservation, South Dakota
Omaha Tribe of Nebraska
Oneida Nation of New York
Oneida Tribe of Indians of Wisconsin
Onondaga Nation of New York
Osage Tribe, Oklahoma
Ottawa Tribe of Oklahoma
Otoe-Missouria Tribe of Indians, Oklahoma
Paiute Indian Tribe of Utah (Cedar City Band of Paiutes, Kanosh Band of Paiutes, Koosharem Band of Paiutes, Indian Peaks Band of Paiutes, and Shivwits Band of Paiutes)
Paiute-Shoshone Indians of the Bishop Community of the Bishop Colony, California
Paiute-Shoshone Tribe of the Fallon Reservation and Colony, Nevada
Paiute-Shoshone Indians of the Lone Pine Community of the Lone Pine Reservation, California
Pala Band of Luiseno Mission Indians of the Pala Reservation, California
Pascua Yaqui Tribe of Arizona
Paskenta Band of Nomlaki Indians of California
Passamaquoddy Tribe of Maine
Pauma Band of Luiseno Mission Indians of the Pauma & Yuima Reservation, California
Pawnee Nation of Oklahoma
Pechanga Band of Luiseno Mission Indians of the Pechanga Reservation, California
Penobscot Tribe of Maine
Peoria Tribe of Indians of Oklahoma
Picayune Rancheria of Chukchansi Indians of California
Pinoleville Rancheria of Pomo Indians of California
Pit River Tribe, California (includes XL Ranch, Big Bend, Likely, Lookout, Montgomery Creek and Roaring Creek Rancherias)
Poarch Band of Creek Indians of Alabama
Pokagon Band of Potawatomi Indians, Michigan and Indiana
Ponca Tribe of Indians of Oklahoma
Ponca Tribe of Nebraska
Port Gamble Indian Community of the Port Gamble Reservation, Washington
Potter Valley Rancheria of Pomo Indians of California
Prairie Band of Potawatomi Nation, Kansas (formerly the Prairie Band of Potawatomi Indians)
Prairie Island Indian Community in the State of Minnesota
Pueblo of Acoma, New Mexico
Pueblo of Cochiti, New Mexico
Pueblo of Jemez, New Mexico
Pueblo of Isleta, New Mexico
Pueblo of Laguna, New Mexico
Pueblo of Nambe, New Mexico
Pueblo of Picuris, New Mexico
Pueblo of Pojoaque, New Mexico
Pueblo of San Felipe, New Mexico
Pueblo of San Juan, New Mexico
Pueblo of San Ildefonso, New Mexico
Pueblo of Sandia, New Mexico
Pueblo of Santa Ana, New Mexico
Pueblo of Santa Clara, New Mexico
Pueblo of Santo Domingo, New Mexico
Pueblo of Taos, New Mexico
Pueblo of Tesuque, New Mexico
Pueblo of Zia, New Mexico
Puyallup Tribe of the Puyallup Reservation, Washington
Pyramid Lake Paiute Tribe of the Pyramid Lake Reservation, Nevada
Quapaw Tribe of Indians, Oklahoma
Quartz Valley Indian Community of the Quartz Valley Reservation of California
Quechan Tribe of the Fort Yuma Indian Reservation, California & Arizona
Quileute Tribe of the Quileute Reservation, Washington
Quinault Tribe of the Quinault Reservation, Washington
Ramona Band or Village of Cahuilla Mission Indians of California
Red Cliff Band of Lake Superior Chippewa Indians of Wisconsin
Red Lake Band of Chippewa Indians, Minnesota
Redding Rancheria, California
Redwood Valley Rancheria of Pomo Indians of California
Reno-Sparks Indian Colony, Nevada
Resighini Rancheria, California (formerly the Coast Indian Community of Yurok Indians of the Resighini Rancheria)
Rincon Band of Luiseno Mission Indians of the Rincon Reservation, California
Robinson Rancheria of Pomo Indians of California
Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota
Round Valley Indian Tribes of the Round Valley Reservation, California (formerly the Covelo Indian Community)
Rumsey Indian Rancheria of Wintun Indians of California
Sac & Fox Tribe of the Mississippi in Iowa
Sac & Fox Nation of Missouri in Kansas and Nebraska
Sac & Fox Nation, Oklahoma
Saginaw Chippewa Indian Tribe of Michigan
St. Croix Chippewa Indians of Wisconsin
St. Regis Band of Mohawk Indians of New York
Salt River Pima-Maricopa Indian Community of the Salt River Reservation, Arizona
Samish Indian Tribe, Washington
San Carlos Apache Tribe of the San Carlos Reservation, Arizona
San Juan Southern Paiute Tribe of Arizona
San Manual Band of Serrano Mission Indians of the San Manual Reservation, California
San Pasqual Band of Diegueno Mission Indians of California
Santa Rosa Indian Community of the Santa Rosa Rancheria, California
Santa Rosa Band of Cahuilla Mission Indians of the Santa Rosa Reservation, California
Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation, California
Santa Ysabel Band of Diegueno Mission Indians of the Santa Ysabel Reservation, California
Santee Sioux Nation, Nebraska (formerly the Santee Sioux Tribe of the Santee Reservation of Nebraska)
Sauk-Suiattle Indian Tribe of Washington
Sault Ste. Marie Tribe of Chippewa Indians of Michigan
Scotts Valley Band of Pomo Indians of California
Seminole Nation of Oklahoma
Seminole Tribe of Florida, Dania, Big Cypress, Brighton, Hollywood & Tampa Reservations
Seneca Nation of New York
Seneca-Cayuga Tribe of Oklahoma
Shakopee Mdewakanton Sioux Community of Minnesota
Shawnee Tribe, Oklahoma
Sherwood Valley Rancheria of Pomo Indians of California
Shingle Springs Band of Miwok Indians, Shingle Springs Rancheria (Verona Tract), California
Shoalwater Bay Tribe of the Shoalwater Bay Indian Reservation, Washington
Shoshone Tribe of the Wind River Reservation, Wyoming
Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho
Shoshone-Paiute Tribes of the Duck Valley Reservation, Nevada
Sisseton-Wahpeton Oyate of the Lake Traverse Reservation, South Dakota (formerly the Sisseton-Wahpeton

Sioux Tribe of the Lake Traverse Reservation)
Skokomish Indian Tribe of the Skokomish Reservation, Washington
Skull Valley Band of Goshute Indians of Utah
Smith River Rancheria, California
Snoqualmie Tribe, Washington
Soboba Band of Luiseno Indians, California (formerly the Soboba Band of Luiseno Mission Indians of the Soboba Reservation)
Sokaogon Chippewa Community, Wisconsin
Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado
Spirit Lake Tribe, North Dakota
Spokane Tribe of the Spokane Reservation, Washington
Squaxin Island Tribe of the Squaxin Island Reservation, Washington
Standing Rock Sioux Tribe of North & South Dakota
Stockbridge Munsee Community, Wisconsin
Stillaguamish Tribe of Washington
Summit Lake Paiute Tribe of Nevada
Suquamish Indian Tribe of the Port Madison Reservation, Washington
Susanville Indian Rancheria, California
Swinomish Indians of the Swinomish Reservation, Washington
Sycuan Band of Diegueno Mission Indians of California
Table Bluff Reservation—Wiyot Tribe, California
Table Mountain Rancheria of California
Te-Moak Tribe of Western Shoshone Indians of Nevada (Four constituent bands: Battle Mountain Band; Elko Band; South Fork Band and Wells Band)
Thlopthlocco Tribal Town, Oklahoma
Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota
Tohono O'odham Nation of Arizona
Tonawanda Band of Seneca Indians of New York
Tonkawa Tribe of Indians of Oklahoma
Tonto Apache Tribe of Arizona
Torres-Martinez Band of Cahuilla Mission Indians of California
Tule River Indian Tribe of the Tule River Reservation, California
Tulalip Tribes of the Tulalip Reservation, Washington
Tunica-Biloxi Indian Tribe of Louisiana
Tuolumne Band of Me-Wuk Indians of the Tuolumne Rancheria of California
Turtle Mountain Band of Chippewa Indians of North Dakota
Tuscarora Nation of New York
Twenty-Nine Palms Band of Mission Indians of California
United Auburn Indian Community of the Auburn Rancheria of California
United Keetoowah Band of Cherokee Indians in Oklahoma
Upper Lake Band of Pomo Indians of Upper Lake Rancheria of California
Upper Sioux Community, Minnesota
Upper Skagit Indian Tribe of Washington
Ute Indian Tribe of the Uintah & Ouray Reservation, Utah
Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah
Utu Utu Gwaitu Paiute Tribe of the Benton Paiute Reservation, California
Walker River Paiute Tribe of the Walker River Reservation, Nevada
Wampanoag Tribe of Gay Head (Aquinnah) of Massachusetts
Washoe Tribe of Nevada & California (Carson Colony, Dresslerville Colony, Woodfords Community, Stewart Community, & Washoe Ranches)
White Mountain Apache Tribe of the Fort Apache Reservation, Arizona
Wichita and Affiliated Tribes (Wichita, Keechi, Waco & Tawakonie), Oklahoma
Winnebago Tribe of Nebraska
Winnemucca Indian Colony of Nevada
Wyandotte Nation, Oklahoma (formerly the Wyandotte Tribe of Oklahoma)
Yankton Sioux Tribe of South Dakota
Yavapai-Apache Nation of the Camp Verde Indian Reservation, Arizona
Yavapai-Prescott Tribe of the Yavapai Reservation, Arizona
Yerington Paiute Tribe of the Yerington Colony & Campbell Ranch, Nevada
Yomba Shoshone Tribe of the Yomba Reservation, Nevada
Ysleta Del Sur Pueblo of Texas
Yurok Tribe of the Yurok Reservation, California
Zuni Tribe of the Zuni Reservation, New Mexico

Native Entities Within the State of Alaska Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs

Native Village of Afognak (formerly the Village of Afognak)
Agdaagux Tribe of King Cove
Native Village of Akhiok
Akiachak Native Community
Akiak Native Community
Native Village of Akutan
Village of Alakanuk
Alatna Village
Native Village of Aleknagik
Algaaciq Native Village (St. Mary's)
Allakaket Village
Native Village of Ambler
Village of Anaktuvuk Pass
Yupiit of Andreafski
Angoon Community Association
Village of Aniak
Anvik Village
Arctic Village (See Native Village of Venetie Tribal Government)
Asa'carsarmiut Tribe (formerly the Native Village of Mountain Village)
Native Village of Atka
Village of Atmautluak
Atqasuk Village (Atkasook)
Native Village of Barrow Inupiat Traditional Government
Beaver Village
Native Village of Belkofski
Village of Bill Moore's Slough
Birch Creek Tribe
Native Village of Brevig Mission
Native Village of Buckland
Native Village of Cantwell
Native Village of Chanega (aka Chenega)
Chalkyitsik Village
Cheesh-Na Tribe (formerly the Native Village of Chistochina)
Village of Chefornak
Chevak Native Village
Chickaloon Native Village
Native Village of Chignik
Native Village of Chignik Lagoon
Chignik Lake Village
Chilkat Indian Village (Klukwan)
Chilkoot Indian Association (Haines)
Chinik Eskimo Community (Golovin)
Native Village of Chitina
Native Village of Chuathbaluk (Russian Mission, Kuskokwim)
Chuloonawick Native Village
Circle Native Community
Village of Clarks Point
Native Village of Council
Craig Community Association
Village of Crooked Creek
Curyung Tribal Council (formerly the Native Village of Dillingham)
Native Village of Deering
Native Village of Diomede (aka Inalik)
Village of Dot Lake
Douglas Indian Association
Native Village of Eagle
Native Village of Eek
Egegik Village
Eklutna Native Village
Native Village of Ekuk
Ekwok Village
Native Village of Elim
Emmonak Village
Evansville Village (aka Bettles Field)
Native Village of Eyak (Cordova)
Native Village of False Pass
Native Village of Fort Yukon
Native Village of Gakona
Galena Village (aka Louden Village)
Native Village of Gambell
Native Village of Georgetown
Native Village of Goodnews Bay
Organized Village of Grayling (aka Holikachuk)
Gulkana Village
Native Village of Hamilton
Healy Lake Village
Holy Cross Village
Hoonah Indian Association
Native Village of Hooper Bay
Hughes Village
Huslia Village
Hydaburg Cooperative Association
Igiugig Village
Village of Iliamna

