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Organization : **Covington & Burling LLP**

Category : **State Government**

Issue Areas/Comments

GENERAL

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See Attachment.

CMS-2258-P-288-Attach-1.DOC

#288

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

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 : Dr. Robert R. Simon **Date:** 03/19/2007

Organization : Cook County Bureau of Health Services

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment;

CMS-2258-P-289-Attach-1.PDF

CMS-2258-P-289-Attach-2.PDF

Cook County Bureau of Health Services

1900 West Polk Street
Suite 123
Chicago, Illinois 60612

#289

March 19, 2007

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

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

Dear Ms. Norwalk:

On behalf of the Cook County Bureau of Health Services (the "Bureau"), I am writing to join hundreds of Members of Congress, as well as hospitals, states and local governments across the country in expressing concerns regarding proposed regulation (CMS-2258-P). We believe the rule inadvertently undermines the critical public hospital and safety net structure in Cook County and throughout the nation and respectfully ask for your reconsideration and withdrawal of the rule.

The Cook County Bureau of Health Services

For decades, the Bureau and its predecessor – Cook County Hospital – has been the largest safety net provider of healthcare services in the State of Illinois. Each year, the Bureau affords hundreds of thousands of patients access to quality care. The Bureau's pioneering excellence in Trauma, Emergency Services, Burn care, Neonatology, and HIV/AIDS care, to name but a few, is well known across the community, across the nation and beyond. Tens of thousands of physicians, nurses, and other medical practitioners have trained at the Bureau's health facilities.

Indeed, in recognition of the historic role of municipal government health providers - - a role which long pre-dates the establishment of the Medicaid program - - the enabling Medicaid statute specifically provided for "local" contributions by municipalities such as Cook County to draw federal financial participation (FFP).

General Comments

The proposed rulemaking fundamentally would alter current financing and payment arrangements that assure that Medicaid covers the costs of treating the most severely ill and underserved patients - - thousands of whom access the Bureau's health facilities every day. The payment arrangements at risk were put in place over decades by the Congress, the federal agency

administering the Program (now the Centers for Medicaid and Medicare Services (CMS)), the states, local governments and providers to cover the costs of the Medicaid population, the uninsured and underinsured.

These payments systems were designed to take into account the extraordinarily high-cost services that the public sector provides, and that the private sector and residents throughout Cook County and the State of Illinois have come to rely upon them providing. These services range from trauma care, burn services, neonatal intensive care, comprehensive emergency room services and HIV/AIDS care, to myriad specialty diagnostic and treatment services that often are not available elsewhere for the medically vulnerable.

The potential undoing of funding for the Bureau and other public and safety net hospitals is even more dramatic in light of federal law that requires hospitals to treat and stabilize all patients, regardless of ability to pay. The combination of these federal law requirements and the Bureau's longstanding commitment to treat all regardless of ability to pay, places our facilities in a uniquely risky financial position because Medicaid —by far our major third party payer—would be unalterably affected by the proposed rule.

The Bureau Supports Fiscal Integrity

As a publicly accountable local government entity whose finances, programs, and services are open to ongoing scrutiny, the Bureau shares the Administration's goal of seeking to end abuses of the Medicaid program. In fact, the Bureau worked closely with the Administration and with Congress in 1999 and 2000 during the planned phase-out of the controversial Medicaid Upper Payment Limit (UPL) arrangements. As part of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), the UPL arrangements were replaced with direct payments to Cook County hospital to ensure the provision of critical care to our underserved populations. See BIPA, Section 701(d).

Therefore, it is clear that we have a shared goal with CMS to seek integrity in the overall Medicaid program, and to end abusive financing arrangements that undermine care in our public systems. We believe strongly, however, that such efforts must be balanced with the major overarching objective: to provide health care services to all in need.

Specific Concerns Regarding the Proposed Rule

1.) A safety net system with multiple facilities such as the Bureau is deprived of much-needed financial flexibility by the proposed rule's application of facility-specific Medicaid UPLs. The unintentional result of the rule will be to degrade the capacity of public hospitals to provide services for the poor.

Moreover, on a broader scale, program flexibility would be undermined by depriving states of the latitude in designing payment systems. This clearly conflicts with the intent of Congress as expressed, for example, in the Balanced Budget Act of 1997.

2.) The application of cost-based reimbursement ceilings must rely upon cost accounting methodologies sufficiently broad to capture all costs necessary to provide governmental safety net services, including, for example, capital and technological infrastructure investments.

The Bureau certainly seeks to ensure that all funds to which it is entitled under Medicaid are paid to our facilities and used for the care provided to our patients; and that we are paid to cover the extraordinary costs of providing such care.

We are concerned that the overall provisions of the proposed rule to limit payments to public providers to their costs of providing health care to all patients far outweigh any stated efforts to eradicate so-called abuses in the program. For example, it is unclear to us how CMS would enforce proposed Section 447.207 requiring providers to retain payments received for services already rendered. This provision lacks the specificity necessary to make it enforceable and raises questions such as whether it means that providers would be required to place all Medicaid revenues in separate accounts and never use them to pay employees or to purchase supplies.

3.) Congress is on record stating that the proposed rule exceeds CMS' authority and ignores the direct opposition of a majority of Congress. This is particularly true in the area of whether Medicaid can be used to pay for uninsured care—something that the proposed rule seeks to limit. Congress never precluded providers from using their Medicaid revenues to care for the uninsured. To the contrary; Congress has expressly provided for that by passing laws, including, but not limited to, the Medicaid Disproportionate Share Program and BIPA, direct funds to a governmentally-owned hospital with a 65% low income utilization rate that was not receiving Disproportionate Share funds as of 2000 (i.e., Cook County Hospital) See BIPA , Section 701(d).

4.) The proposed rule attempts to limit, in a number of ways, the ability of local governments to contribute to a state's share of the Medicaid program. Congress has been clear in its intent that Intergovernmental Transfers (IGTs) were not to be restricted. IGTs are used by the Bureau and numerous other counties nationwide as a critical component for accessing FFP for financing essential health care services for the poor.

It is important to point out that Cook County is a general purpose local government and that the Bureau is owned and operated directly by the County. The County is clearly a taxing authority and the Bureau has direct access to the proceeds of that authority, as an entity of the County. Therefore, there has never been a question that Cook County is qualified under law to contribute to the state share of Medicaid for purposes of FFP.

Even so, we are concerned that the preamble of the proposed rule includes a statement that tax revenue is the only valid source of IGTs. Neither current law nor the proposed regulations themselves specifically impose such a requirement. Section 1902(a)(2) of Medicaid has long been interpreted as granting states authority to use public funds other than state funds, to finance Medicaid expenditures. Section 1902(a)(2), beyond a broad reference to the adequacy of "local sources" of funds, has been in place in its current form since 1967 and imposes no restriction on the sources of local funds that may be used by states.

Concern for Overall Population: Public Health Preparedness and the Safety Net

In addition to the substantive issues outlined here and by Congress and many others, we at the Bureau are very concerned about the timing of this proposed regulation. Cook County hospitals

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

Organization : **Massachusetts Office of Medicaid**

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-290-Attach-1.PDF

#290

March 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Attention: CMS-2258-P

Re: Massachusetts' Comments on Proposed Rule: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership [File Code CMS–2258–P]

Dear Ms. Norwalk:

The Commonwealth of Massachusetts appreciates the opportunity to submit comments on the Proposed Rule regarding the Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership. Massachusetts would first like to express its support for comments prepared and submitted by the National Association of State Medicaid Directors (NASMD). Massachusetts specifically supports NASMD's concerns regarding the implementation timeframe of this proposed rule.