Inupiat Community of the Arctic Slope
Iqurmuit Traditional Council (formerly the Native Village of Russian Mission)
Ivanoff Bay Village
Kaguyak Village
Organized Village of Kake
Kaktovik Village (aka Barter Island)
Village of Kalskag
Village of Kaltag
Native Village of Kanatak
Native Village of Karluk
Organized Village of Kasaan
Native Village of Kasigluk
Kenaitze Indian Tribe
Ketchikan Indian Corporation
Native Village of Kiana
King Island Native Community
King Salmon Tribe
Native Village of Kipnuk
Native Village of Kivalina
Klawock Cooperative Association
Native Village of Kluti Kaah (aka Copper Center)
Knik Tribe
Native Village of Kobuk
Kokhanok Village
Native Village of Kongiganak
Village of Kotlik
Native Village of Kotzebue
Native Village of Koyuk
Koyukuk Native Village
Organized Village of Kwethluk
Native Village of Kwigillingok
Native Village of Kwinhagak (aka Quinhagak)
Native Village of Larsen Bay
Levelock Village
Lesnoi Village (aka Woody Island)
Lime Village
Village of Lower Kalskag
Manley Hot Springs Village
Manokotak Village
Native Village of Marshall (aka Fortuna Ledge)
Native Village of Mary's Igloo
McGrath Native Village
Native Village of Mekoryuk
Mentasta Traditional Council
Metlakatla Indian Community, Annette Island Reserve
Native Village of Minto
Naknek Native Village
Native Village of Nanwalek (aka English Bay)
Native Village of Napaimute
Native Village of Napakiak
Native Village of Napaskiak
Native Village of Nelson Lagoon
Nenana Native Association
New Koliganek Village Council (formerly the Koliganek Village)
New Stuyahok Village
Newhalen Village
Newtok Village
Native Village of Nightmute
Nikolai Village
Native Village of Nikolski
Ninilchik Village
Native Village of Noatak
Nome Eskimo Community
Nondalton Village
Noorvik Native Community
Northway Village
Native Village of Nuiqsut (aka Nooiksut)
Nulato Village
Nunakauyarmiut Tribe (formerly the Native Village of Toksook Bay)
Native Village of Nunapitchuk
Village of Ohogamiut
Village of Old Harbor
Orutsararmuit Native Village (aka Bethel)
Oscarville Traditional Village
Native Village of Ouzinkie
Native Village of Paimiut
Pauloff Harbor Village
Pedro Bay Village
Native Village of Perryville
Petersburg Indian Association
Native Village of Pilot Point
Pilot Station Traditional Village
Native Village of Pitka's Point
Platinum Traditional Village
Native Village of Point Hope
Native Village of Point Lay
Native Village of Port Graham
Native Village of Port Heiden
Native Village of Port Lions
Portage Creek Village (aka Ohgsenakale)
Pribilof Islands Aleut Communities of St. Paul & St. George Islands
Qagan Tayagungin Tribe of Sand Point Village
Qawalangin Tribe of Unalaska
Rampart Village
Village of Red Devil
Native Village of Ruby
Saint George Island (See Pribilof Islands Aleut Communities of St. Paul & St. George Islands)
Native Village of Saint Michael
Saint Paul Island (See Pribilof Islands Aleut Communities of St. Paul & St. George Islands)
Village of Salamatoff
Native Village of Savoonga
Organized Village of Saxman
Native Village of Scammon Bay
Native Village of Selawik
Seldovia Village Tribe
Shageluk Native Village
Native Village of Shaktoolik
Native Village of Sheldon's Point
Native Village of Shishmaref
Shoonaq' Tribe of Kodiak
Native Village of Shungnak
Sitka Tribe of Alaska
Skagway Village
Village of Sleetmute
Village of Solomon
South Naknek Village
Stebbins Community Association
Native Village of Stevens
Village of Stony River
Takotna Village
Native Village of Tanacross
Native Village of Tanana
Native Village of Tatitlek
Native Village of Tazlina
Telida Village
Native Village of Teller
Native Village of Tetlin
Central Council of the Tlingit & Haida Indian Tribes
Traditional Village of Togiak
Tuluksak Native Community
Native Village of Tuntutuliak
Native Village of Tununak
Twin Hills Village
Native Village of Tyonek
Ugashik Village
Umkumiute Native Village
Native Village of Unalakleet
Native Village of Unga
Village of Venetie (See Native Village of Venetie Tribal Government)
Native Village of Venetie Tribal Government (Arctic Village and Village of Venetie)
Village of Wainwright
Native Village of Wales
Native Village of White Mountain
Wrangell Cooperative Association
Yakutat Tlingit Tribe

[FR Doc. 03–30244 Filed 12–4–03; 8:45 am]
BILLING CODE 4310–4J–P

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

June 9, 2006 **SMDL#06-014**

Dear State Medicaid Director:

On October 18, 2005 The Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director (SMD) letter containing guidance for participation by Tribal organizations in arrangements that use certified public expenditures by a "unit of government" to fulfill the non- federal matching requirements for administrative activities under the Medicaid program. The letter set forth criteria under which a Tribal organization may be considered as a unit of government that can certify expenditures as the non-Federal share of Medicaid administration claims. The letter contained the following footnote:

"Federal funds may not be used to meet State matching requirements, except as authorized by Federal law. Although Federal HHS funds awarded under ISDEAA [the Indian Self-Determination and Education Assistance Act, or Pub.L. 93-638] may be used to meet Tribal matching requirements, that authority does not include State matching requirements. As a result, Tribal expenditures certified for this purpose must be funded through non-ISDEAA sources."

Although the footnote correctly states the applicable principles of law, after further review, we have determined that the conclusion in the last sentence would not apply when the full financial benefit and responsibility has been assigned to the tribal organization. The Indian Health Service (IHS) and CMS are issuing this joint SMD letter to clarify that footnote.

When a State assigns to a tribal organization the full right to the federal matching share, without any diminution, along with the full responsibility for establishing the non-federal share through certified public expenditures, the State effectively drops out of the financial equation. What remains is a funding arrangement under which federal matching funds are directly available to the tribal organization based on the tribal organization's expenditures. This is effectively a tribal matching obligation, rather than a contribution to a larger State matching obligation.

Based on this analysis that such an arrangement effectively results in a tribal matching obligation, the Indian Health Service (HIS) has determined that ISDEAA funds may be used for certified public expenditures under such an arrangement to obtain federal Medicaid matching funding. The net required contribution by the Tribal organization cannot exceed the non-Federal share of such expenditures; thus the State must pass through to the Tribal organization the full amount of Federal Medicaid matching funding received based on the certified expenditures.

It is important to note that ISDEAA funds may only be used to fund activities permissible under the ISDEAA. This includes activities authorized under the Snyder Act, 25 U.S.C. 13, and the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. §1601 et seq. Thus, any Medicaid administrative activities that are funded with ISDEAA funds must also be permissible activities under the Snyder Act or the IHCIA.

The October 18, 2005 State Medicaid Director letter also contained four criteria for recognition of Tribal organization expenditures as the non-Federal share of Medicaid administration claims. The fourth criterion, stating that expenditures for allowable administrative activities which are certified by the Tribal organizations must be made with Tribal sources of revenue other than Medicaid revenues or ISDEAA funds is amended to delete the reference to ISDEAA funds, which may now be used as outlined in this letter. Additionally, a fifth criterion is hereby added. The fourth and fifth criteria now read as follows:

4. Expenditures for allowable Medicaid administrative activities which are certified by the Tribal organization are made with funds derived from Tribal sources of revenue other than Medicaid revenues.

5. Expenditures made with funds derived from ISDEAA agreements may be certified by the Tribal organization only to the extent that the State passes the entire amount of Federal Medicaid matching funding to the Tribal organization.

Tribes, as well as Tribal organizations, which certify Medicaid administration expenditures made with funds derived from ISDEAA agreements, must receive the full amount of Federal Medicaid matching funding.

If you have questions regarding this matter, please contact Ed Gendron at CMS on 410-786-1064 or Carl Harper at HIS on 301-443-3216.

Sincerely,

/s/
Dr. Charles Grim, D.D.S.,M.H.S.A.
Director
Indian Health Service

/s/
Dennis G. Smith
Director
Center for Medicaid and State Operations

Cc:

CMS Regional Administrators

CMS Associate Regional Administrators
For Medicaid and State Operations

Martha Roberty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
Director of Policy and Programs
Association of State and Territorial Health Officials

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Lynne Flynn
Director for Health Policy
Council of State Governments

H. Sally Smith
Chairperson
National Indian Health Board

Valerie Davidson
Chairperson
CMS Tribal Technical Advisory Group

HIS Area Directors

Submitter : David Lopez **Date:** 03/19/2007

Organization : Texas Coalition of Transferring Hospitals

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attached.

CMS-2258-P-274-Attach-1.DOC

CMS-2258-P-274-Attach-2.DOC

#274

★Texas Coalition of Transferring Hospitals

March 21, 2007

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

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

Dear Ms. Norwalk:

The following comments are submitted by the Texas Coalition of Transferring Hospitals (TCTH), 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:

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

I. Introduction

TCTH member hospitals provide care to Medicaid patients and the uninsured in counties and cities throughout Texas. For example, Parkland Health & Human Systems in Dallas provided approximately $409 million in uncompensated care in 2006. R.E. Thomason – located in one of the largest, yet poorest cities in Texas – provided more than $159 million in uncompensated care in 2005. However, the hospital received only $42.8 million from local taxes and was reimbursed at lower levels than the area's private hospitals. More than 30% of Thomason's total patient population is covered by Medicaid or Medicare.

In total, member hospitals provided over $1.5 billion in care to patients without health insurance. Further, uninsured costs continue to rise for these hospitals due to the treatment of refugees relocating from areas affected by Hurricane Katrina. Federal disproportionate share hospital payments reimburse these hospitals for less than half of these costs. Even when adding Medicaid upper payment limit (UPL) payments, these providers are significantly underpaid for the care they provide to Medicaid and uninsured patients. Local ad valorem tax support (increasingly used as intergovernmental transfers) are necessary to ensure the continued viability of this critical health safety net.

In addition to providing uncompensated care, most TCTH member hospitals are teaching hospitals, incurring large medical training expenses. Many of the hospitals are also the only trauma centers for their regions.

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

The need for federal funding to support the healthcare safety-net system of 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 largest 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, however, depending 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 Tarrant County, Texas, 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

> [S]ixty-four percent of net Medicaid DSH payments went to hospitals with at least 30 percent low-income patients while 80 percent of net payments went to hospitals with at least twenty 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]

TCTH's members <u>are</u> the backbone of the heath care safety net in Texas.

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[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. Many concerns have been voiced regarding this lack of clarity – most relevant is the possibility that non-public facilities have the ability to make intergovernmental transfers (IGTs). This has the potential of inflating federal Medicaid payments.

In an attempt to address this issue, 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."

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.

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, public 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 require public providers to limit Medicaid reimbursement to cost while allowing private facilities to continue receiving full reimbursement for services provided.

Rather than limiting Medicaid (non-DSH) reimbursement to Medicaid cost for public facilities only, a fairer approach would be to limit *all* Medicaid reimbursements to a hospital's cost of care of serving Medicaid and uninsured patients – whether the facility is deemed to be a unit of government or not.

CMS' proposed cap on public hospital 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 from public facilities 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 not by implementing a punitive cap

on Medicaid payments to public hospitals. In Texas, intergovernmental transfers derive directly from local ad valorem taxes and IGTs do not exceed the local revenue raised for the support of health care. There has been no abuse of IGTs in Texas. Nonetheless, the proposed rule will result in a loss of over $300 million in federal Medicaid reimbursement to these Texas safety net facilities.

2. Recommendation

CMS should limit Medicaid reimbursement to all hospitals based upon a hospital's cost of care to 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 for all providers.

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 TCTH.

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 safety-net facilities such as those that are members of TCTH. To remain viable and thus continue to provide the services that "shield" other providers from a larger burden of care to the uninsured, safety-net hospitals must meet salaries, contractual payments to physician groups, and support of community clinics. In addition, such hospitals incur legitimate costs for capital costs, investments in technology, and important reserve funds. Moreover, as noted above, most of the members of TCTH have a great responsibility for the training of medical personnel; thus, they incur significant medical education costs.

Safety-net providers 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-nets provide care for the uninsured which is beyond current Medicaid reimbursement. Absent universal health coverage, safety-net hospitals must rely on Medicaid reimbursements 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 cap. As noted above, most of the TCTH member hospitals provide valuable services to the whole state of Texas by virtue of its training of medical personnel. This adds to the hospitals' financial burden and cannot be borne by the teaching hospital alone.

2. Recommendation

Given the above, TCTH recommends that CMS adequately defines 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 by entities without public status or public funds. 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 the members of TCTH. CMS should ensure fair and equitable Medicaid reimbursement for all providers regardless of their public or private status. The proposed public hospital cost cap fails to do so. 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, TCTH appreciates the opportunity to comment on the proposed rule changes.

Sincerely,

David Lopez
CEO, Harris County Hospital District
On behalf of the Texas Coalition of Transferring Hospitals

Submitter : Dr. Larry Fields **Date:** 03/19/2007

Organization : American Academy of Family Physicians

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-275-Attach-1.DOC

#275

March 15, 2007

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

Dear Ms. Norwalk:

I am writing on behalf of the American Academy of Family Physicians, which represents more than 93,800 family physicians, family medicine residents, and medical students nationwide. Specifically, I am writing to offer our comments on 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," as published in the *Federal Register* on January 18, 2007.

CMS indicates that this NPRM addresses a number of key Medicaid financing issues. CMS states that the proposed rule seeks to ensure that statutory requirements within the Medicaid program are met. The proposed rule: (1) reiterates that only units of government are able to participate in the financing of the non-Federal share of Medicaid payments; (2) establishes minimum requirements for documenting cost when using a certified public expenditure; (3) limits providers operated by units of government to reimbursement that does not exceed the cost of providing covered services to eligible Medicaid recipients; (4) provides that providers receive and retain the total computable amount of their Medicaid payments; and (5) makes appropriate conforming changes to the State Child Health Insurance Program (SCHIP) regulations.

The regulation seeks to redefine three types of Medicaid financing mechanisms: intergovernmental transfers; certified public expenditures; and the use of state and local tax revenue.

We are disappointed that CMS chose to issue this new rule on the heels of the *Deficit Reduction Act of 2005 (DRA)*. The various and sundry changes to Medicaid contained in the DRA still are being implemented by the states, District of Columbia and U.S. insular areas participating in the program. Implementation of this rule would pose an undue financial burden on states while they are in the midst of reorganizing programs designed to support the sickest and poorest of this nation as a result of DRA requirements.

Such a large cost shift to the states, at this time, will hamper state efforts to expand access to care for all children qualifying for Medicaid and SCHIP, as well as threaten access to, and quality of, care to disabled, chronically ill, and elderly confined to nursing facilities. Community health centers, the backbone of care to the medically disenfranchised, as well as local, regional and state hospitals all will be hurt by implementation of this rule during the midst of significant state reorganization of Medicaid due to new federal requirements.

We hope CMS will allow states to implement changes to Medicaid both authorized and mandated under the DRA before making such a significant alteration to established state health care financing practices. Family physicians share CMS' goal of clear and fair funding of Medicaid for all states and territories. However, the proposed rule will have an adverse effect on the most vulnerable patients.

In closing, we appreciate the opportunity to comment on this proposed regulation. As always, the American Academy of Family Physicians looks forward to working with CMS in its continued efforts to ensure access to care for our most vulnerable patients.

Sincerely,

Larry S. Fields, MD, FAAFP
Board Chair

cc: Secretary Michael O. Leavitt

Submitter : Mr. Matthew Gutwein **Date:** 03/19/2007

Organization : Health and Hospital Corporation of Marion County

Category : Hospital

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See attachment.

CMS-2258-P-276-Attach-1.DOC

#276

The Health and Hospital Corporation of Marion County 3838 North Rural Street, 8th Floor Indianapolis, IN 46205-2930 March 19, 2007	

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

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

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 Health and Hospital Corporation of Marion County and its Division of Public Hospitals d/b/a Wishard Health Services ("HHC" or "Wishard"), located in Indianapolis, IN, respectfully submits these comments to the Centers for Medicare & Medicaid Services ("CMS") regarding the proposed rule set forth at 72 F.R. 2236 (January 18, 2007) ("Proposed Rules"), which propose to redefine a public entity to be a unit of government with generally applicable taxing authority, limit public providers to Medicaid reimbursement that does not exceed their costs, and otherwise limit Medicaid reimbursement received by public hospitals and other public healthcare providers. HHC, a municipal corporation, is a governmental entity, which has a statutory mission of furnishing "medical care to the indigent of the county", as well as the authority to extend its programs throughout the State, and which has the authority to levy taxes.[1] Wishard Hospital, a major teaching hospital, is specifically required to "be for the benefit of the residents of the county and of every person who becomes sick, injured or maimed within the county."[2] Serving Indiana's most populated county, HHC is an integral part of Indiana's safety-net and relies extensively on its Medicaid reimbursement, as well as its relationship with the State, to help finance such reimbursement through the appropriations it receives. Therefore, Medicaid reimbursement, particularly the ability to obtain such reimbursement and help the State of Indiana pay for the Medicaid program, is of particular concern to HHC and is crucial to HHC's ability to fulfill its mission.

Like other members of the health care safety-net, HHC provides a substantial portion of care for the poor and indigent members of our community, and any reduction of reimbursement will

[1] See Indiana Code Sections 16-22-8-34(a)(6) and 16-22-34(a)(8).
[2] See Indiana Code Section 16-22-39(a).

undoubtedly endanger HHC's ability to provide care to Medicaid patients, as well as to other members of the community at large. In 2006, HHC's Wishard payer mix was 22.5% Medicare, 27.5% Medicaid, 8.9% commercial, 35.5% uninsured and 5.8% other, making it the largest public hospital in Indiana and one of only two general acute care hospitals most recently qualifying for Medicaid disproportionate share payments based upon is low-income utilization rate. CMS' Proposed Rules would limit HHC's Medicaid payments to its Medicaid costs, which HHC projects to cost a minimum of ten million ($10,000,000) in annual revenues to Wishard, but more likely to result in a loss of forty million dollars ($40,000,000) to HHC alone. HHC objects to the Proposed Rules, which will unfairly injure HHC, as well as the members of the community and of the State of Indiana that it serves, for CMS' reasoning of promoting efficiency and economy in the Medicaid program. This loss of revenue will undoubtedly impact HHC's programs and the people served by them, including its operation of:

- One of only two Level 1 Trauma Centers in Indiana;
- The Richard M. Fairbanks Burn Center, which is one of only four burn centers in Indiana, one of only fifty (50) burn centers in the United States that is verified by the American College of Surgeons and the American Burn Association, and the only adult burn center that serves central and southern Indiana;
- Its medical education programs with the Indiana University School of Medicine and other state institutions;
- Long-term care programs for Medicaid patients in Marion County and around the State of Indiana, which have greatly improved quality of care, efficiency and facilitated movement of Medicaid-eligible seniors into the community;
- Inpatient and outpatient mental health services through its Midtown Community Mental Health Center, which serves as Wishard's department of psychiatry and which was the first in the State of Indiana to provide a psychiatric emergency room;
- The hospital-based ambulance service for the City of Indianapolis, surrounding townships and the City of Speedway; and
- Its innovative Wishard Advantage program, which was one of the first "managed care" programs for qualifying indigent members of the community in the country, providing preventive care in outpatient settings for a true continuum of care for the uninsured and for the prevention of more costly disabling conditions.

As a non-state governmental entity, HHC has the ability to certify its Medicaid expenditures for federal financial participation. The Proposed Rules would require a complex and overly burdensome process, which would require many provider and State resources, to provide minimal, if any, savings to the Medicaid program. Therefore, HHC is concerned about this unnecessary process.

HHC has long been a partner with the State of Indiana in providing such innovative programs and needed health care safety-net services for both Medicaid-eligible individuals in the community and throughout the State of Indiana. HHC is critical to maintaining appropriate

access to care for Indiana Medicaid patients. As a local governmental entity, with the mission of providing medical care to every person who becomes sick, injured or maimed in Marion County and with the ability to levy local property taxes, HHC helps support the State's Medicaid program by contributing local property tax dollars for the Medicaid program, including the non-federal share of Medicaid outreach services in Marion County and the State of Indiana, a substantial portion of the non-federal share of Medicaid disproportionate share and Medicaid supplemental payments for its own hospital and for other qualifying safety-net providers around the state, and the non-federal share of other general State Medicaid expenditures. The Proposed Rules would jeopardize this fragile relationship, which enables Medicaid recipients to obtain Medicaid's required access to care and quality services throughout the State of Indiana in the least restrictive and most appropriate setting. Congress has specifically and intentionally limited CMS' ability to restrict the use of such local governmental funds in recognition of the unique relationships between State and local governments to fund programs that benefit the persons living within the State. For this reason, HHC questions CMS' authority in creating certain provisions of the Proposed Rules, as HHC believes the Proposed Rules exceed the authority given to CMS by Congress and interfere with State sovereignty in many respects. Specific issues with, and comments regarding, the Proposed Rules are set forth below, in the following order:

1. Defining a "Unit of Government"
   A. County Hospitals
   B. State Universities
2. Sources of State Share and Documentation of Certified Public Expenditures
3. Cost Limit for Providers Operated by Units of Government
   A. Lack of Authority to Limit Governmental Providers to their own Costs
   B. Negative Impact upon Patient Care and of Medicaid Patients' Access to Such Care
   C. Medicaid Supplemental Payments to Governmental Providers Help Supplement Low Statewide Medicaid Disproportionate Share Allocations
   D. Valuable Programs Benefiting Medicaid Recipients will be Jeopardized
   E. Impermissible Limit on Certified Public Expenditures
4. Retention of Payments
5. Elimination of Payment Flexibility To Pay Providers in Excess of Cost and Conforming Changes to Reflect Upper Payment Limits for Governmental Providers

1. Defining a "Unit of Government" (42 CFR § 433.50).

The Proposed Rule impermissibly narrows the definition of a "unit of government" and a "health care provider" that may be "considered a unit of government". CMS should withdraw this definition and utilize the statutory definition of "unit of local government" provided at Section 1903(w)(7)(G) of the Social Security Act.

It is well settled that an agency regulation can be set aside if the agency exceeds its statutory authority or if the regulation is arbitrary, capricious, or otherwise not in accordance with law.[3] If an administrator promulgates a regulation which is inconsistent with the plain language of the governing statute, federal courts are constrained to declare that regulation invalid.[4]

Here, Congress has expressly defined the term "unit of local government" for purposes of Title XIX of the Social Security Act (the "Medicaid Statute") as follows:

> The term "unit of local government" means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.[5]

However, CMS is proposing to add the following new language to 42 CFR § 433.50, ostensibly to "clarify" Congress' definition of "unit of local government":

> (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.*
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> (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:
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> (A) The health care provider *has generally applicable taxing authority*; or
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> (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.[6]

Although HHC has generally applicable taxing authority, HHC believes this particular language of the Proposed Rule exceeds CMS's statutory authority under Medicaid and is inconsistent with the plain language of the Medicaid statute. The imposition of additional requirements that a unit of government have "generally applicable taxing authority" and be "legally obligated to fund the health care provider's expenses, liabilities, and deficits" – provisions found nowhere in the express language of the Medicaid Statute – impermissibly restricts the meaning of "unit of local government" as Congress intended that term to be defined.

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[3] *Meade Township v Andrus*, 695 F.2d 1006, 1009 (6th Cir. 1982).
[4] Id.
[5] 42 U.S.C. § 1396b(w)(7)(G).
[6] Emphasis added.

Case law provides that the starting point in every case involving construction of a statute is the language itself.[7] Where a statute states what a term "means," then all other meanings not stated are excluded.[8] Moreover, where Congress knows how to say something, but chooses not to, its silence is controlling.[9] Courts are obligated to refrain from embellishing statutes by inserting language that Congress has opted to omit.[10]

The Medicaid Statute defines the term "unit of local government" to mean "a city, county, special purpose district, or other governmental unit in the State."[11] Nothing in the language utilized by Congress engrafts upon the governmental unit the further requirement that it have generally applicable taxing authority. Quite the contrary, the familiar understanding of a local governmental unit, often referred to as a political subdivision, is that they are created merely "'as convenient agencies for exercising such of the governmental powers of the State as may be entrusted to them' . . . in [its] absolute discretion."[12] Additionally, "[l]ocal governmental entities are frequently charged with various responsibilities incident to the operation of state government. In many States much of the legislature's activity involves the enactment of so-called local legislation, directed only to the concerns of particular political subdivisions."[13] These various responsibilities of local governmental units, however, do not necessarily encompass the authority to tax.

Indeed, Congress has in other contexts defined the term "unit of local government" to mean "any general purpose political subdivision of a State *which has the power to levy taxes* and spend funds, *as well as general corporate and police powers*[.]"[14] Implicit in this definition is the recognition that the authority to tax is but one of many powers that a State in its absolute discretion may confer upon a unit of local government – a power that is not an absolute prerequisite to the creation and existence of a governmental unit. Moreover, it is a principle of statutory construction that "when Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion."[15] That precept applies with equal force here. Congress knew how to define a unit of local government to include the ability

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[7] *Abramson v United States*, 42 Fed. Cl. 621, 628 (1998).

[8] *Id.*

[9] *VJC Productions, Inc. v Kyles*, 903 F. Supp. 42, 44 (S.D. Ga. 1995).

[10] *Root v New Liberty Hospital District*, 209 F.3d 1068, 1070 (8th Cir. 2000).

[11] 42 U.S.C. § 1396b(w)(7)(G).

[12] *Wisconsin Public Intervenor v Mortier*, 501 U.S. 597, 607-08 (1991) (citations omitted); *Reynolds v Sims*, 377 U.S. 533, 575 (1964) ("Political subdivisions . . . have been traditionally regarded as subordinate governmental instrumentalities created by the State to assist in the carrying out of state governmental functions" at the absolute discretion of the State); BLACK'S LAW DICTIONARY 1159 (6th ed. 1990) (defining political subdivision as "[a] division of the state made by proper authorities thereof, acting within their constitutional powers, for purpose of carrying out a portion of those functions of state which by long usage and inherent necessities of government have always been regarded as public").

[13] *Reynolds*, 377 U.S. at 580-81.

[14] 29 U.S.C. § 2101(a)(7) (definition for purposes of WARN Act) (emphases added).

[15] *In re Hart*, 328 F.3d 45, 49 (1st Cir. 2003).

to levy taxes, yet purposely chose not to include this express language in the Medicaid Statute. Since Congress has deliberately declined to include this additional requirement, CMS is precluded from adding to the definition of a local governmental unit the condition that it must also have generally applicable taxing authority.[16]

HHC believes this particular language would likely (A) prohibit most of Indiana's other county hospitals from being considered units of government; and (B) prohibit state universities from being considered units of government. Both are discussed below

A. County Hospitals.

While HHC has its own taxing authority as it is a municipal corporation explicitly provided such power by statute,[17] Indiana's other governmental health care providers, including county and city hospitals in Indiana, do not have such authority. However, that does not negate the fact of Indiana's treatment of such providers as political subdivisions or units of local government – irrespective of any generally applicable taxing authority.

County hospitals in Indiana are created pursuant to Ind. Code § 16-22, *et seq.*[18] Under Indiana law, a county hospital is defined as a "Municipal corporation" or "Political subdivision,"[19] which is controlled by a "governing board."[20] The legal status of the board is "a body corporate and politic....",[21] which can sue and be sued and possess the real and personal property of the hospital and the hospital's funds.[22]

Under Indiana law, county commissioners exercise substantial powers with respect to the establishment, oversight, control, and dissolution of their respective county hospitals.[23] First and foremost, a county hospital is established by the county executive (usually county commissioners), and the hospital board is entirely appointed by the county executive.[24] Each

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[16] *See Abramson*, 42 Fed. Cl. at 628 (explaining that where statute states what a term "means," then all other meanings not stated are excluded); *VJC Productions*, 903 F. Supp. 44 (stating that where Congress knows how to say something but chooses not to, its silence is controlling); *Root*, 209 F.3d at 1070 (noting that courts must refrain from embellishing statutes by inserting language that Congress has opted to omit).

[17] Ind. Code § 16-22-34(a)(8).

[18] *See Kentuckiana Medical Center LLC v. Clark County, Indiana*, 2006 WL 146625, *6 (S.D. Ind. Jan. 18, 2006).

[19] Ind. Code §§ 36-1-2-10 and 13.

[20] Ind. Code § 16-22-3-1.

[21] Ind. Code § 16-22-3-24.

[22] The Supreme Court had occasion to examine the definition of the term "body corporate and politic" in *Will v. Michigan Dept. of State Police*, 491 U.S. 58, 70 n.9 (1989), citing numerous sources defining the term as a "public corporation" or a "corporation having the powers of government." *See Kentuckiana*, 2006 WL 146625 at *6 n.10. Similarly, *Blacks Law Dictionary*, 7th Edition, 1999, defines body politic as: "A group of people regarded in a political (rather than private) sense and organized under a single governmental authority." *Id.*

[23] *Kentuckiana*, 2006 WL 146625 at *6.