Massachusetts, however, has the following additional comments and clarifying questions related to ambiguities in the proposed rule.

Scope and Applicability of Regulations

1. Please specify in the regulations themselves (as opposed to the preamble) which, if any, provisions of the proposed rule apply to (1) administrative expenditures, costs, and services, (2) waiver expenditures, costs, and services (4) Disproportionate Share Hospital expenditures, costs, and services, (4) Medicaid Managed Care entity expenditures, costs, and services, and (5) SCHIP expenditures, costs and services.

2 There already is an established process for determining and reporting administrative expenditures. If any provision of the proposed rule applies to administrative expenditures, how, if at all, would these regulations alter that process?

3. If the cost identification or reporting requirements are intended to apply to administrative expenditures, then will all currently approved Cost Allocation Plans still be compliant under this new rule? Will CMS accept all cost allocation methods that are specified in OMB Circular A-87? If not, how will CMS inform the states regarding allowable administrative cost identification and allocation methods?

42 CFR 433.50, Defining a Unit of Government

1. Please clarify in the regulations the criteria for an entity to be considered a unit of government. The following are specific questions we believe the regulation leaves unanswered. We note that there are a number of legislatively-created entities that do not, themselves, have taxing authority. Such legislatively-created entities may include state and municipal agencies, departments, authorities, universities and local and regional public schools and public school districts.

    a. Does a legislatively-created entity constitute a "unit of government" if it does not have taxing authority, but receives a government appropriation?

    b. Does a legislatively-created entity constitute a "unit of government" if it does not have taxing authority, and does not receive a government appropriation, but

        1. is able to access funding as an integral part of a unit of government with taxing authority? (This is stated expressly for providers, and should be specified for other entities that do not themselves, have taxing authority, but are clearly units of government.)

        2. has legislatively-established revenue-raising authority (e.g., collects fees, or earns revenues in the course of engaging in legislatively authorized or directed activities)?

        3. performs a legislatively-mandated function?

    c. Does a legislatively-created entity constitute a "unit of government" if it does not have taxing authority, but receives both a government appropriation and other revenues through its legislatively-established revenue-raising authority? If yes, are there any limits on the amount or source of funds that such an entity may spend, transfer or contribute as the non-federal share of an expenditure eligible for FFP?

2. Is the state's obligation to demonstrate a certifying entity is a unit of government a one-time obligation, or must the state so certify to support each and every CPE?

3. Please define what is meant by special purpose district.

4. Please clarify what entities would constitute 'other governmental unit'.

5. Once states submit the CMS form for entities that states determine are governmentally operated providers, what action will CMS take? Please specify in the regulations the process, timeframes, and appeal rights for the states to request a determination from CMS and for CMS to determine whether an entity is or is not a unit of government as defined by the regulations.

42 CFR 433.51 (and 42 CFR 433.51(b)), Funds from Units of Government as the State share of financial participation

1. The preamble to the regulations states that CMS will issue a certification form that would be "required for governments using a CPE for certain types of services where we have found improper claims (for example, school based services)." When does CMS plan to do this?

2. What is the compliance date for changes concerning funding of the non-federal share?

42 CFR 447.206, 447.271, 447.272; and 447.321;), Cost Limit for Providers Operated by Units of Government

1. How should states identify costs for providers operated by units of government that do not serve Medicare patients and, therefore, do not use and have never used Medicare cost reports?

2. Please provide clarification in the regulation on timing requirements for reconciliation and for final payments.

3. Please specify in the regulations the process, timeframes, and appeals rights regarding CMS' action on a state's request to approve its cost reports for non-hospital/non-nursing facility providers, and for adjusted Medicare cost reports for hospitals/nursing facilities.

4. What do the regulations require, if anything, when the state uses CPEs to fund a non-cost-based reimbursement method for a private provider (that is, when a unit of government makes a payment to a provider not operated by a unit of government)?

42 CFR 447.207, Retention of Payments

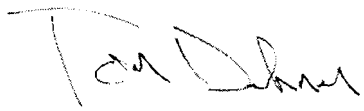
1. Please clarify in the regulation what CMS considers an 'associated transaction'.

2. Please clarify in the regulation that this section does not apply to services that are financed through CPEs.

3. The regulation should make clear that the requirement to 'retain' a payment does not prohibit a provider from spending earned revenue. CMS should more clearly tailor its regulation to clarify what activities are prohibited.

Thank you for considering Massachusetts' comments and concerns about the proposed rule. We look forward to receiving the Final Rule and to continuing to work with CMS to ensure the fiscal integrity of the Medicaid program.

Sincerely,



Thomas Dehner
Acting Medicaid Director
Office of Medicaid
Massachusetts Executive Office of Health and Human Services

Submitter : Ms. Ann Kempski **Date:** 03/19/2007

Organization : Service Employees International Union

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-2258-P-291-Attach-1.PDF

CMS-2258-P-291-Attach-2.PDF

#291

March 19, 2007

Ms. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Room 445-G, Hubert Humphrey Building
200 Independence Ave, S.W.
Washington, DC 20201

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

Dear Ms. Norwalk:

On behalf of the Service Employees International Union (SEIU) and the one million members of SEIU who deliver health care on the frontlines of our troubled and fragmented health care system, I am writing to express our strong disappointment with and opposition to the proposed Medicaid regulation published on January 18, 2007, CMS-2258-P. We are disappointed that CMS is pursuing a regulation that Congress has repeatedly rejected through bi-partisan communications with your agency, and declining to adopt Administration recommendations to enact these changes legislatively. We are concerned that CMS would propose this regulation at a time when it claims to want to work in partnership with states to expand health care coverage and reform the delivery of care.

SEIU members work in safety net hospitals and public university and teaching hospitals throughout the United States. Not only do they labor to uphold the mission of access for those who need care, regardless of ability to pay or country of origin, but they also serve as first-responders in the event of emergencies and public health threats. Unfortunately, the patchwork of federal, state, and local rules and uneven funding that safety net facilities must contend with often prevents them from structuring their delivery systems in the most ideal way. The proposed rule of January 18 will only further cripple the ability of our health care safety net to satisfy the unmet needs of communities and be prepared for disasters and other threats to public health.

Cost Limit for Providers Operated by Units of Government (Sec. 447.206)
We are puzzled why CMS would single out public providers, who are the most dependent on Medicaid and most likely to serve low income and uninsured, unreimbursed patients, and limit their Medicaid reimbursement to cost. Already, public providers are challenged to fund important services such as outpatient clinics that can relieve emergency room overcrowding and provide primary care; to fund "stand by" or "surge" capacity for specialized services; to fund physician and other professional services and graduate medical education; and to make investments in new equipment and information technology that will lead to greater efficiencies and improvements in quality of care.

Cross-subsidies are a necessity in hospitals who serve uninsured and underserved populations, and who face payment levels across different payers and different services that are often below the cost of delivering services. We urge CMS to withdraw this proposal and retain the current Medicare upper payment limit for government providers.

ANDREW L. STERN
International President

ANNA BURGER
International Secretary-Treasurer

MARY KAY HENRY
Executive Vice President

GERRY HUDSON
Executive Vice President

ELISEO MEDINA
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Intergovernmental Transfer (72 Fed. Reg. 2238) and Certified Public Expenditures
The preamble of the proposed rule discusses narrower definitions of both intergovernmental transfers and certified public expenditures than those which have been used by CMS to approve and reaffirm practices employed by states for many years. We question whether CMS has the authority to make such changes and request that this language be withdrawn.