[24] *Id.* (citing Ind. Code § 16-22-2, *et seq.*).

year, the hospital board must file an annual financial statement with its respective county executive and the county fiscal body.[25] Upon the sale of a county hospital's real property, the respective county commissioners, along with the hospital board, must execute a deed of conveyance to the purchaser.[26] A county hospital cannot be dissolved or sold to a for-profit corporation without a joint resolution by the board, county executive, and county fiscal body,[27] and the proceeds from such a sale are controlled by the county commissioners.[28] Similarly, the assets of a county hospital cannot be transferred to a non-profit corporation without a joint resolution by the board, county executive, and county fiscal body, and the proceeds from such a transfer are controlled by the county executive.[29]

In addition, county hospitals enjoy several powers allowed county government. County hospital boards have the power of eminent domain, as exercised through their respective county commissioners.[30] County hospital boards can be supported by a tax levy from their respective counties,[31] and a hospital board can enter into a sublease or loan agreement with a state agency whereby part of the lease or loan payment is payable through taxes from the respective county.[32] Moreover, the county is required to pay its portion of the loan or lease payment even if the hospital board cannot make its payments.[33]

As Indiana's county hospital statutes establish, the authority to tax is not dispositive of whether a county hospital is a political subdivision or unit of local government. Rather, as one Indiana federal district court recently noted:

> These statutory provisions reveal a substantial entanglement of interest, control, and power between the county commissioners and a county hospital board. Additionally, these statutes demonstrated that [in] many ways, . . . a unitary economic interest exists between the county and its hospital.[34]

In fact, Ind. Code § 36-1-1-1, *et seq.*, Indiana's local government statute, provides that a unit of local government *does not* have "[t]he power to impose a tax, *except as expressly granted by*

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[25] *Id.* (citing Ind. Code § 16-22-3-12).
[26] *Id.* (citing Ind. Code § 16-22-3-17(c)(3)).
[27] *Id.* (citing Ind. Code § 16-22-3-17(e))
[28] *Id.* (citing Ind. Code § 16-22-3-17(j)).
[29] *Id.* (citing Ind. Code § 16-22-3-18 (a) and (e)).
[30] *Id.* (citing Ind. Code § 16-22-3-25).
[31] Ind. Code § 16-22-3-27.
[32] *Infra.*, see note 23 (citing Ind. Code § 16-22-3-27.5).
[33] *Id.* (citing Ind. Code § 16-22-3-27.5(e)).
[34] *Id.* (noting that interrelationships between counties and county hospitals "support an inference that a county hospital and its respective county can constitute a single economic actor for purposes of an anti-trust analysis, thereby attributing the actions of a county hospital to its respective county commissioners"); *Crosby v. Hospital Authority of Valdosta*, 873 F. Supp. 1568, 1575-76 (S.D. Ga. 1995) (cataloging cases finding state legislature-created hospital authorities to be municipalities or political subdivisions for purposes of immunity from federal antitrust laws).

statute."[35] In other words, a local governmental unit *does not* automatically have the authority to tax, and it must be granted such authority by the Indiana Legislature.

Along these same lines, city and county hospitals are specifically included in the definition of "political subdivision" for purposes of the Indiana Tort Claims Act.[36] Similarly, courts have held that public hospitals are subject to claims under 42 U.S.C. § 1983, because their actions are "under color of state law."[37] Significantly, the employees of Indiana county hospitals are treated as county employees, and thus receive the benefits of county employees, including eligibility to participate in PERF, the Public Employees' Retirement Fund.[38]

Notably, Indiana's legislative creation and governance of county hospitals does not mandate that the county hospital be funded by county tax revenues either - a condition implied by CMS's proposed amendment to 42 CFR § 433.50. On the contrary, "[t]he governing board *may* request support from the county, either by appropriation from the county general fund or by a separate tax levy, . . . to maintain, operate, or improve the hospital for the ensuing year."[39] The absence of a hospital budget funded by taxpayer dollars does not render the hospital any less of a political subdivision of the State, particularly given the tremendous control a county exercises over the operation and management of county hospitals. For a hospital to be county-operated under Indiana law, it is irrelevant whether the hospital *actually* receives tax revenues.[40]

Finally, one court has found the imposition of the powers a State gives a unit of government to violate state sovereignty, stating:

> [I]nterfering with the relationship between a State and its political subdivisions strikes near the heart of State sovereignty. Local governmental units within a State have long been treated as mere "convenient agencies" for exercising State

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[35] Ind. Code § 36-1-3-8(a)(4) (emphasis added).

[36] Ind. Code § 34-13-3, *et seq.* Ind. Code § 34-6-2-110 (8); *Hasty v Floyd Memorial Hospital*, 612 N.E.2d 119, 122 (Ind. Ct. App. 1992) (holding that hospital was county hospital and therefore fell within the ambit of the Indiana Tort Claims Act such that it was entitled to notice of claim prior to suit); *Brunton v Porter Memorial Hospital Ambulance Service*, 647 N.E.2d 636, 639 (Ind. Ct. App. 1994) (same).

[37] *Fitzgerald v Porter Memorial Hospital*, 523 F.2d 716, 718 (7th Cir. 1975).

[38] *See* Ind. Code § 5-10.3-7-1 (employees of the State "or of a participating political subdivision" become members of the fund upon employment); Ind. Code § 5-10.3-1-6 (defining political subdivision to mean "a county, city, town, township, political body corporate, public school corporation, public library, public utility of a county, city, town, township, and any department of, or associated with, a county, city, town, or township, which department receives revenue independently of, or in addition to, funds obtained from taxation").

[39] Ind. Code § 16-22-3-27(a) (emphasis added).

[40] To the extent CMS would argue that the health care provider's *receipt* of tax revenues is necessary to be considered county-operated, even its own definition of "unit of local government" does not support this construction. The proposed language of 42 CFR § 433.50 requires that the "health care provider *is able to access funding* as an integral part of a unit of government . . ." A county hospital in Indiana is certainly able to *access* funding through county council appropriations pursuant to Ind. Code § 16-22-3-27. Whether the county hospital chooses to exercise that right is another matter.

> powers. . . . And the relationship between a State and its municipalities, including what limits a State places on the powers it delegates, has been described as within the State's "absolute discretion."[41]

Therefore, CMS's interpretation of "unit of local government" in its Proposed definition of "unit of government" to require "generally applicable taxing authority" and a legal obligation "to fund the health care provider's expenses, liabilities, and deficits" is not only inconsistent with the plain language of the Medicaid Statute, and in excess of its Congressional authority, but it also undermines the very framework of political subdivisions and units of local government.

B. State Universities.

While Congress has defined "unit of local government", CMS is attempting to define "unit of government", not "unit of local government" and to apply the requirement of having general taxing authority to arms of State government without general taxing authority, e.g. state universities.

With respect to state university teaching hospitals, this Proposed Rule is contrary to the Medicaid Statute, which explains:

> [T]he 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 . . .[42]

If the proposed definition of "unit of government" is finalized, it would arguably prohibit a State teaching hospital, operated by a state university that does not have general taxing authority but that receives State appropriations, from being considered a unit of government for purposes of providing the non-Federal share of Medicaid payments. While HHC assumes a state university itself would continue to be considered a state agency and could provide an intergovernmental transfer of funds on behalf of its health care providers pursuant to the Proposed Rule at 42 CFR 433.51(b), the language regarding certified public expenditures in the same Proposed Rule would seem to prohibit the state university from certifying public expenditures because only "units of government" may do so. This Proposed Regulation would thus impermissibly limit the use of funds appropriated to state universities for teaching hospitals by restricting them from being used to certify public expenditures.

In conclusion, HHC believes the Proposed Rule at 42 CFR § 433.50 exceeds CMS's statutory authority under the Medicaid Statute and imposes further restrictions on the meaning of "unit of

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[41] City of Abilene, Texas v. Federal Communications Comm'n, 164 F.3d 49, 52 (D.C. App. 1999).
[42] Section 1902(w)(6)(A) of the Social Security Act [42 USC 1396b(w)(6)(A)].

local government" and of a "health care provider" that may be "considered a unit of government" not found in the definition of "unit of local government" found at 42 U.S.C. § 1396b(w)(7)(G). Such Proposed Rule thus impermissibly restricts the use of funds derived from State and local taxes for the Medicaid program, as specifically prohibited by 42 USC 1396b(w)(6)(A) .[43]

Thus, HHC recommends CMS withdraw its changes to 42 CFR § 433.50, or amend such changes so as to conform the Proposed Rule to the statutory definition of "unit of local government", by clarifying that generally applicable taxing authority is not required to be considered a unit of government and by specifying the ability of a state agency, such as a state university, to certify public expenditures on behalf of its health care providers.

2. **Sources of State Share and Documentation of Certified Public Expenditures (42 CFR § 433.51(b))**

The Proposed Rule would impermissibly limit sources of non-federal share funding and would require overly burdensome documentation and reconciliation of certified public expenditures. For this reason, CMS should withdraw the Proposed Rule or further clarify that a "unit of government" is not required to have generally applicable taxing authority and should also withdraw the language adding burdensome documentation and auditing of certified public expenditures.

First, as outlined above, CMS' Proposed Rule attempts to limit the types of entities that may provide non-federal matching funds for the Medicaid program to only those entities with generally applicable taxing authority or the ability to access funding as a part of an entity with generally applicable taxing authority, which is legally obligated to fund the health care provider's expenses, liabilities and deficits. As provided above in Section 1 of these comments, HHC believes this proposed definition would impermissibly limit the entities considered units of local government as defined in the Medicaid Statute, which in turn impermissibly limits the sources of non-Federal share of Medicaid payments. Of particular concern to HHC is the limiting of state universities from being considered units of government, as Indiana University is an important partner of HHC. HHC also requests CMS to clarify how the Proposed Rule would affect non-federal matching funds provided by state universities.

Second, CMS' Proposed Rule imposes a host of new and burdensome requirements on entities that certify public expenditures, providing:

[43] *See Meade Township*, 695 F.2d at 1011 (holding that Secretary of Interior exceeded statutory authority when he included a "primary provider of services" standard in his definition of "units of general government," such that regulation should be stricken and Secretary directed to conform his administrative policy to the plain language of the statute).

> Certified public expenditures must be expenditures within the meaning of 45 CFR 95.13 that are supported by auditable documentation in a form approved by the Secretary that, at a minimum --
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> (1) Identifies the relevant category of expenditures under the State plan;
>
> (2) Explains whether the contributing unit of government is within the scope of the exception to limitations on provider-related taxes and donations;
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> (3) Demonstrates the actual expenditures incurred by the contributing unit of government in providing services to eligible individuals receiving medical assistance or in administration of the State plan; and
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> (4) Is subject to periodic State audit and review.[44]

The above provisions could require a provider to engage in exhaustive cost reporting in order to certify its expenditures as eligible for federal financial participation, particularly for expenditures eligible for FFP which are not currently subject to cost reporting, which therefore is contrary to principles of efficiency and economy. The first requirement under this section states that the provider would be required to identify a relevant category of expenditures under a State plan in order to be reimbursed. This raises the question of how specific such identification must be. If the identification required relates solely to the authority under the State plan, for example, that the expenditures are for inpatient and outpatient Medicaid disproportionate share expenditures or for inpatient and outpatient Medicaid expenditures, which are currently offset from HHC's hospital-specific limit, this would not be burdensome and is, in fact, in accordance with HHC's and the State's current practice. However, if HHC would be required to identify individual medical services or treatments as expenditures eligible for FFP, as indicated by the third requirement, this would be much more burdensome for both HHC and the State, as this would require detailed cost reporting prior to any certification of expenditures by HHC.

HHC is also concerned about CMS' comment in the preamble "[t]hat certification must be submitted and used as the basis for a State claim for FFP within two years from the date of expenditure."[45] The Medicaid Statute does not presently limit a governmental entity's ability to certify public expenditures to two years after expenditures are incurred. In Indiana, the State often does not schedule final Medicaid disproportionate share payments and other supplemental payment distributions until after two years from the year to which the Medicaid payments are attributable. If the State is not permitted to make interim payments to HHC and other safety-net providers for Medicaid disproportionate share payments and if HHC is not permitted to certify its expenditures as eligible for FFP when Medicaid disproportionate share and other supplemental payments are not made until two years after the expenditure was incurred, HHC will be adversely affected with what appears to be an impermissible limitation placed on its ability to make a certification of public of expenditures.

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[44] "Proposed Rules", 72 FR at 2246.

[45] 72 FR at 2241.

Finally, the fourth requirement in the Proposed Rule, making certified public expenditures subject to periodic State audit and review, is an added administrative burden for the State. Currently, in Indiana, Medicaid disproportionate share providers are required to complete a lengthy survey for purposes of Medicaid disproportionate share qualification, which is then tested and verified by the State. Individual providers must also have independent audits of their hospital-specific limits. Such records are also currently subject to CMS and other federal agency audits. While HHC supports such requirements as they currently exist in Indiana, HHC believes that required State audits will be too administratively burdensome for the State and will further delay the payment of Medicaid disproportionate share and other Medicaid supplemental payments.

HHC respectfully requests CMS to withdraw its proposed revisions to 42 CFR § 433.51(b), which impermissibly limit State and local funds that may be used for non-federal share and which would create a burdensome and unnecessary process for certification of public expenditures.

3. Cost Limit for Providers Operated by Units of Government (42 CFR § 447.206).

CMS' Proposed Rule would limit Medicaid payments to each governmental provider to its Medicaid costs. CMS should withdraw its Proposed Rule which would impermissibly limit Medicaid payments to governmental providers.

A. Lack of Authority to Limit Governmental Providers to their own Costs.

HHC believes this Proposed Rule is in excess of CMS' authority and respectfully requests CMS to withdraw it.

The Proposed Rule would limit Medicaid reimbursement to a governmental health care provider to the provider's own costs of rendering covered Medicaid services to Medicaid-eligible recipients.[46] This Proposed Rule would effectively eliminate the aggregate Medicaid upper payment limit that Congress specifically instructed CMS to create in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"). Section 705(a) of BIPA specifically stated that Congress should issue, "a final regulation based on the proposed rule announced October 5, 2000, that . . . modifies the upper payment limit test applied to State medicaid spending . . . by applying an aggregate upper payment limit to payments made to government facilities that are not State-owned or operated facilities".[47]

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[46] 72 FR at 2246.

[47] See Section 705(a) of HR 5661, 106th Cong., referenced at Section 1(a)(6) of PL 106-554. (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA")).

When CMS issued the final regulations referred to by Congress in Section 705(a) of BIPA, the upper payment limits were aggregate payment limits that limited aggregate Medicaid payments to an amount not to exceed a reasonable estimate of the amount that would be paid for the services under Medicare payment principles. In accordance with Congress' instructions, the final regulations also created three separate aggregate State Medicaid upper payment limit pools for private, State, and non-State governmental providers.[48] While these rules specifically created the three separate aggregate upper payment pools "to ensure State Medicaid payment systems promote economy and efficiency", the rules also specifically provided an increased upper limit for payments "to non-state public hospitals to recognize the higher costs of inpatient and outpatient services in public hospitals."[49]

While the increased upper payment limit for non-state governmental providers was later reduced to that for the other categories of providers, it is noteworthy that when questioned about why non-state governmental providers were given this increased limit, CMS defended its decision to pay non-state governmental hospitals at a higher rate for inpatient and outpatient hospital services, stating, "[w]e have made every reasonable effort to assure that we pay these facilities only what is necessary to meet the demand for service for Medicaid individuals . . . should we find that the payments made under the higher limit are not being retained by hospitals to support Medicaid services, we would be open to making further revisions in subsequent rulemaking."[50] This comment from the 2001 final rule indicates that so long as hospitals were keeping their entire upper payment limit payment, CMS would not further limit the aggregate Medicaid upper payment limits for these providers. If CMS has since found that governmental hospitals are not keeping the entirety of their Medicaid payments, but are being required to send these funds back to the State, then CMS should do what it indicated in the final regulations by requiring providers to keep the entirely of their payments and then auditing individual providers to ensure they are doing so, instead of jeopardizing the entire public health care safety net by limiting all Medicaid payments for all governmental providers to their reportable Medicaid costs.

Additionally, in the preamble to the Proposed Rules, CMS specifically explains or justifies its proposed limitation of Medicaid payments to governmental providers by indicating that it believes governmental providers receiving more than their Medicaid costs either send the additional funds to the State for impermissible recycling of funds and/or use such funds to pay for non-Medicaid program costs. This comment is in opposition to its earlier statement in the preamble to the 2001 rules, specifically stating that the then higher upper payment limit for non-State governmental providers was not for the purpose of covering uncompensated care, but to assure "the continued existence and stability of the core providers who serve the Medicaid population."[51] However, in the Proposed Rule, CMS specifically rejects this earlier notion, stating "Congress has expressly provided for certain kinds of limited Federal participation in the

[48] 66 FR 3148 (January 12, 2001).
[49] 66 FR at 3148.
[50] Id. at 3154.
[51] Id.

costs of providing service to non-Medicaid populations and public health activities"[52] outside of the Medicaid program only, and has not involved the Medicaid program in financing such costs. CMS then gives a few examples of programs that reimburse providers for unreimbursed medical care as evidence that Congress has not authorized Medicaid funding for non-Medicaid purposes. CMS names the Medicaid disproportionate share hospital program,[53] the Medicaid program reimbursing emergency services for undocumented immigrants who would otherwise qualify for Medicaid services,[54] and Federal funds for emergency services provided to undocumented immigrants pursuant to the Emergency Medical Treatment and Labor Act ("EMTALA").[55] However, HHC believes and argues that this is evidence to the contrary, namely, that Congress, when posed with the challenge to protect the health care safety-net, has done so, and that, with respect to Medicaid upper payment limits, it has specifically done so. In the present instance, as stated above, Congress specifically directed CMS to create an aggregate upper payment limit to non-state governmental providers based upon CMS' proposed UPL rules announced October 5, 2000,[56] which rules limited payments to non-state governmental providers to not exceed an aggregate upper payment limit of a reasonable estimate of what would have been paid under Medicare reimbursement principles.[57]

Additionally, legislative history of the Boren Amendment provides that Congress directed CMS "to maintain ceiling requirements that limited state payment in the aggregate from exceeding Medicare payment levels".[58] The Boren Amendment is also indicative of Congressional intent to give States flexibility to reimburse Medicaid providers based upon something other than Medicare's cost reimbursement principles.[59] Because Congress has not since specifically required States to reimburse providers based upon cost principles or to remove the "ceiling" that it specifically created to protect the public health care safety-net, that for CMS to do so through these Proposed Rules is contrary to Congressional intent of protecting the safety-net for Medicaid patients and allowing States flexibility in payment to its providers.

CMS should withdraw its Proposed Rules limiting Medicaid reimbursement to governmental providers to costs because CMS does not have the authority to do so.

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[52] 72 FR at 2238.
[53] 42 USC § 1396r-4 et seq.
[54] 42 USC § 1396(b)(v)(2).
[55] Section 1101 of the Medicare Modernization Act.
[56] 65 FR 60151 (these rules were in fact published on October 10, 2000).
[57] 65 FR at 60158.
[58] 66 FR at 3149 (explaining the birth of the upper payment limit during the Congressional hearings regarding the Boren Amendment.)
[59] 66 FR at 3149.

B. Negative Impact upon Patient Care and Access of Medicaid Patients to Such Care.

By implementing the Proposed Rules, CMS will negatively impact patient care and Medicaid patients' access to such care.

Currently, Medicaid patients comprise 27.3 % of HHC's hospital patient base, with Medicare patients representing 22.5% of its patient mix and uninsured patients representing 35.5% of its payer mix. Only 8.9% of HHC's patients have commercial insurance. The other 5.8% of patients have other types of third party coverage. Traditionally, hospitals have shifted the costs associated with Medicaid patients and the uninsured to its patients with commercial insurance, but this is becoming more difficult. In HHC's case, with only 8.9% of its patients having commercial insurance, it cannot do so at all. Instead, HHC has streamlined its operations, improved its efficiency, and has utilized its resources to the best of its ability to cover the costs of care it provides to the members of its community. HHC has done this while also achieving excellence in quality of care for its patients and while providing a broad array of medical services, including: (1) state and nationally recognized Trauma and Burn units; (2) an innovative electronic medical records and quality assurance system; (3) mental health services for the seriously and chronically mentally ill; (4) community clinics for Medicaid and the uninsured through its Wishard Advantage program and partnership with Indiana University faculty physicians; (5) enhanced long term care facilities and other senior services for Medicaid patients; (6) Medicaid outreach services; and (7) its support of Indiana University's School of Medicine medical education program and other medical training programs. While HHC has achieved success in providing these services to Medicaid patients, many of the costs associated with providing such services are not reflected or captured on national cost reports, such as the Medicare cost report for hospitals and long term care facilities.

The types of indirect and unreimbursed costs associated with treating these patients are many. For example, Medicaid patients' socio-economic status often contributes to (i) higher rates of missed appointments than private pay and Medicare patients, (ii) the under-utilization of preventive care leading to more costly and complex care, (iii) increased severity of medical conditions upon presentation, as well as presenting with several medical conditions requiring treatment, (iv) lack of follow-through or compliance with treatment plans or care instructions resulting in repetitive treatments and more lengthy visits, (v) use of hospital emergency departments as a primary care source despite available community clinics, and (vi) other medical challenges. Because of the high numbers of Medicaid and uninsured patients who receive services at HHC, the Medicaid program essentially sets the payment rates for HHC, as there is virtually no ability to cost-shift to other payors. If Medicaid now begins to reimburse for its patients based strictly on certain costs, then CMS must ensure that the true costs associated with treating Medicaid patients can somehow be captured. Otherwise, HHC will be faced with a crisis in which it will not be able to make up such costs, except by limiting or even eliminating

some of its innovative programs directed at helping these very patients. Medicaid upper payment limit payments are intended to help resolve this disparity by providing sufficient funds for HHC, as well as other public safety-net providers, to ensure that Medicaid recipients have adequate access to care in accordance with 42 USC 1396(a)(30) and 42 CFR 447.205.

CMS should withdraw the Proposed Rule as it jeopardizes Medicaid patients' access to care in violation of the Medicaid Statute.

C. Medicaid Supplemental Payment to Governmental Providers Help Supplement Low Statewide Medicaid Disproportionate Share Allocations.

CMS should withdraw the Proposed Rule to limit Medicaid payments to governmental providers to Medicaid costs because, due to the increased number of hospitals that have become eligible for Medicaid disproportionate share payments, and the growth, both their Medicaid shortfall and costs of care for uninsured patients, as well as the limit or cap on Indiana's statewide Medicaid disproportionate share allocation, Medicaid supplemental payments supplement insufficient Medicaid disproportionate share funding and are vital to ensuring the continued operation of Wishard and other safety-net providers.

Currently, all of Indiana's general, acute care hospitals are able to receive Medicaid supplemental payments, through Medicaid supplemental payments for either non-State governmental or privately-owned hospitals. These programs are critical to safety-net providers in Indiana due to the insufficiency of Indiana's Medicaid disproportionate share allocation of $216,000,000,[60] which is insufficient to pay all of the hospitals qualifying for Medicaid disproportionate share payments the aggregate amount of their hospital-specific limits, which approximated $623,000,000 in federal fiscal year 2004.[61] Due to this deficit, Indiana has implemented Medicaid supplemental payment programs for both non-state governmental and privately-owned hospitals in combination with a graduated payment schedule for newly eligible Medicaid disproportionate share hospitals and has added language that would permit pro-rata Medicaid disproportionate share payment reductions for all eligible Medicaid disproportionate share hospitals. Although these programs have certainly helped Medicaid disproportionate share providers, they do not fully compensate the hospitals for their Medicaid and uninsured costs.

The Proposed Rules would necessarily eliminate Indiana's Medicaid supplemental payment program for non-state governmental providers and would create a huge funding deficit for all Indiana hospitals, including privately-owned hospitals, qualifying for Medicaid disproportionate share payments. The Proposed Rules would cause hospitals currently considered governmental hospitals in Indiana, but which do not have taxing authority, to move into the privately-owned

[60] This number is the amount of the federal share for federal fiscal year 2004 and is net of the allocation paid to Indiana's State Institutions of Mental Disease.

[61] This number reflects the federal share only.

Medicaid upper payment limit pool without the ability to provide the non-federal share of their payments. As a result, more hospitals will be required to share the same limited amount of non-federal funds for privately-owned and operated Medicaid supplemental payments, resulting in smaller Medicaid supplemental payments for privately-owned hospitals and more dependence upon the already insufficient Medicaid disproportionate share program as the mechanism for eligible Medicaid disproportionate share hospitals to be reimbursed for uncompensated costs. Indiana's situation clearly contradicts CMS' assertion in the preamble to the Proposed Rules, that privately-owned hospitals will not be affected by the reduction of Medicaid reimbursement to governmental hospitals to their Medicaid costs.[62]

As the only one of Indiana's governmental hospitals qualifying for Medicaid disproportionate share payments based upon its Low Income Utilization Rate, HHC is particularly concerned with this situation, as it depends upon Medicaid disproportionate share payments more than any other hospital in Indiana. With the Proposed Rules' limitation of HHC's Medicaid reimbursement to its covered Medicaid costs and the certain reduction in available Medicaid disproportionate share dollars due to the proposed definition of "unit of government", HHC will lose valuable funding for its vital safety-net programs, which benefit Medicaid patients as well as the community at large.

HHC respectfully requests CMS to withdraw the Proposed Rules limiting Medicaid reimbursement to governmental providers to their own Medicaid costs, as this will cause funding shortfalls for the State of Indiana's Medicaid supplemental and Medicaid disproportionate share payment programs.

D. Valuable Programs Benefiting Medicaid Recipients may be Jeopardized.

HHC asks CMS to withdraw the Proposed Rules limiting Medicaid reimbursement to governmental providers to Medicaid costs as such reimbursement is insufficient to pay for valuable programs that benefit Medicaid recipients.

The Proposed Rules would reimburse individual governmental providers an amount not in excess of their individual costs of providing covered Medicaid services to eligible Medicaid recipients.[63] This language necessarily excludes many costs reimbursed by Medicaid disproportionate share payments, which include unreimbursed Medicaid costs and costs of treating the uninsured. While the preamble to the Proposed Rules indicates that that Medicaid disproportionate share payments would continue to include both Medicaid unreimbursed costs (which would supposedly not exist for a governmental provider and thus not be included in governmental Medicaid disproportionate share hospitals hospital-specific limits) and costs of providing medical care to uninsured individuals, the actual proposed provision does not provide

[62] 72 FR, at 2244.
[63] 72 FR 2246.

language indicating that the costs of the uninsured could be reimbursed, as well as all costs associated with Medicaid patients. CMS thus needs to correct this language to specify that the costs of the uninsured for purposes of Medicaid disproportionate share payments will also be paid to governmental providers, and not capped by federal financial participation. Additionally, the preamble to the Proposed Rules indicates that these Proposed Rules do not apply to SCHIP and Medicaid Managed Care payments. However, the actual Proposed Rule does not exclude such payments from its purview. CMS thus needs to correct this language to specify these payments are excluded from cost reimbursement.

Further, neither the preamble nor the Proposed Rules discuss the fate of graduate medical education costs or professional services costs and whether they would be subject to the proposed cost reimbursement methodology for governmental providers. HHC has both graduate medical education costs and physician services costs in the operation of its hospital that benefit Medicaid recipients and which costs Medicaid should reimburse. Thus, HHC requests that if the Proposed Rules are finalized that all such costs be clearly included in Medicaid reimbursable costs.

HHC also contracts with the faculty practice plans of Indiana University to provide its physician services for its hospital and clinics. These physicians receive Medicaid supplemental payments, which are not limited to their Medicaid costs, but to usual and customary charges, as defined in Indiana's approved Medicaid State plan. The language of the Proposed Rules would not limit Medicaid reimbursement based upon costs to only institutional providers, but would include "[a]ll health care providers that are operated by units of government". HHC believes the use of a cost based reimbursement system for physician services would jeopardize access to care for Medicaid patients in Indiana, as there is no presently recognized cost reporting system for physician services. The Proposed Rules should thus specifically exclude the application of the Proposed Rules to physician services, such that Medicaid supplemental payments to physicians would not be limited to costs, as continued Medicaid supplemental payments for physician services provided by Indiana University's faculty practice plans are crucial for maintaining access to care for Medicaid patients.

Finally, HHC operates a hospital-based ambulance service, which serves the City of Indianapolis, surrounding townships and the City of Speedway. Indiana has an approved but not yet implemented Ambulance medical supplemental payment program that would pay the difference between Medicaid payments and usual and customary charges for ambulance services utilized by Medicaid recipients. As provided above, HHC believes the broad language of the Proposed Rules could also include cost-based Medicaid reimbursement for its ambulance service. However, Medicare would not include ambulance services for purposes of cost-based reimbursement as ambulance services are reimbursed by Medicare through a fee schedule. The Proposed Rule should thus specifically exclude the application of the Proposed Rules to ambulance services, such that Medicaid supplemental payments for ambulance services would not be limited to reimbursement of covered Medicaid costs.