Defining a Unit of Government (Sec. 433.50)
SEIU also objects to the strict definition of a public provider in the proposed rule. Taxing authority is not as important as governance and governmental oversight in determining whether a safety net provider is fulfilling an essentially public purpose. Many public hospitals have reorganized and restructured over the last two decades in order to respond to policy and market changes such as the implementation of Medicaid managed care and the consolidation of private hospitals in their local markets.

SEIU strongly advocates for hospital governance structures that allow elected officials to evaluate and determine whether the mission of the public hospital is being met; whether any and all contributions, subsidies, or credit guarantees from local and state taxpayers are properly spent; and any and all contractual obligations between governmental entities and safety net hospitals are met. We recommend that CMS focus on these approaches to ensure that only those entities accountable to a public purpose are permitted to finance the state share of Medicaid.

Impact on Section 1115 Waivers
The language in the proposed rule appears to jeopardize or potentially jeopardize the financing that was carefully structured and approved by CMS to allow certain states to expand coverage, contain costs, and reform the delivery system. In effect, CMS is breaking faith with several states that are in the midst of implementing or designing important reforms. We urge CMS to clarify that the proposed rule would not result in reduced funding below the levels that were already agreed upon in the terms and conditions of waivers. We also urge CMS to apply criteria used to approve waivers and establish their terms and conditions in a consistent and transparent manner across states.

Over the years, state and local governments have worked hard to meet the unmet health care needs in their communities, and tailor their health care safety nets to unique local needs and preferences. Moreover, state and local governments have crafted these health care safety nets in the context of their own state constitutions, laws, and fiscal situations, as well as local obligations and authorities. Medicaid payment policy should be flexible and accommodate the many variations of local health care safety nets that have developed over recent years during which the number of uninsured and underinsured residents continues to climb and the burden of disease, chronic conditions, violence, and preventable injuries mounts for our entire society and economy.

SEIU appreciates the opportunity to comment on this proposed rule, and respectfully requests that CMS withdraw the rule and pursue a more cooperative strategy with both the Congress and states to expand coverage and reform the delivery system.

Sincerely,

Ann Kempski

Ann Kempski
Deputy Director of Health Care Legislation

AK:gmb
opeiu#2
afl-cio, clc

Submitter : Mr. Mike Fogarty **Date:** 03/19/2007

Organization : Oklahoma Health Care Authority

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-292-Attach-1.DOC

#292

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

March 16, 2007

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

Attention: **CMS-2258-P**

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

The Oklahoma Health Care Authority (OHCA) respectfully submits this comment letter on the regulations proposed regarding cost limitations for providers operated by units of government and provisions to ensure the financing integrity of the Medicaid program. OHCA is commenting on the proposed rule published in the January 18, 2007 Federal Register (Volume 72, Number 11) for the Centers for Medicare and Medicaid Services (CMS). OHCA is the designated single state agency that administers the Medicaid program in Oklahoma.

OHCA appreciates the intent of the proposed rules to curtail what the federal government considers to be abuses of the source of the Medicaid non-federal share and potential "recycling" of federal funds. We do not condone the misuse of federal Medicaid funds and support efforts to ensure the appropriate use of such funds for the purpose of providing needed health care services to eligible members of the program. However, the proposed rules appear to go beyond legitimate efforts to curb misuse by placing undue burden on the administering state and federal agencies as well as the traditional safety net providers, including State and local governments. Congress and CMS previously imposed limits to restrict excessive payments to public providers and we question why the additional restrictions are necessary. These additional reforms undermine our state's effort to establish fair, equitable and efficient payment methodologies to provider groups and could result in reduced payments to providers serving the neediest patients. Reduced provider payments may impact access to care for Medicaid beneficiaries, particularly specialty care.

General Points and Summary

- **Attempts to define "public agency" by federal rule thus eliminating the State authority either by State Constitution or State Statute to make such a definition**

- **Ignores existing standards of acceptable accounting practices and creates an overly bureaucratic yet to be determined cost reporting system for State and Local Governments**
- **Establishes a bifurcated reimbursement system which unfairly treats public and government service providers as slaves to provider specific cost limitations while allowing private non-government providers to be exempt from such limitations and potentially exceed cost**
- **Allows States which were out of compliance with the last revisions to the Upper Payment Limit Regulations to continue to transition into compliance while forcing States which were in compliance to conform to the new and onerous regulations**

Comments on Provisions of the Proposed Rule

Defining a Unit of Government (§433.50)

This provision removes the state's discretion in defining a "public agency" and replaces it with regulations that allows CMS to more narrowly define a "unit of government" that is eligible to participate in the non-federal share of Medicaid. Medicaid statutes (1903 (w)(7)(G)) define a unit of government as a state, city, county, special purpose district, or other governmental unit in the State. The proposed rule adds to the definition by restricting to those entities *that have generally applicable taxing authority or are able to access funding as an integral part of a governmental unit with generally applicable taxing authority*. In part, this seems to change the long-standing practice of many non-state government owned hospitals being allowed to participate in the non-federal share of Medicaid. Often, these hospitals maintain a public status but are not specifically *operated* by a government, for the sake of efficiency. This proposed change could eliminate traditional funding provided by local hospitals and others. CMS seems to be exercising power to define governance without recognizing the many State-local relationships that may exist via State Constitution or statutory authority. CMS does not explain its legal authority to further restrict this definition and we ask that the definition of a unit of government continue to reside with the State.

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

This provision clarifies that the state share of Medicaid expenditures may only be contributed by units of government by removing the terms "public" and "public agency" from §433.51 and replacing with the new term "units of government" as defined in §433.50. The proposed regulatory language further states that the non-federal share of Medicaid expenditures may be appropriated directly to the State or local Medicaid agency or may be transferred from other units of government to the State or local agency. The source of state share becomes confusing, however, when taken in the context of the comments included in the preamble and given the current questions and documentation being required by CMS for State plan amendments.

First, the preamble defines an IGT as a transfer of funding from a local governmental entity to the State. We find this to be an accurate definition; however CMS' current practice has been to include funds transferred from one agency of the State to the Medicaid agency in discussions of an IGT. Since the "unit of government" is the State, these transfers are *intra*governmental transfers and are recorded as such in accounting records. We ask CMS to clarify that transfers within a unit of government are not considered intergovernmental transfers.

CMS also states in the preamble that, where a governmentally operated health care provider has transferred the non-federal share, the State must demonstrate that the source of the transferred funds is *State or local tax revenue*. At the same time, the regulations are revised to say that eligible funds may be appropriated directly to the State or local Medicaid agency or are transferred from other units of government to the State or local agency. The explanation provided by CMS that the State must demonstrate that the source of funds is *State or local tax revenue* is more restrictive than the actual regulation and does not recognize the right of a government to define the combination of methods that will be used to finance its services to the public. There are many revenues available to government agencies which they are authorized to assess and collect that are not direct appropriations of State or local taxes. These revenues include penalties and certain fines and fees assessed for the purpose of funding the agency's general operations. In a school or institution such funds may come from a retained percentage of vending machine sales. In a State agency, there may be an "unreserved fund balance" at year end that would be available for spending with the approval of the legislature. In Oklahoma, the collection of authorized revenues by a State agency for the purpose of funding its operations are, by law, "appropriated and budgeted" upon deposit of the monies into the appropriate fund. In the strictest sense, however, these funds are not always from tax revenue but should be considered State monies that are eligible to pay for the non-federal share of Medicaid expenditures.