HHC respectfully requests CMS to withdraw the Proposed Rule limiting Medicaid reimbursement to governmental providers to Medicaid costs as the Proposed Rule, as written, would unfairly limit HHC's and other governmental providers' reimbursement for Medicaid disproportionate share payments, Medicaid managed care programs, graduate medical education programs, physician services, and ambulance services, which would jeopardize these and other valuable Indiana safety-net programs providing care for Medicaid patients.

E. Impermissible Limit on Certified Public Expenditures.

HHC respectfully requests that CMS withdraw the Proposed Rule limiting the use of certification of public expenditures to Medicaid expenditures.

The Proposed Rule is disconcerting in that it would require HHC to provide proof of actual ***Medicaid*** expenditures in order to certify public expenditures and would limit the use of certifications of public expenditures to Medicaid cost reimbursement methodologies. Currently, HHC certifies its expenditures for upper payment limit payments and its expenditures for its own Medicaid disproportionate share payments. This is in accordance with the Medicaid Statute, which does not specifically limit the use of certifications of expenditures to Medicaid costs, but to expenditures under the Medicaid statute (which includes Medicaid disproportionate share payments). However, the Proposed Rule specifically states that it "applies when States use a cost reimbursement methodology funded by certified public expenditures."[64] The Proposed Rule then indicates that governmental providers will be required to submit a cost report to the Medicaid agency that reflects the costs of serving Medicaid recipients during the year and that States must then reconcile any payments based upon certified public expenditures to an entity's cost report. This indicates that certified public expenditures could not be used except to fund Medicaid expenditures that are stated on a cost report and would thus prohibit governmental providers from certifying public expenditures for Medicaid disproportionate share payments, as well as other costs of caring for Medicaid patients not reflected in cost reporting methodologies. Because the Medicaid Statute expressly prohibits CMS from restricting the use of certifications of public funds for the non-federal share of expenditures made under the Medicaid Statute, which specifically includes Medicaid disproportionate share payments for uncompensated costs of providing medical care to Medicaid recipients and to the uninsured, the Proposed Rule, if implemented, would exceed CMS' authority under the Medicaid Statute.

HHC respectfully requests that CMS withdraw the Proposed Rule because it would impermissibly limit the use of certified public expenditures as the non-federal share of Medicaid disproportionate share payments.

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[64] 72 FR at 2246.

4. Retention of Payments (42 CFR § 447.207).

HHC requests that CMS not attempt to limit the source of the non-federal share of Medicaid payments provided by governmental providers to tax revenues, but that CMS clarify that governmental providers may use all of their non-federal revenues, as all such revenues are "public" funds, derived from State or local taxes.

CMS is proposing to require providers to retain all Medicaid payments and to have separate accounts for tax revenues to demonstrate that all non-federal share is paid with tax appropriations rather than operating revenues. While HHC keeps all of its Medicaid payments for its use and does not engage in the impermissible use of federal funds for the non-federal share of Medicaid payments, HHC does not agree with CMS' comments to the Proposed Rules indicating that the non-federal share of Medicaid payments must be funded by taxes. In fact, HHC believes CMS' interpretation to be contrary to the Medicaid Statute, which provides, "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)",[65] and also refers to "adequate funds from local sources"[66] as those that may be used for the non-Federal share of Medicaid payments. This does not state that such funds must be tax revenues.

While it is HHC's understanding the CMS has been scrutinizing whether funds used for the non-federal share of Medicaid payments are direct tax appropriations, the law does not require direct tax appropriations to be used as the source of non-Federal share of Medicaid payments, but instead specifically limits CMS' ability to restrict the use of funds if such funds are "derived" from local taxes. While an exact meaning of what is intended by the term "derived" from local tax dollars has not been legislated, the Webster's definition of the word "derived", means "to issue from a source; originate".[67] This language indicates that so long as the funds used by the governmental entity for the non-federal share of Medicaid payments *issue from* or *originate* from local taxes, they would fall under the type of funds that may not be restricted by CMS. As a municipal corporation, which was established by statute, HHC believes that all of its revenues originate from local taxes. Local taxes were used to construct HHC, are used to fund much of HHC's operations, provide for capital improvements, pay its staff and its employees, etc. Almost every part of HHC's operations originate from local taxes. Surely, revenues generated by HHC such as those generated by patient care, which is provided by employees who participate in the Public Employees Retirement Fund in facilities financed by public tax dollars, are *derived from, issue from, or originate from* the local taxes that support HHC. HHC believes that any other interpretation is not compliant with the Medicaid Statute and would exceed CMS' authority. Thus, HHC, while not having issue with CMS' Proposed Rule requiring health care

[65] 42 USC 1396b(w)(6)(A). (Emphasis added).
[66] 42 USC 1396a(a)(2).
[67] See Webster's online dictionary at http://dictionary.reference.com/.

providers to retain their Medicaid payments, does wish CMS to clarify that all of a governmental entity's revenues, whether received as direct appropriations from its local taxing authority or derived from such appropriations, which help to pay for capital improvements, employees and other costs, are public "funds" and can be used as the non-federal share of Medicaid payments.

HHS respectfully requests that CMS clarify that the non-federal share of Medicaid payments are all revenues, including both the tax revenues and operating revenues, of the governmental provider.

5. **Elimination of Payment Flexibility To Pay Public Providers in Excess of Cost (42 CFR § 447.271(b)) and Conforming changes to Reflect Upper Payment Limits for Governmental Providers (42 CFR §§ 447.272 and 447.321).**

HHC respectfully requests that CMS withdraw its Proposed Rules and the changes it would make to the nominal charge limit for governmental providers under 42 CFR § 447.271(b), the aggregate Medicaid upper payment limit provisions under 42 CFR §§ 447.272 and 447.321, and the conforming changes under 42 CFR §§ 457.220 and 457.628.

As reflected in HHC's comments above, HHC believes CMS' proposal to: (1) define a unit of government to include only those entities with generally applicable taxing authority; (2) limit entities able to participate in the non-federal share of Medicaid payments to governmental entities with generally applicable taxing authority or health care providers that may access such funding as an integral part of a unit of government with taxing authority; (3) limit Medicaid reimbursement to all governmental providers to actual Medicaid costs reflected in a cost report, and (4) only permit tax revenues, and not all revenues generated by a governmental provider, to be used as the non-federal share of Medicaid expenditures, exceeds its authority under the Medicaid Statute, and consequently is impermissible. As a result, the above Proposed Rules should be withdrawn.

Thank you for the opportunity to submit these comments, which are submitted with the utmost respect and sincerity. We appreciate that CMS is attempting to protect the integrity of the Medicaid program and to curb abuses which have taken place. However, we believe that these Proposed Rules are both inconsistent with the legal basis of the Medicaid Program and specific directions to CMS provided by Congress, and that the Proposed Rules have the potential to impermissibly limit access to care to Medicaid recipients and States' ability to ensure that health care safety-net providers, like HHC, remain viable with the ability to provide high quality, innovative and effective programs for our country's poor and indigent citizens.

Very truly yours,

/s/ Matthew R. Gutwein

Matthew R. Gutwein, President and CEO
The Health and Hospital Corporation of Marion County

/s/ Daniel E. Sellers
Daniel E. Sellers, Treasurer
The Health and Hospital Corporation of Marion County

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Submitter : **Ms. Deborah Long** **Date: 03/19/2007**

Organization : **Ms. Deborah Long**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-277-Attach-1.DOC

#277

DEBORAH J. LONG
1547 E. Brenda Dr.
Casa Grande, AZ 85222
(520) 836-1728

March 19, 2007

Centers for Medicare 7 Medicaid Services, HHS
Proposed Rules

Re: CMS-2258-P

To Whom It May Concern:

I am writing to inform you that the proposed rule change will cause significant hardship on small and medium sized school district accounting offices. Most schools are subject to federal, state, and local regulations for accounting and reporting. While this system is complex, it does not automatically lend itself to the type of cost accounting procedures proposed in rule 42CFR433, 447, & 457.

Please reconsider the cost/benefit of requiring such a sweeping change in accounting procedures for small to medium sized schools.

I am available to answer questions related to this issue during working hours at Casa Grande Elementary School District, (520) 876-3214.

Thank you for your attention to this matter.

Yours truly,
Deborah J. Long

Deborah J. Long

Submitter : **Ms. Holly Bates Snow** **Date: 03/19/2007**

Organization : **Piedmont Healthcare**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2258-P-278-Attach-1.DOC

#278

PIEDMONT HEALTHCARE

March 19, 2007

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

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

Dear Ms. Norwalk:

This letter is on behalf of Piedmont Healthcare located in Atlanta, Georgia. Piedmont operates four hospitals located in the Georgia cities of Atlanta, Jasper, Fayetteville, and Newnan. We are submitting comments on Centers for Medicare & Medicaid Services' (CMS) above mentioned proposed rule that, if enacted, would further destabilized Georgia's healthcare delivery system. We are opposed to this rule and would like to highlight the harm that this proposed policy change would cause to Georgia's healthcare delivery system.

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 Georgia's 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. The rule will drastically reduce reimbursement for Georgia's "safety net" hospitals, which treat the largest number of indigent and uninsured patients, without any evidence such hospitals ever utilized the financial practices these rules are designed to erase. The preamble describes two financing arrangements which CMS believes are improper: (1) those in which the providers are required to refund a portion of the Medicaid payments received and (2) those in which federal funds are used to absorb costs outside the Medicaid program. Georgia's Medicaid financing arrangement employs none of these characteristics.

2001 Peachtree Road, N.E. Suite 400 Atlanta, Georgia 30309 404-605-3636

This rule also amounts to a budget cut for 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 223 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. It is unreasonable for CMS to contend the current UPL program results in excessive payments to hospitals, since such payments are based on Medicare rates, which are clearly non-excessive.

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, including Georgia, have adopted this method of hospital reimbursement, yet CMS is proposing to resurrect a cost-based limit that Congress long ago declared less efficient. Limiting a public hospital's Medicaid payment to the undefined "cost" of its services merely punishes those hospitals who have struggled to reduce their cost. In addition, since the proposed rule imposes these cost limits only on government-operated hospitals, they have the insidious effect of paying government hospitals less than private hospitals. There has been no articulated justification for this policy change.

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 healthcare 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 effectively amends the statutory definition of governmental hospitals – 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.***" The statute places no additional requirements to qualify as a governmental unit. CMS's proposed rule, however, impermissibly amends this statutory definition by requiring, for example, that a governmental unit must have "generally applicable taxing authority." There is no basis in federal statute that supports this proposed change in definition.

The proposed rule is so restrictive that only one general acute care hospital in Georgia would qualify as a "unit of government." The State of Georgia 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 counties' legal duty of caring for their indigent sick. Both the law creating hospital authorities and subsequent judicial precedent consistently confirm that Georgia hospital authorities are indeed local units of government.

Hospital authorities, however, do not have the power to tax. Instead, counties have the power to impose taxes and to agree by contract to utilize those tax revenues to reimburse hospital authorities for their cost of providing indigent care. Since the proposed rule stipulates that a contractual arrangement is insufficient to qualify the receiving hospital as a unit of government, virtually every hospital authority in the State would be disqualified simply because they receive their funds through contract rather than direct appropriation.

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. The overall annual impact in Georgia is estimated to be over $362 million. These figures suggest the actual loss of funding to hospitals and state Medicaid programs is likely far greater than CMS' estimates. 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. As noted previously, Georgia does not do so. 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, Georgia's healthcare safety net will unravel, and healthcare services for millions of vulnerable people in both Georgia and the rest of the nation will be jeopardized.

Sincerely,

Holly Bates Snow

Holly Bates Snow
Vice President
Government & External Affairs

2001 Peachtree Road, N.E. Suite 400 Atlanta, Georgia 30309 404-605-3636

Submitter : **Ms. Cristal Thomas** **Date: 03/19/2007**

Organization : **Ohio Department of Job and Family Services**

Category : **State Government**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See attached comments

GENERAL

GENERAL

See attached comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attached comments

Regulatory Impact Analysis

Regulatory Impact Analysis

See attached comments

CMS-2258-P-279-Attach-1.PDF

#279

Ted Strickland
Governor

Helen E. Jones-Kelley
Director

OHIO Job & Family SERVICES

30 East Broad Street Columbus, Ohio 43215-3414
jfs.ohio.gov

March 19, 2007

To: Centers for Medicare & Medicaid Services

From: Cristal A Thomas, State Medicaid Director

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

Ohio respectfully submits the following comments regarding the proposed rules: Cost Limits for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, which was published by CMS on January 18, 2007 in the Federal Register.

Limit Payments to Public Providers to Costs (42 CFR 447.206). The proposed regulation would require reconciliation to cost and lead to cost reimbursement for public providers, which has been inherently inflationary and is why Medicare and Medicaid programs have moved away from this type of reimbursement. This will require every public provider, regardless of type of provider or payment method, or the amount of Medicaid payments received, to complete and file some type of cost report. Types of providers who do not file cost reports now but would have to under the proposed regulations include physicians, pharmacies, public health clinics, and health departments. We believe that the time, resources and added burdens of cost reconciliation for numerous public providers will be detrimental to the provision of care for Ohio's most vulnerable population.

Changes to 42 CFR 433.50 and 42 CFR 433.51. In 42 CFR 433.50 and 433.51, CMS proposes to change both the entities that can contribute to the non federal share of Medicaid expenditures as well as the funds that can be used as contributions. We are quite concerned that the proposed changes could deny some providers, long considered to be appropriate public contributors of the non federal share, the ability to contribute. We are equally concerned that for those entities eligible to contribute to the non federal share that the proposed regulations restrict the type of funds that can be used as the non federal share eliminating the use of funds long considered appropriate for match purposes.

State Plan Submission. The preamble to the proposed regulations requires the state to obtain from public providers the completed CMS questionnaire to allow CMS to determine if a provider is in fact operated by a unit of government for all new plan amendments that reimburse government providers, regardless of whether they participate in financing the

state share. For existing plan amendments states will be required to provide the information within 3 months of the effective date of the final regulation. This could complicate the submission and approval of time sensitive state plan amendments and will require a large amount of state staff time to administer the collection and submission of the CMS forms with the plan amendments.