This regulatory change also imposes minimum standards for documentation required to support a certified public expenditure. In the future, such costs must be reported in a form approved by the Secretary. While we have no issue with the requirement to submit auditable documentation, we are concerned whether CMS has considered that complicated approved methodologies exist today whereby an agency captures both administrative costs and program costs through cost allocation that are used to claim administrative costs by CPE and to set rates for programs such as TCM. We ask that CMS be aware that while requirements for reporting administrative costs and for reporting service costs are very different, they are also sometimes integrated in time studies. In such instances, we prefer the documentation requirements accommodate both administrative claiming and/or collection of the cost to provide a service, thereby avoiding a duplicative reporting process. Also, to what extent will CMS define how administrative claiming is documented? We request these requirements not go beyond the activities defined in OMB A-87 or GAAP to avoid potential changes to the State or agency accounting system. At the same time, we expect the allowable costs to be fully inclusive of costs as defined by OMB A-87.

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

The proposed rules for cost limits for governmentally operated providers are in direct conflict with many of the advances the State of Oklahoma has made in recent years related to provider reimbursements. For example, Oklahoma developed a DRG reimbursement system for hospitals consistent with the Medicare payment methodology so that all hospitals are reimbursed by the same methodology. No hospital providers are participating in the non-federal share or CPE. Because Oklahoma is currently paying at or near cost, there may be government operated hospitals from which this rule will require the agency to recoup significant funds annually using the DRG system. To avoid future overpayment scenarios and to be fair in general, the proposed rules will force Oklahoma to abandon the DRG system for government operated hospitals and return to the antiquated and inefficient cost-based system. By its own admission, CMS recognizes in the proposed rules that States may need to change reimbursement methods for government operated facilities. Establishing an alternative methodology that reconciles annually to cost

is a more labor intensive process for the agency and could create cash flow problems for the facilities. The government operated facilities represent some of the most vulnerable, rural hospitals in the State. Even CMS admits that they "*...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, including governmentally operated small rural hospitals...*"

The proposed rules will create an administrative burden on the State which will be inefficient, time consuming and redundant. Under the proposed rules all government operated providers, even those not currently required to, will be forced to submit cost reports and will be treated differently from private providers. By CMS rule, the proposed changes impose onerous reporting and accounting processes to government systems, including schools, which would likely not be beneficial to the end result of a Medicaid payment for the effort required. We urge CMS to eliminate the individual provider cost limitation and to consider a reasonable measurement to ensure a proper and efficient reimbursement limitation without the unnecessary administrative burden and without creating the double standard of payment between private and government operated providers. Oklahoma generally agrees that government and even non-government operated providers should be paid a proper and efficient rate to reasonably cover the cost of services provided. What we object to is the bifurcation of our reimbursement systems for institutional and non-institutional providers that we created with CMS' approval to comply with the overriding mandate that our payments are consistent with efficiency, economy and quality of care and are adequate to enlist a sufficient amount of providers.

For non-hospital and non-nursing facility services, the proposed rules stipulate that payment to government operated providers are limited to cost, based on documentation in a form to be approved by the Secretary. We are concerned with implementation issues of this provision: 1) when will the form be available?; and 2) what happens in cases where rates have been established and approved by CMS but do not potentially meet the cost test provided by the form? We are especially concerned with the potential implications of this rule, again to the traditional safety net providers, considering that these providers have never been required to produce cost report information. These providers include school-based service providers, health department clinics, community mental health clinics, physician services provided by state employees, and graduate medical education payments to universities. Since cost data for non-institutional services has never been captured, it is difficult to gauge the impact of whether the current rates are higher or lower than any provider's individual cost. This provision encompasses many providers and will require a great effort on the part of the State and on the part of the providers to collect, report, analyze and reconcile these costs annually.

At the end of the day, this policy for both institutional and non-institutional providers seems to be a big win for the many consulting companies that specialize in Medicaid and health care data as States short on resources will be forced to pay their high administrative fees to comply with the new requirements. Again, the effort seems ill-advised to implement a policy that establishes a double standard between private and government operated provider types and at the same time encourages government operated providers to ignore the provision of efficiency. The long term impact that the illusive potential short term savings of a cost reimbursement based policy may achieve is to send us directly into the inflationary abyss of a system that has no incentives for efficiency and only financial rewards for spiraling costs.

Also, CMS has encouraged States to consider innovative payment strategies to pay providers a higher rate for adhering to certain quality indicators to achieve better patient outcomes. Oklahoma is currently considering a Pay for Performance, or P4P, model for nursing homes and certain physician services. How can we logically expect to move forward with sound reimbursement policies incorporating quality measures if they don't apply to all providers of a service? A government operated provider subject to cost limitation will not be incentivized to meet quality goals or performance standards if they are cost reimbursed anyway. We request that CMS clarify how the cost limitation for government operated providers can successfully be integrated with a P4P model.

The expected compliance date of the cost limit provision is September 1, 2007. First, CMS has yet to define the manner in which non-institutional providers will be required to report costs. Second, these providers do not necessarily have accounting and cost allocation systems established to report cost information. We cannot be expected to collect cost data from these entities timely to make rational decisions regarding rate-setting methodologies by September 1. The State will need time to make rule changes, amend State plans, change rates and develop new payment methodologies for government operated providers. Of course, this can only be done after CMS has evaluated each provider based on the new assessment tool and has determined which providers qualify as a government operated provider. In Oklahoma, we expect to remove government operated hospitals from the DRG methodology, which will also require several months of work with consultants to recalibrate all the DRG weights and peer groupings excluding these facilities. We would also expect that changes could be forthcoming to our state-employee physician rates once cost report data is established. Since this includes a primary care case management capitation, actuaries would need time to reestablish payment ranges based on cost. We would also need time to amend the 1115 waiver for certain payments provided by government operated providers that may be in excess of cost. For all these reasons, the State takes issue with the compliance date and asks that a longer transition period be provided.

It is also important to question how much of the estimated federal savings in the Regulatory Impact Analysis is expected due to the cost limitation provision. We believe the payment methodologies we currently have in place for both institutional facilities and non-hospital and non-nursing home government providers provide adequate and equitable payments within the framework of the proper and efficient administration of the State plan. In order to hold individual providers to cost, the State of Oklahoma has no interest in achieving savings based on an overpayment of an interim rate. Our intent would be to ensure that such savings are redistributed to the providers that were paid less than cost, thereby negating any federal savings that may be assumed from this proposed change.

Retention of Payments (§447.207)

This is a new regulatory provision requiring that providers receive and retain the full amount of the total computable payment provided to them for services rendered. CMS suggests that compliance may be demonstrated by showing that the funding source of an IGT is clearly separated from the Medicaid payment received by the health care provider. This is another example of CMS' definition of an IGT being inconsistent with their current practice. In evaluating State plan amendments, CMS has previously considered funds transferred from a State agency to the State Medicaid agency as an IGT. As previously stated, we believe this constitutes an *intra*governmental transfer within the same unit of government and therefore CMS has no authority to evaluate these transfers with the same level of scrutiny as an *inter*governmental transfer.