Proposed Effective Date. As proposed these regulations would go into effect on September 1, 2007. The proposed effective date will not allow enough time for states whose reimbursement methods are in statute to amend those statutes to accommodate cost reconciliation.

Time and Cost Estimates. CMS estimates of complying with the proposed regulations contained in the Notice of Proposed Rule Making, for both providers and the state, are woefully low. The department will now have to develop a cost report in a form acceptable to CMS for the public provider type; educate historic fee based public providers on the chosen cost principles; issue the cost reports to the public providers; track to make sure cost reports are timely filed and if not take action to force the filing of the report.

Once the report is filed the department will have to obtain claims paid data for each provider and compare this to the filed cost report and prepare a final reconciliation document that could be disputed by the provider. If the final report is disputed the department will have to engage in some type of dispute resolution process. Once a reconciliation is final and money is owed the department will have to engage in collection activity. All told through the course of a year this could easily amount to 50 hours per public provider and would require substantial investment in state resources.

Submitter : **Ms. Carmen Hooker Odom** **Date: 03/19/2007**

Organization : **North Carolina DHHS**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Comments and Cover letter in two attachments

CMS-2258-P-280-Attach-1.PDF

CMS-2258-P-280-Attach-2.PDF

#280

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 NORTH CAROLINA

The State of North Carolina submits these comments in response to the proposed regulations, published January 18, 2007, that would transform, for the worse, the methods by which Medicaid services for the needy have been financed in North Carolina and throughout the nation. North Carolina participated in the Joint Comments submitted on behalf of a group of states in opposition to the proposed rules, and believes that those Comments set forth compelling reasons for CMS to abandon its ill-conceived proposal.

In these Comments North Carolina will not repeat the cogent arguments and points advanced in the Joint Comments. Instead, it will demonstrate how the proposed rules would adversely impact the North Carolina Medicaid program, and in so doing how they will diminish the ability of the State to provide the basic health care and services to those who are being served by the State's Medicaid program.

The North Carolina Hospital Reimbursement Program

Over the past two years North Carolina has implemented a major transformation in the manner of reimbursing hospitals for Medicaid services and services to indigents. The new methodology, carefully reviewed and approved by CMS, involves certification of expenditures by public hospitals as the basis for earning FFP. The cost finding methods utilized by the hospitals was thoroughly reviewed and accepted by CMS, and is based on Medicare cost reporting conventions and Medicare principles of cost reimbursement. This new methodology has allowed North Carolina to identify and capture more non-federal resources that have traditionally supported the service provided by hospitals to Medicaid eligibles and indigents than did prior methodologies. It has enabled North Carolina to maintain a decent level of payment to hospitals, and thus has helped these hospitals to stay afloat in a most difficult environment.

Although North Carolina had, in the past, employed intergovernmental transfers as part of its funding approach, the new methodology does not do so.

Apart from two hospitals that are part of the state university and which have traditionally been reimbursed on a cost basis, there are 42 public hospitals that participate in the recently-adopted CPE-based reimbursement program. The status of these hospitals is determined under state law, in particular Article 2 of Chapter 131E of the North Carolina General Statutes dealing with "Public Hospitals." In Article 2, Chapter 131E of the North Carolina General Statutes, Part 1 is the Municipal Hospital Act; Part 2 is the Hospital Authorities Act, and Part 3 is the Hospital District Act. These provisions set forth alternative methods for the establishment and operation of public hospitals. Each alternative includes the requirement that any hospital established under these provisions be a "community general hospital" operated primarily for the residents of the community in which it is located, on a non-discriminatory basis (including no

discrimination against Medicaid patients), without fees that have the effect of denying essential services because of a patient's immediate inability to pay, and making care available as needed to indigents in the service area of the hospital. Further, the alternatives share the condition that if at any time the hospital ceases to operate, or to operate in accordance with the requirements of the law, the assets will revert to the municipality or the authority established by the municipality.

The differences in the three categories of hospitals relate to their form of organization. Municipal hospitals are owned by the municipal government itself, although the governments are empowered to lease them (for not more than ten years except to a nonprofit association) or convey them to non-profit corporations, as long as the lease or conveyance terms embody the statutory requirements. The municipalities are granted the power to levy property taxes, issue bonds, and acquire property to support the hospital. The statute specifically declares that the exercise of the powers granted by the Municipal Hospital Act constitutes "public and governmental functions." N.C.G.S. § 131E-12.

Hospital authorities are public bodies defined as bodies "corporate and politic" created by a city council or county board of commissioners, governed by a board appointed by the chief executive of the establishing governmental body, and incorporated as an authority under state law. N.C.G.S. §§ 131E-16(14), 131E-17 and 131E-19. The authority has power to issue bonds and notes that are tax exempt and the power of eminent domain. N.C.G.S. §§ 131E-23, 131E-24, 131E-26 and 131E-28. It is exempt from taxation itself, and is entitled to receive appropriated funds from the city or county in which it is located. N.C.G.S. §§ 131E-28, 131E-30. The authority is entitled to operate through lessees or management contractors.

Hospital districts are established by petition of voters in an area, or (in certain instances) by the county board of commissioners, with the approval of the North Carolina

Medical Care Commission. N.C.G.S. § 131E-41. Like a hospital authority, a hospital district is designated a "body corporate and politic" and it possesses the same powers as an authority, including the power to issue tax exempt bonds. N.C.G.S. § 131E-44 The board of county commissioners is the governing board of the district, and the board is authorized to levy taxes to support the hospital's operations. N.C.G.S. § 131E-45

The foregoing provisions of the North Carolina statutes reflects a determined state policy to encourage the establishment and maintenance of public hospitals throughout the state, particularly in areas that are not fully served by the private hospital system. The State is particularly proud that the progressive approach reflected in these statutory provisions has led to the creation of a system of public hospitals that assures the availability and accessibility of needed health care to virtually every citizen of the State.

The proposed regulations threaten to undermine the recently-adopted and CMS approved system of reimbursement of hospitals for serving Medicaid patients and indigents pursuant to the disproportionate share payment provisions. North Carolina is particularly concerned about the proposed limit on sources of the non-federal share of Medicaid payments, and the limits on which hospitals can be included as "units of government" for purposes of certifying expenditures.

As can be seen from the brief sketch of the extensive statutory regime governing public hospitals in North Carolina, hospital expenditures are likely to be derived from various sources, including but not limited to taxes. To the extent the hospitals are able to cover expenses from operating income, that is clearly preferable, and certainly ought not be a reason which prevents the hospitals to be treated as public (or governmental) for Medicaid purposes. Where operating income is not sufficient, the hospitals look to borrowed funds (which, needless to say,

must ultimately be repaid), to subsidies from the cities or counties that created them (whether derived from taxes or other revenues of those municipalities), or to contributions from the general public. North Carolina can perceive no reason in policy, and is aware of no legal constraint, that would preclude hospitals that are funded in this manner from qualifying as public (or governmental) for Medicaid reimbursement purposes. In this respect, the proposed regulations advance no legitimate federal interest, and are a punitive response to the efforts of a state like North Carolina to use government to secure the health care needs of its citizens.

For much the same reasons, the proposed restrictive definition of what entities can qualify as "units of government" is unwarranted and can only be harmful to North Carolina's legitimate program. The proposed regulation demands that to constitute a "unit of government" the provider must either have taxing authority itself or be part of an entity that has such authority and is legally obligated to fund the provider's expenses, liabilities and deficits. While some of the authorities or districts established in North Carolina may satisfy these qualifications, it is by no means clear that all would. But they should not have to in order to be treated as public (or governmental) entities capable of certifying expenditures, for as shown in the Joint Comments, there is neither legal nor policy justification for making these qualifications a pre-condition to the right to certify.

Currently, North Carolina public hospitals (other than the University affiliated hospitals) certify approximately $651,855,002 in Medicaid expenses annually and another $248,283,455 in indigent care costs that are used to support DSH payments. The proposed rules threaten this source of FFP, the loss of which would devastate the North Carolina Medicaid program, and result in a substantial loss of support for the State's public hospitals. The cost to the people who are served by these hospitals in terms of lost service is incalculable.

Private hospitals would not escape the harm that adoption of the proposed rules would bring. In North Carolina, the FFP earned by the certified expenditures of public hospitals is pooled with state and county funds and is the source of payments to all hospitals serving Medicaid patients. A massive reduction in the pool, which is what the proposed rules threaten, would mean a reduction in the ability to reimburse all hospitals.

Other Adverse Impacts of the Proposed Regulations

The proposed regulations would also disrupt and would likely reduce North Carolina's efforts to provide health care to children through the state's public schools. Currently, some 115 school districts, representing 2,282 individual schools, participate in the school-based services program. These schools are a vital front-line resource in helping to secure appropriate preventive care for children and to deal with health issues before they become health crises. The State reimburses for administrative services provided in the schools on a ~~[fee or rate]~~ cost reimbursement basis.

The public schools undoubtedly would satisfy even the narrow CMS proposed definition of "unit of government," for they are overwhelmingly supported by local (and in some cases state) tax dollars. Nonetheless, the proposed rules threaten to undo Medicaid reimbursement for medical services provided in schools, because of the enormous burdens they would place on all participating schools, no matter how they are reimbursed for the services they provide. The proposed rules limit reimbursement to public providers to cost and require complicated, substantial reporting (presumably at the level of each individual school district) to ensure that the cost limit is not exceeded. Most schools [school districts] would not have either the capability or the inclination to develop cost reports of the type that would apparently be demanded under the proposed CMS regulations. Many would undoubtedly cease to participate

in the school based services program rather than undertake the massive reporting burden that the proposed rules would impose. This result would, for obvious reasons, adversely impact the health of the children served and the Medicaid program as a whole.

Conclusion

North Carolina strongly urges that CMS not proceed further with its proposed regulations.

On Behalf of the State of North Carolina, Department of Health and Human Services:

Carmen Hooker Odom 3/19/07

Carmen Hooker Odom, Secretary Date

#280-2

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645
Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

March 19, 2007

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

File Code: CMS – 2258 – P: Cost Limit for Providers Operated by Units of government and Provisions to Ensure the Integrity of Federal-State Financial Partnership

Via: Electronic web submission

Dear Mr. Secretary:

The State of North Carolina, Department of Health and Human Services, Division of Medical Assistance has reviewed the proposed Medicaid Program Rules for Cost Limit for Providers Operated by Units of government and Provisions to Ensure the Integrity of Federal-State Financial Partnership as published in the Federal Register, Volume 72, No. 11, Thursday, January 18, 2007. Please accept this letter and its attachment as our formal submission of comments to the proposed regulations.

While our position is detailed below, North Carolina urges in the strongest possible terms that CMS not proceed further with the proposed rules. If implemented, these proposed rules would adversely impact the North Carolina Medicaid program and diminish the ability of the State to provide the basic health care and services that are being served by the State's Medicaid program.

The Division of Medical Assistance appreciates the opportunity to express its comments and concerns regarding the proposed rules. If CMS has any questions or needs clarification, DMA personnel will be pleased to assist.

Sincerely,

Carmen Hooker Odom

Cc: Mark T. Benton
L. Allen Dobson, Jr., MD
Dan Stewart
Roger Barnes

Location: 101 Blue Drive • Adams Building • Dorothea Dix Hospital Campus • Raleigh, N.C. 27603

Submitter : **Date: 03/19/2007**

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2258-P-281-Attach-1.DOC

#281

UNIVERSITY of IOWA HOSPITALS & CLINICS

University of Iowa Health Care

University of Iowa Hospitals and Clinics

Hospital Administration
200 Hawkins Drive, 1353 JCP
Iowa City, Iowa 52242-1009
319-356-3155 Tel
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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 University of Iowa Hospitals and Clinics appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) 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 Hospital Association (AHA), Association of American Medical Colleges, and the National Association of Public Hospitals and Health Systems (NAPH) that the proposed rule should be withdrawn. The changes proposed would seriously compromise an already fragile safety net system. In particular, we are concerned that the changes in this proposed rule would significantly upset the delicate balance of resources that teaching hospitals rely on to fulfill our patient care and other missions. We estimate a reduction in payments between $2-$5 M a year at our hospital if this rule is adopted.

The proposed rule would limit reimbursement for government-operated hospitals, such as the University of Iowa Hospitals and Clinics, to the cost of providing Medicaid services to Medicaid recipients. 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.

The proposed rule also does not address specifically what costs would be included in the determination of the facility specific-cost limits. It should be all those costs necessary to operate the hospital. For the University of Iowa Hospitals and Clinics, such costs include those associated with graduate medical education.

In conclusion, 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 concerns about current Medicaid policies. Should this course of action not be adopted, at a minimum, the effective date for the new cost limit must be extended beyond September 1, and the final rule must be accompanied by a significant transition period. Thank you for your consideration of these comments.

Sincerely,

Donna Katen-Bahensky
Senior Associate Vice President for Medical Affairs &
Director and CEO of University of Iowa Hospitals and Clinics

Submitter : Ms. Joy Wilson **Date:** 03/19/2007

Organization : National Conference of State Legislatures

Category : Health Care Professional or Association

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

Defining Unit of Local Government (433.50)
Cost Limit for Providers Operated by Units of Local Government (447.206)

GENERAL

GENERAL

See attached

Regulatory Impact Analysis

Regulatory Impact Analysis

Impact on patient services
Section D - Alternatives Considered

CMS-2258-P-282-Attach-1.PDF

CMS-2258-P-282-Attach-2.PDF

#282

NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

Leticia R. Van de Putte, R. Ph.
State Senator
Texas
President, NCSL

Stephen R. Miller
Chief, Legislative Reference Bureau
Wisconsin
Staff Chair, NCSL

William T. Pound
Executive Director

March 19, 2007

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

Re: CMS-2258-P

On behalf of the National Conference of State Legislatures (NCSL), I submit the following comments regarding the proposed rule, *Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of the Federal-State Partnership.* NCSL is committed to doing all it can to promote integrity in the federal-state relationship in the Medicaid program. Unfortunately, we believe the provisions proposed in this rule will harm and undermine the federal-state relationship and more importantly will severely handicap the already fragile health care safety net. We urge you to withdraw this rule.