We further believe that CMS goes too far in requiring that a transfer within the same unit of government must take place prior to a Medicaid payment and that the non-federal share must originate from taxes from an account that is separate from the account that receives the Medicaid payment. Government accounting principles, established by GASB, encourage States to use the least number of funds that are necessary to comply with legal operating requirements. The State of Oklahoma follows the GASB standards of fund classification, which generally means agency operations are accounted for in a general revenue fund unless funds are legally restricted for a specific purpose. This means that an agency's appropriated funds are deposited into the general revenue fund, with no account designation, and are expended from the same fund. In some cases where a State agency is also a health care provider, the Medicaid payment could be deposited into the same fund as the appropriation. In order to comply with CMS' rigid practice, the State legislature will need to statutorily create more funds to clearly segregate these monies. We ask again that CMS clarify its intent that this segregation of funds does not apply to *intra*governmental transfers and that a State's compliance with GASB standards in accordance with generally accepted accounting principles and a State agency's compliance with all applicable laws, rules and regulations with respect to fund accounting and budgeting should provide sufficient accountability.

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

At the present time, State's Medicaid payments to hospitals may not exceed the upper payment limit defined by federal statute as a reasonable estimate of the amount that Medicare would have paid to furnish the same set of services provided under the Medicaid State Plan. There are three aggregated UPL tests for both inpatient and outpatient services: privately owned; state owned and non-state government owned. CMS does not provide a formula to determine the upper payment limit, but has allowed States flexibility in calculating amounts within the statutory definition.

Oklahoma has traditionally used the cost method to determine UPL, primarily because, until late 2005, the methodology Oklahoma used to pay hospitals did not easily compare to the Medicare DRG model, thereby making it difficult to compute "the amount that Medicare would have paid..." However, since Oklahoma converted to the DRG model, we have considered a different calculation of the UPL test. The proposed rule and regulatory changes would further restrict the UPL definition for all government owned facilities to the cost method, and apparently would not allow the DRG UPL model except for private hospitals. This further enhances the double standard of payment being created by not only allowing a private facility to be paid higher than cost but also allowing the UPL to be set at a higher level than the cost method. These changes appear to establish two distinct UPL standards for private and governmental providers. The limit for private providers appears to allow a state flexibility in calculating the amount Medicare would have paid for the same services, potentially creating a system whereby Medicaid payments for private facilities could be higher than payments to governmental providers for the same services, without the private facility having to incur the cost. We ask CMS to reconsider these regulatory changes for government operated providers so that, if each facility is to be held to an individual UPL test, the standard for determining the upper payment limit for both private and government operated providers is at least the same standard that exists today.

Also, States that are still out of compliance from the last round of changes to the upper payment limit regulations because of the transition period do not have to conform to the new UPL provisions by the September 1, 2007 deadline. These States, where abuses previously occurred, will be allowed to continue transitioning out of their abusive systems while States like Oklahoma that have not abused the

system will have to immediately comply with the new and cumbersome administrative process. We ask that CMS try to come up with a fair implementation process and standardized implementation date for all States that does not continue to reward those that are not currently in compliance.

Tool to Evaluate the Governmental Status of Providers

It is clear that the assessment tool must be completed for any provider who is financing the non-federal share. However, States are also required to complete the form within 3 months of the effective date of the final version of the proposed rule for existing arrangements that involve payment to a governmentally operated provider. To what extent is the Medicaid agency responsible for identifying a provider as government operated? For example, if a facility has not asserted itself as a government provider, must the agency establish procedures to identify them?

In conclusion, we again urge CMS to reconsider the adoption of these severely restrictive policies that will impose significant administrative burdens on the State and federal government and on government providers without consideration of whether the benefit will be relative to the effort involved. It is our belief that the federal government has overstated the savings expected to be achieved by these proposed changes. In reality, the current rules and regulations should be sufficient to impede further abuses described by CMS from happening. The spirit of these changes – limiting government operated providers to cost – can easily be accomplished by adoption of a rational policy that holds ***all*** providers within a service type to rates that are based on the same measure of efficiency and economy within the context of the proper and efficient administration of the State plan without the need for extreme, arduous reporting requirements. We feel this is already primarily accomplished in our State using the Medicare DRG and physician fee schedule as models where appropriate. We further believe that the UPL aggregate groups currently established in regulation succeed in limiting the States' ability to abuse payments to providers and there is no need to limit the UPL standard to any individual provider.

We would be pleased to provide any additional information that may be helpful to you regarding these matters. Thank you for considering our comments. If you have any questions, please do not hesitate to contact me at (405) 522-7417.

Sincerely,

Mike Fogarty

Submitter : **Ms. Pamela Townsend** **Date: 03/19/2007**

Organization : **Coosa Valley Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-293-Attach-1.DOC

#293

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, NO 11), January 18, 2006

Dear Ms. Norwalk:

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

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. These changes would cause major disruptions to our state Medicaid program and hurt providers and beneficiaries alike. CVMC and many other Alabama hospitals are already providing care to Medicaid beneficiaries at below the cost to care for these patients. To further reduce payments would seriously jeopardize services currently being provided.

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

We urge CMS to permanently withdraw this rule, and we would like to outline our most significant concerns, which include: (1) the limitation on reimbursement of governmentally operated providers; (2) the narrowing of the definition of public hospital;

(3) the restrictions on intergovernmental transfers and certified public expenditures; and
(4) the absence of data or other factual support for CMS's estimate of savings.

Limiting Payments to Government Providers

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

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. We are very concerned that, in CMS' zeal to reduce federal Medicaid spending, important costs would not be recognized and therefore would no longer be reimbursed.

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

New Definition of "Unit of Government"

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

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

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

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

Pamela J. Townsend
Vice President Finance/CFO

Submitter : Mr. Edwin Stephens **Date:** 03/19/2007

Organization : Agency for Health Care Administration

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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. Susan Lucas **Date:** 03/19/2007

Organization : State of Washington, DSHS

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

As requested we are providing information on how the proposed rule CMS-2258-P will affect Washington State. The following comments attached provide overall context, specific areas of concern and a statement of general concerns.

CMS-2258-P-295-Attach-1.PDF

#295

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Health and Recovery Services Administration
626 8th Ave. S.E. • P.O. Box 45502
Olympia, WA 98504-5502

March 19, 2007

Centers for Medicare and Medicaid Services
Covington & Burling
P.O. Box 8017
Baltimore, MD 21244-8017

As requested we are providing information on how the proposed rule CMS-2258-P will affect Washington State. The following comments provide overall context, specific areas of concern and a statement of general concerns.

Washington State has an approved SPA for nursing home and hospital Certified Public Expenditures (CPE) and the State has been negotiating a protocol for hospital CPE processes for over a year. The hospital protocol has not been officially approved, but the language and requirements are essentially agreed upon. The negotiation has resulted in the State's processes for hospitals and nursing homes being very close to the requirements of the draft rule. For that reason, Washington State does not have significant issues with some aspects of the rule with respect to hospital and nursing home CPE.

Washington State has historically used CPE to fund school-based services. The State began negotiation on a protocol for these services several months ago. CMS was very clear in these negotiations that continued use of CPE for school based services is not advised, but that Intergovernmental Transfer (IGT) payments would be acceptable. The requirements for use of IGTs contained in the rule require extensive administrative effort possibly in excess of the benefit of continuing the program as financed. Comments below include the effect of complying with the rule for school-based services paid with an IGT mechanism.

The stated definition of "governmental entity" is consistent with law in Washington State that specifically grants public hospitals and nursing homes general taxing authority.

Washington State has agreed to and has begun implementing processes to ensure that public providers' payments are limited to cost when those providers are in our state's CPE program these processes are burdensome for hospitals and for the State because Washington has never required a Medicaid Cost Report from public hospitals or nursing homes. A requirement that all public provider payments are limited to cost, and that the State verify this requirement, is extremely burdensome to implement. The effect on providers and on the State will be significant.

In addition, for school-based services, this requirement is extremely burdensome. It is questionable whether schools will be able to fulfill this requirement, which may result in medically necessary and allowable services not being paid for appropriately.

Washington State has never audited governmental providers. This requirement will be costly, since the state currently has 296 school districts and over 25 public hospital and nursing home districts participating in CPE programs.

If the State continues to utilize IGTs for school-based services, the rule's limits on IGTs will be virtually impossible to comply with. Demonstrating that the match is paid from tax revenues for 296 school districts will place such a large administrative burden on schools and on the state that use of the IGT mechanism will not be feasible. In addition, the process of collecting match from each district before the district's claims are paid cannot be implemented without significant changes to the State's MMIS. Tracking, accounting for and remitting unused match funds to each district is a massive undertaking that the State has no resources for.

It is unclear how the State would comply with the requirements in the rule related to the limitations on sources of non-federal share. This is likely to be an issue for all providers in the State that utilize CPE or IGT. We are concerned with any requirements that limit the source of match funds in any way, including a limitation related to unencumbered tax revenue.

Finally, we agree with many other states and organizations that these rules are excessively broad. The approach requires processes that will cost far more than the benefit of eliminating what CMS considers inappropriate activities. These rules move reimbursement back to a cost-based methodology and away from more effective and efficient payment structures that have been developed in recent years.

If you need more information on these comments, please contact me at 360-725-1828.

Sincerely,

Susan Lucas

Susan Lucas, Director
Division of Rates and Finance

cc: Doug Porter, Assistant Secretary
Roger Gantz
Annette Meyer
Thuy Hua-Ly
Carolyn Adams
Chuck Miller

Submitter : Mr. Kenneth Reid **Date:** 03/19/2007

Organization : Carlinville Area Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-296-Attach-1.WPD

#296

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

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

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

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

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

Limiting Payments to Government Providers

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

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

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

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

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

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

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

Sincerely,

Kenneth G. Reid, CEO
President
Carlinville Area Hospital

Submitter : Mr. Ben Wiederholt **Date:** 03/19/2007

Organization : Flaget Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-297-Attach-1.DOC

#297

CATHOLIC HEALTH INITIATIVES

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

Dear Ms. Norwalk:

Catholic Health Initiatives appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. CHI is a faith-based, mission-driven health system that includes 71 hospitals, 42 long-term care, assisted-living and residential units, and two community health service organizations in 19 states. **We oppose this rule.**

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 state Medicaid programs and hurt providers and beneficiaries alike. And, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

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

We urge CMS to permanently withdraw this rule. 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,

Ben Wiederholt
Vice President of Mission Integration

Submitter : Ms. ALISSA FOX **Date:** 03/19/2007

Organization : Blue Cross and Blue Shield Association

Category : Health Plan or Association

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

CMS-2258-P-298-Attach-1.DOC

#298

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4780
Fax 202.626.4833

March 19, 2007

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

Attention: CMS-2258-P
Submitted Electronically

Dear Ms. Norwalk:

The Blue Cross and Blue Shield Association (BCBSA) appreciates the opportunity to provide comment 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, 2006 (72Federal Register 2236).

BCBSA represents the 39 independent Blue Cross and Blue Shield Plans ("Plans") that provide health coverage to more than 98 million – one in three – Americans. Collectively, Blue Cross and Blue Shield Plans have the largest Medicaid managed care enrollment in the country with a collective enrollment of over 3.6 million recipients.

BCBSA appreciates CMS' on-going efforts to strengthen Medicaid by changing the program's financing policies. However, we recommend that changes to Medicaid financing should also be accompanied by expanded Medicaid managed care that will result in more efficient and effective delivery systems for states.

Partnerships between states and Plans have allowed states to stretch limited resources to provide cost-effective coverage as well as expand access to quality care for disadvantaged populations. Plans have demonstrated success in improving access to

preventive services, achieving improved outcomes for acute care, and coordinating care for those with chronic conditions. We value the partnership our Plans have with states and CMS to bring valued benefits to Medicaid beneficiaries.

We offer a number of concerns as well as recommendations regarding the proposed rule. Our comments and recommendations are as follows:

1. Cuts in Medicaid Funding Will Diminish Access and Quality in Medicaid

- ***Issue***: We are concerned that this proposed rule will erode access to Medicaid managed care by leaving holes in state Medicaid budgets. We understand the necessity of assuring federal Medicaid funds are spent in accordance with statutory requirements. However, the proposed rule will reduce Medicaid spending by $3.9 billion or more over five years which will seriously undermine the financial ability of both plans and providers to furnish health care services for Medicaid beneficiaries. In order to accommodate the substantial loss of federal Medicaid funds resulting from this proposed rule, many states would be faced with cutting payments to plans along with other payment, benefit and eligibility reductions.

  Recommendation: We urge CMS to modify the proposed rule regarding Medicaid financing policy in a manner that does not reduce existing levels of federal Medicaid funding.

2. Matching State Spending on Services Provided Through Capitated Medicaid Managed Care Contracts Will Increase the Efficiency and Quality of Care

- ***Issue***: Current federal upper payment level (UPL) policies only allow states to count the utilization of services of Medicaid paid on a fee-for-service (FFS) basis. The UPL match does not include amounts spent through capitated contracts in the calculation of the federal UPL. Thus, states currently have a disincentive to establish Medicaid managed care programs where payment is on a capitated basis.

  A recent Lewin Group report highlighted the difficulties states face and how the current UPL policy detracts from savings that could be achieved through more efficient and effective delivery systems.[1] The report provides state examples of experiences with payment policies and Medicaid managed care.

  For example, in Illinois, the Intergovernmental Transfer (IGT) and UPL arrangements played a key role in policy decisions to eliminate Managed Care Organization contracting altogether.[2] Texas attempted to expand Medicaid managed care, but

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[1] Menges, Joel, and Aaron McKethan. Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion. The Lewin Group. Medicaid Health Plans of America, 2006. 14-15.

[2] Id. at 8.

faced resistance from public hospitals due to the potential loss of UPL revenues, and although California and Florida established special funding pools that allow them to protect their UPL funds for safety net providers while also expanding Medicaid managed care, these pools were negotiated with CMS as part of an involved waiver process.[3]

Recommendation: While considering fundamental policy changes in the scope and financing of the Medicaid program, BCBSA recommends that CMS modify the upper payment limit (UPL) policy to remove barriers to expansion of Medicaid managed care. The UPL policy should be modified to allow the inclusion of managed care utilization in the federal match for UPL.

3. Matching Funds for Services Provided Through Capitated Medicaid Managed Care Contracts Should be Available to All States

- ***Issue***: As mentioned above, some states have negotiated an agreement with CMS for special pools with defined funding levels that effectively accomplish equal treatment in federal UPL policy between Medicaid managed care and fee-for-service Medicaid.

  State Medicaid programs need to have the financial stability and the flexibility to form viable partnerships with Plans.

  Recommendation: CMS should not rely solely on the waiver process to accomplish reforms in Medicaid managed care. We recommend that CMS establish a uniform federal policy that allows for the inclusion of managed care utilization in the federal match for UPL.

4. The Rule Should Further Specify How Individual Waivers Will Be Impacted

- ***Issue***: BCBSA is concerned about modifications to state waivers as a result of this rule. Although page 2240 of the preamble states that payments under Medicaid waiver and demonstration authorities are subject to all provisions of this regulation, it is unclear how CMS will apply the provisions of this rule to individual waivers. Specifically, it is not clear how the rule would impact budget-neutrality expenditure caps in states where reductions in payments to public providers formed a significant part of the budget-neutrality calculation.