Defining Unit of Local Government (433.50)

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 encroached on traditional state authority in an unprecedented way, by limiting how a state may use its taxing authority regardless of the nexus of the tax to Medicaid. The Medicaid Modernization Act (MMA) includes the "claw back" provision which establishes state expenditures as a line item in the Medicare budget. For better or worse, these are **federal laws**. This **proposed rule** would presume to decide for state governments what constitutes a local government unit within its borders. There is no underpinning federal law, despite efforts to assert there is, to support CMS's effort to: (1) impose a new definition of unit of local government; or (2) to require the entity to have taxing authority.

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

This rule proposes to require cost-based reimbursement for state and local government providers, despite the fact most providers, in large part due to Medicare's reimbursement policies, have moved to a prospective payment system. This change in policy will require a significant amount of new reporting requirements that many of our safety net providers (public hospitals, community health centers, school-based clinics and university hospital systems) will find difficult, if not impossible to comply with. The move to a prospective payment system was not an accident. It was adopted to improve efficiency and to provide incentives for cost-containment by participating providers. This

move to cost-based reimbursement would seem to suggest that efficiency and quality of services to Medicaid beneficiaries is not as important as the "integrity initiatives" at CMS.

Regulatory Impact Analysis

According to the analysis, the impact of the proposed rule on patient services would be "minimal." This rule proposes to reduce federal Medicaid expenditures in the last two quarters of FY 2007 by $120 million and by $530 million in FY 2008. It is hard for us to imagine how a $650 million reduction in federal expenditures to these safety net providers over an 18 month period would have only a "minimal" effect on patient care. A number of alternative approaches are briefly mentioned in section D, "Alternatives Considered." We believe more attention should be given to some of the alternatives mentioned and that perhaps other approaches should be explored. It is also important to note the number of fiscal integrity initiatives already underway regarding Medicaid and the State Children's Health Insurance Program (SCHIP). Perhaps these efforts should be monitored and evaluated before additional initiatives are undertaken.

In closing, NCSL believes this is the wrong approach. I am concerned about both the short and long-term impact this rule might have on the health care safety net and to the health and safety of some of our most vulnerable citizens. I urge you to withdraw this rule and to continue to work with us and others to support and improve the Medicaid program and to better serve Medicaid beneficiaries. Please contact Joy Johnson Wilson, Health Policy Director at 202-624-8689 or at joy.wilson@ncsl.org if you have any questions or if NCSL can be of additional assistance to you.

Sincerely,

Carl Tubbesing
Deputy Executive Director
National Conference of State Legislatures

Submitter : Mr. Roy Cooper **Date:** 03/19/2007

Organization : NC Department of Justice

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-283-Attach-1.DOC

#283

March 19, 2007

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

Re: File code CMS-2258-P; Limitation of Payments to Public Providers

Dear Sirs:

My staff has reviewed the subject rule changes proposed by the Centers for Medicare and Medicaid Services (CMS) published in the January 18, 2007, Federal Register. Based on that review, which is attached, on behalf of the State of North Carolina, I respectfully request that these rules be rejected as drafted.

The proposed rules may reduce health care availability to North Carolina children and uninsured North Carolinians. The costs of these changes will likely be borne by North Carolina taxpayers. Providing for the legitimate health care needs of the poor and elderly should not be unilaterally eliminated by rule.

Please include the attached memorandum into your record. I urge you to assess the potentially negative impacts of these rule changes and reject their adoption.

Sincerely,

Roy Cooper
Attorney General

-- MEMORANDUM --

TO: Grayson Kelley
Chief Deputy Attorney General

FROM: Ann Reed
Senior Deputy Attorney General

DATE: March 19, 2007

SUBJECT: File Code CMS-2258-P; Limitation of Payments to Public Providers

On January 18, 2007, CMS published in the Federal Register a Notice of Proposed Rule Making ("NPRM"), CMS-2258-P. The CMS proposals exceed the agency's authority, disrupt long-standing practices, impose onerous new administrative burdens on North Carolina and impose fiscal burdens on the State that will threaten the state's safety net for the poor and uninsured. Providers that will be impacted by these proposals have advised this Office that this dramatic policy change will jeopardize their ability to serve Medicaid and uninsured populations and perform other critical services in their communities. The magnitude and scope of this NPRM is beyond the scope of the regulatory process and should only be implemented, if at all, after thorough review by Congress with participation by the States.

CMS's new definition of "unit of government" excludes public bodies which have long been allowed to certify expenditures. CMS's new definition is not authorized by the statutory text. Section 1903(w)(7)(G) of the Social Security Act defines "units of government" to include "a city, county, special purpose district, or other governmental unit in the state." The CMS proposal adds the requirement, not contained in the Act, that the unit of government must have general taxing authority or be part of a unit of government with taxing authority. A unit of government must also be 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. Proposed 42 C.F.R 433.50(a)(1)(ii)(A), (B). CMS's proposed definition is not consistent with the traditional understanding of the term used by Congress, is inconsistent with the design of the Medicaid Act and encroaches on a process which is primarily and historically a matter of state concern. Congress, in including as a unit of government in Section 1903(w)(7)(G) any "other governmental unit in the state" manifestly reserved to state lawmakers the authority to determine what is and what is not a unit of government in the state. Congress did not call upon CMS to make an independent assessment of state law.

North Carolina has two state university hospitals and 42 public hospitals that provide services to Medicaid recipients. Even those public hospitals that meet the new definition of governmental unit will be subject to a new regulatory provision. Proposed 42 C.F.R. § 447.207. This provision will require that providers receive and retain the full amount of the total computable payment provided to them. It is common practice for public providers to be funded by state and county appropriations which are returned to the state and counties after the public providers receive their federal reimbursements. The proposed rule change will prohibit this funding procedure. CMS does not have the authority to dictate how states should transfer money between and among their own agencies. CMS's rulemaking power does not include the power to declare funding arrangements between units of state government that are not prohibited by Congress to be illegitimate.

Section 1902(a)(30)(A) of the Social Security Act establishes that reimbursement rates must be consistent with efficiency and economy and promote quality care and access to services. Moreover, Congress has never defined the upper payment limit (UPL) for public providers to be the actual cost incurred for services. The current UPL is based on Medicare costs and the aggregate amount of all payments that could be made to an entire class of providers if every provider were paid the Medicare rate for all services. The present reimbursement process encourages cost savings by government providers. The NPRM will limit Medicaid reimbursement to public entities to the individual provider's cost. In addition to eliminating the incentive for cost savings, this change will impose a huge administrative burden on schools and small governmental providers by requiring massive accounting and reporting requirements that are unreasonably out of proportion to the Medicaid services these smaller units of government provide. The increase in administrative costs is likely to discourage schools and smaller providers from even offering health care services to Medicaid recipients.

Finally, in the past two years, North Carolina has adopted major changes in the manner in which hospitals are reimbursed. These changes obviate any need for CMS's proposed rule changes. Moreover, the proposed CMS regulations exceed CMS's authority and intrude on state authority. The proposed changes are so radical that they should not be adopted without full consideration of the Congress. CMS is attempting to do by regulation what the administration has failed to accomplish through Congress. The proposed rules threaten the safety net for poor and uninsured North Carolina residents and should not be adopted.

Submitter : Mr. Paul Shaheen **Date:** 03/19/2007

Organization : Michigan Council for Maternal and Child Health

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

284

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

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

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

Submitter : **Ms. Donna Mason** **Date: 03/19/2007**

Organization : **Emergency Nurses Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2258-P-285-Attach-1.DOC

#285

March 15, 2007

The Honorable Leslie V. Norwalk, Esq.
Acting Administrator
Center for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Attention: CMS-2258-P

Dear Ms. Norwalk:

The Emergency Nurses Association (ENA), on behalf of its more than 32,000 members, strongly requests that the Centers for Medicare and Medicaid Services (CMS) withdraw its proposed Medicaid Program rule: ***Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership.*** As proposed, this rule would limit the reimbursement for health care providers (i.e. public hospitals) that are operated by units of government to an amount that does not exceed the provider's cost.

ENA understands that CMS views this proposal as a means to hold the health care system accountable and reduce cost which the agency believes is unrelated to direct Medicaid program costs. However, by limiting the reimbursement to actual cost, CMS does not allow health care providers to support related services which, in the long run, also serve the needs of Medicaid program recipients. There are many services that hospitals must provide which are never seen as "direct" costs yet are vital to serving the needs of their patient populations.

Examples of services that may not be eligible for direct cost reimbursement, yet have tremendous impact on quality care outcomes, include:

- Cost of readiness related to emergency preparedness, trauma and emergency care
- Support functions such as social services and children's services
- Psychiatric emergency care
- Patient education to promote recovery and chronic disease management
- Staff education to meet competency standards
- Technology enhancements related to improving the quality and safety of care.

Removal of Medicaid-based support for America's health care safety net equates to severely compromising essential health care services for Medicaid patients, as well as the uninsured. Health care organizations, which rely upon this funding, will no longer be able to meet the current demand for services nor keep pace with the rapid changes in

technology, research, and best practices as well as preparation for disaster-related events.

The Emergency Nurses Association is very concerned that the loss of this vital funding stream, for which no other mechanism has been developed to replace it, will have serious repercussions on access and quality for low-income Medicaid and uninsured patients. The estimated impacts of the anticipated cuts related to this rule are in the tens and hundreds of millions of dollars annually per state. Anticipated impacts to essential patient services include closed community clinics, increased reliance on emergency departments for routine care, a

reduction in emergency preparedness, reduction in outreach and patient education efforts, little or no investment in electronic medical records, less ability to provide translation services to non-English speakers, and reduced capacity to maintain or launch intensive disease management programs.

Imposing a cost limit, and its resulting financial impact on hospitals, would also undermine important policy goals shared by the Administration and providers alike; such as quality, patient safety, emergency preparedness, enhancing access to primary and preventative care, reducing costly and inappropriate use of hospital emergency departments, adoption of electronic medical records and other health information technology, and reducing disparities.

The impact on the emergency care system will be profound. As outlined in the 2006 IOM report, ***The Future of Emergency Care in the U.S. Health System***, we already have a tenuously held together emergency care system in which emergency departments are beyond saturation and have become the safety net of the safety net of health care. ENA believes these proposed cost limits, in addition to the existing unfunded mandate EMTALA imposes, would force greater stress on a system already at the breaking point.

In closing, the Emergency Nurses Association urges CMS to withdraw this imposed rule and seek a more appropriate means by which to address the needs of Medicaid patients as well as provide funding support for essential patient care.

Sincerely yours,

Donna L Mason

Donna Mason, RN, MS, CEN
President

Emergency Nurses Association
915 Lee Street
Des Plaines, IL 60016-6569
Telephone: 847/460-4000
Fax: 847/460-4001

Submitter : Mr. Chad Smith **Date:** 03/19/2007

Organization : Cherokee Nation

Category : Other Government

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

NA

GENERAL

GENERAL

Leslie V. Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services

Dear Ms. Norwalk:

On behalf of the Cherokee Nation, please accept the following comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule published on January 18, 2007.

During the February 2007 meeting of the CMS Tribal Technical Advisory Group (TTAG), CMS officials in attendance confirmed the agency s intent that the proposed rule would not have a negative impact on the ability for Indian Tribes 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.

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 refereneed. Although in principle Indian Tribes do have taxing authority, such authority is complex and is often the subject of litigation between Indian Tribes and States. Delving into issues related to taxing authority will greatly hinder the willingness of States to enter into cost sharing agreements with Indian Tribes. Attached please find recommended language for section 433.50(a)(1)(i).

Conformity to Previous CMS Positions Over the past two years, the CMS TTAG has worked closely with CMS and the Indian Health Service (IHS) to determine the circumstances by which Indian tribes and tribal organizations could certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services. The circumstances were reflected in the two State Medicaid Director (SMD) letters, issued on October 18, 2005 and June 9, 2006. The proposed rules should be amended in order to be consistent with CMS policy as communicated in the two referenced SMD letters.

Washington State Medicaid Administrative Match Implementation Plan Also during the February TTAG meeting, the Cherokee Nation learned of a new limitation by CMS with regard to approving the Washington State Medicaid Administrative Match Implementation Plan. The limitation excludes Tribally-operated facilities that are reimbursed at the all-inclusive rate from participation in the tribal administrative claiming program. Such a limitation is of critical concern to the Cherokee Nation as CMS has indicated that the agency intends to apply the same criteria when approving plans for other states, including Oklahoma.

During thc development of the CMS policy regarding the ability for Indian Tribes to participate in financing the non-Federal portion of medical assistance expenditures in support of certain Medicaid administrative services, it was the common understanding of CMS, IHS, and the CMS TTAG that the all-inclusive rate does not include expenditures for the types of activity covered by Administrative Match Agreements. Therefore, the proposed rule should include explicit language stating that the form of Medicaid reimbursement received by an Indian Tribe will not disqualify it from participating in the tribal administrative claiming program.

Your commitment to working with Indian tribes is to be commended and serves as an example of the cooperative efforts necessary to improve the health status of American Indians and Alaska Natives.

Sincerely,
Chad Smith, Principal Chief
Cherokee Nation

Provisions of the Proposed Rule

Provisions of the Proposed Rule

NA

Regulatory Impact Analysis

Regulatory Impact Analysis

NA

CMS-2258-P-286-Attach-1.DOC

#286

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Chad "Corntassel" Smith
Principal Chief

Joe Grayson, Jr.
Deputy Principal Chief

March 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

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

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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. Although in principle Indian Tribes do have taxing authority, such authority is complex and is often the subject of litigation between Indian Tribes and States. Delving into issues related to taxing authority will greatly hinder the willingness of States to enter into cost sharing agreements with Indian Tribes. Below please find recommended 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] .

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Medicaid expenditures for Medicaid administrative services. The circumstances were reflected in the two State Medicaid Director (SMD) letters, issued on October 18, 2005 and June 9, 2006. The proposed rules should be amended in order to be consistent with CMS policy as communicated in the two referenced SMD letters.

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Sincerely,

Chad Smith, Principal Chief
Cherokee Nation

Cc: National Indian Health Board