  Recommendation: The final rule should clarify how states with current waivers must come into compliance with the changes in the final regulation with specific information about the impact of the rule on budget neutrality caps.

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[3] Id. at 8-15.

Thank you for the opportunity to provide comment. We look forward to continuing to work with CMS in partnership with Plans and states in improving Medicaid.

Questions on our comments and recommendations may be addressed to Jerod Brown at (202) 626-4819 or jerod.brown@bcbsa.com.

Sincerely,

/s/

Alissa Fox
Vice President, Legislative and Regulatory Policy

Submitter : Ms. Meghan Clune **Date:** 03/19/2007

Organization : Advocate Health Care

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-2258-P-299-Attach-1.PDF

#299

2025 Windsor Drive
Oak Brook, Illinois 60523
Telephone 630.572.9393

Advocate Health Care

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 Acting Administrator Norwalk:

On behalf of Advocate Health Care (Advocate), a non-profit, faith-based organization of physicians and health care professionals dedicated to serving the health needs of individuals, families, and communities in northern Illinois, I am writing to voice our serious concerns about the Centers for Medicare & Medicaid Services' (CMS) proposed rule CMS-2258-P. We appreciate the opportunity to comment on this proposal and thank you in advance for your attention to our concerns.

Advocate is the largest integrated health care system in Illinois and is recognized as one of the top ten health care systems in the country. Based in Oakbrook, Illinois, Advocate maintains eight adult hospitals and two children's hospitals with 3,500 beds in addition to having the state's largest privately held full-service home health care company among more than 200 sites of care. Given Advocate's size and scope, we play a critical role in the provision of care to Illinois' residents, particularly those who rely on the presence of a strong health care safety net, such as individuals served by the Medicaid program. As such, we are in a unique position to evaluate the proposed rule and understand its impact on our system as well as the Medicaid population throughout our state.

We oppose the proposed rule because we believe that it would weaken an already fragile safety net in Illinois. CMS estimates that the rule will cut $3.9 billion in federal spending over five years which will result in significant cuts to hospitals and systems such as Advocate; by some estimates, the proposed rule will cut $623 million from certain hospitals in our state alone. In turn, this means that many of the individuals we exist to serve will not have access to the care they need and deserve. Recently 226 House members and 43 Senators signed letters urging their leaders to take legislative action to stop the proposed rule from moving forward due to the adverse impact on the hospitals and people in their states and communities. We join with these Members of Congress in opposing the rule and call upon CMS to permanently withdraw it.

Thank you very much for your consideration of our views. If we can be of any assistance to you or your staff, please contact Meghan Clune, our Director of Government Relations (meghan.clune@advocatehealth.com, 630/990-5514).

Sincerely,

Tony Mitchell
Senior Vice President
Communications and Government Relations

Submitter : Dr. Virigina Foxx **Date:** 03/19/2007

Organization : U.S. House of Representatives

Category : Congressional

Issue Areas/Comments

GENERAL

GENERAL

i.e. See Attachment

CMS-2258-P-300-Attach-1.DOC

#300

March 19, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: (CMS-2258-P)
200 Independence Ave, SW. Room 445-G
Washington, DC 20201

Dear Ms. Norwalk:

On January 18, 2007, CMS released 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." In light of this I would like to take this opportunity to comment on a certain provision of the rule.

This rule proposes to amend the provisions of § 433.51 to conform the language to postdate provisions of sections 1903(w)(6)(A) and 1903(w)(7)(G) of the Social Security Act by removing the terms "public" and "public agency" and replace with references to units of government. Presently, North Carolina has 43 public hospitals that certify their public expenditure to draw down matching federal funds to make enhanced Medicaid payments and disproportionate share hospital (DSH) payments to the public and non-public hospitals that provide hospitals that provide hospital care to Medicaid and uninsured patients. Since 1995, under all the North Carolina plan amendments which have been approved by CMS, these 43 public hospitals have qualified for intergovernmental transfers (ITG) and certified public expenditures (CPE) payments.

According to CMS, the regulations as proposed would decrease Medicaid spending by $3.8 billion over five years. While I truly believe in ensuring the fiscal integrity of the Medicaid program I do not trust that under the proposed definition substantial savings would occur. If this proposed provision were to take effect and public hospitals, like the 43 in North Carolina, are unable to be considered for supplemental Medicaid funding, public hospitals may be forced to reduce or stop services to Medicaid beneficiaries to counter their loss of funds. Additionally, no matter where the definition is drawn between public hospitals and units of government, hospitals have the ability to reorganize to regain qualification for supplemental Medicaid funding.

Not only do North Carolina's 43 public hospitals play a unique and critical role in the health care system but CMS has allowed them to participate in the system for more than a decade. There are other ways for CMS and Congress to address the increasing cost of Medicaid; however, punishing entities that CMS has explicitly approved for years is not the answer. Therefore, I urge CMS to reconsider its position on the definition of units of government and withdraw that provision from the proposed rule.

Sincerely,

F

Virginia Foxx
Member of Congress

Submitter : Mr. Edwin Stephens **Date:** 03/19/2007

Organization : Agency for Health Care Administration

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-301-Attach-1.DOC

#301

FLORIDA MEDICAID

CHARLIE CRIST
GOVERNOR

ANDREW C. AGWUNOBI, M.D.
SECRETARY

March 19, 2007

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

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

File code: CMS-2258-P

Via electronic submission to http://www.cms.hhs.gov/eRulemaking

Dear Sir/Madam:

The State of Florida Agency for Health Care Administration (the State) submits the comments listed below regarding the above rule, CMS-2258-P, published on January 18, 2007.

Our comments appear in order of "List of Subjects" beginning on page 2246 of the Federal Register Notice, Volume 72, No.11. Specific draft rule provisions are referenced, followed by our comments:

1. Draft Rule Provision: Part 433 - State Fiscal Administration. In background section II, Tool to Evaluate the Governmental Status of Providers, specifies "States will need to identify each health care provider purportedly operated by a unit of government to CMS and provide information needed for CMS to make a determination as to whether or not the provider is a unit of government." A questionnaire was published in conjunction with the proposed rule, CMS-2258-P. The questionnaire is required to be completed for all existing governmentally operated providers (for any who receive payments in addition to any who participate for the non-Federal share of Medicaid expenditures), within three (3) months of the effective date of the final rule following this proposed rule.

   Comment: It is unclear how or when States will receive a determination from CMS as to whether the provider is considered by CMS as a unit of government. There is no indication of what steps States should take if there is a discrepancy between the State and CMS regarding which providers qualify as units of government. There is no information regarding a transition period. If there are discrepancies, we recommend that States be given time to work with the respective State Legislatures to address funding issues.

2. Draft Rule Provision: Part 447 - Payments for Services. Section 447.206 is added to include a cost limit for providers operated by units of government, where such providers would be limited to reimbursement not in excess of the individual provider's cost of providing covered Medicaid services to eligible recipients.

   Comment: In applying the cost limit for states that have approved waivers such as Florida's 1115 Research and Demonstration Waiver specific to Florida Medicaid Reform, CMS must continue to allow Title XIX expenditures for costs not otherwise matchable under the waiver.

3. Draft Rule Provision: Part 447 – Payments for Services. Section 447.206(e), *Payments not funded by certified public expenditures*, states "...each provider must submit annually a cost report to the Medicaid agency that reflects the individual provider's cost of servicing Medicaid recipients during the year. The Medicaid Agency must review the cost report to determine that costs on the report were properly allocated to Medicaid and verify that Medicaid payments to the provider during the year did not exceed the provider's cost."

   Comment: The State has approved cost based prospective Medicaid reimbursement plans for providers that include hospitals, nursing homes, intermediate care facilities for the developmentally disabled, and county health departments. We suggest that CMS, in applying this provision, give consideration to those States that have approved cost based prospective reimbursement plans. This will allow this requirement to be met with the most recent historical costs used in establishing prospective rates.

Thank you for the opportunity to provide comments on the proposed rule, CMS-2258-P. Should you have any questions, please contact Genevieve Carroll of my staff, by phone, at (850) 414-2759, or via email at carrollg@ahca.myflorida.com.

Sincerely,

Phil E. Williams
Chief, Medicaid Program Analysis

PEW/gc

Submitter : Mr. Allen Warshaw **Date:** 03/19/2007

Organization : Chief Counsel, PA Department of Public Welfare

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-302-Attach-1.PDF

#302

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 COMMONWEALTH OF PENNSYLVANIA

The Commonwealth of Pennsylvania submits these comments in response to the above-captioned proposed regulations, published January 18, 2007. Pennsylvania has joined in Joint Comments submitted on behalf of a group of states in opposition to the proposed rules, and believes that those Comments set forth compelling reasons for CMS to abandon the proposal, which would cause great harm to state Medicaid programs and the people they serve. Pennsylvania submits these individual comments to identify areas in which the proposals imperil the Medicaid program in our State.

I. Proposal to Limit Payments to Units of Government to Cost and To Require Cost Reporting by All Such Providers

The Joint Comments demonstrate conclusively the lack of legal authority to limit payments to "units of government" to cost, and the ill-wisdom of such a policy even if there were

Pennsylvania has similar concerns about the imposition of cost limits and the associated documentation requirements on county-operated Area Agencies on Aging (AAA's). These entities are also reimbursed on a fee basis for the services they provide under section 1915(c) waiver authority. Those waivers incorporate the cost efficiency requirements, which require showings that the costs incurred are less than the cost of institutional care for which the recipients qualify and would presumably utilize but for the waiver services provided to them. Satisfaction of the cost efficiency standard provides the federal government with ample assurance that its funds are being properly and efficiently used by the states. To lay on top of this a requirement that payments not exceed cost, with the attendant cost finding and reporting requirements, not only will undermine efforts to assure efficient operation by the agencies but saddle them with burdens they are not currently equipped to handle. This would be bad public policy and should not be pursued.

The limitation of payments to "units of government" to cost would also impact county-operated nursing homes. These facilities currently receive supplemental payments funded by intergovernmental transfers from the county governments that help to keep them solvent and able to provide the safety net coverage that would otherwise be unavailable or unaffordable to elderly citizens no longer able to maintain themselves in home or community settings. Because of the long-standing nature of this supplemental payment program, Pennsylvania continues to be able to supplement the reimbursement of these facilities at levels even higher than otherwise permitted under the current Upper Payment Limit (UPL) standard, under the transition provisions of the BIPA statute (Public Law 106-554, §705), albeit at levels

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aspect of the program validates the concerns about the effects of requiring similar documentation for school-based services.

of payment that decline every year. Those provisions will continue in effect through September 2008. The current UPL regulations (42 C.F.R. §§447.272 and 447.321) specifically incorporate these statutorily-mandated transition provisions. The proposed regulations omit reference to the provisions. While CMS cannot by regulation trump the operation of a statute (and there is no suggestion in the preamble to the proposed rules of any such intent) Pennsylvania nonetheless urges that any regulation that is adopted continue to incorporate the transition provisions of the BIPA law.

But the more basic proposition is that the proposed new limits should not be adopted. Current law allows payment to all nursing homes, including those operated by "units of government," up to the level that Medicare would pay for comparable services. That is a sufficient ceiling to protect the federal interest while at the same time allowing realistic levels of reimbursement that recognize the special contribution as well as the hidden costs that are embedded in the operation of county nursing homes. Medicaid should not be adopting rules that would preclude payment to governmental facilities at least up to the level that the Medicare program actually pays to the same facilities.

2. Proposal to Require Retention By Providers Of The Full Amount of Payments for Medicaid-Funded Services

The proposed new regulation (proposed 42 C.F.R. §447.207) requiring that "all providers receive and retain the full amount of the total computable payment provided to them for services furnished under the approved State plan (or the approved provisions of a waiver or demonstration)" is, as shown by the Joint Comments, ill-considered and promises to be a source of continued dispute and uncertainty. The purpose of the proposal is apparently to preclude transfer by the provider of some portion of its Medicaid reimbursement to its funding agencies. See Preamble, 72 Fed. Reg. 2238.

The proposal represents an enormous overreaction to a concern apparently perceived by CMS but which it has, by its own admission, been able to deal with through the state plan or waiver approval process. As drafted, the proposal would cast doubt on, if not expressly prohibit, valid fund transfers that raise no issue of "recycling" and involve no abuse of Medicaid funding.

Pennsylvania's experience confirms this conclusion. Its county nursing homes are financed by the county governments, which use appropriated funds to cover the homes' costs of operation. As in other states, state and county tax receipts in Pennsylvania are not received in even proportions throughout the year. To assure funding of governmental operations during period of slack revenue, Pennsylvania counties issue debt securities, known as short term tax anticipation notes, portions of the proceeds of which are transferred to the Commonwealth to help fund Medicaid payments to County nursing homes. Upon receipt of payments from payors, including Medicaid, the homes return funds to the counties to enable them to repay the tax anticipation notes.

There is nothing untoward in these arrangements. The counties are paying for the operations of the nursing homes with their tax dollars (except to the extent of the FFP). The transfers from the nursing homes to the counties out of their revenues are part of a financing structure that assures a steady flow of county funds for all of the activities funded by the counties, including nursing homes. Yet the excessively broad proposed regulation would seem to prohibit this entirely appropriate financing method. This simply illustrates the damage that can be caused by overly-broad federal regulations that impinge on state financial operations.

The proposed retention-of-payments regulation is ill-considered, and unnecessary to serve any legitimate federal interest. It should be dropped.

Conclusion

For the reasons set forth above, and in the Joint Comments in which Pennsylvania has joined, the proposed Medicaid financing regulations should be withdrawn in their entirety.

Respectfully submitted,

Allen C. Warshaw
Chief Counsel
Commonwealth of Pennsylvania
Department of Public Welfare

Submitter : Mr. Donald Ching **Date:** 03/19/2007

Organization : University of South Alabama Hospitals

Category : Hospital

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

I am writing on behalf of the University of South Alabama Hospitals in Mobile, Alabama. We strongly oppose this rule change and believe that, if implemented, it would cause irreparable harm to our hospitals and the populations they serve.

The proposed rule is a complete abandonment of both existing Medicaid policy and the intent of Congress. It not only imposes changes in how the states fund their Medicaid programs, but it also places unreasonable restrictions on how the programs may reimburse providers. In effect, the rule represents an unfunded mandate effectuated by a unilateral administrative fiat. Changes in the existing federal-state balance of funding for the Medicaid program cannot be made without legislative action.

Our position on each of the major provisions of the rule are outline below:

1. Lack of adequate supporting data. CMS is required to support the need to change current policy with relevant data. No such relevant information is included in the proposed rule.

2. Limiting payments to government providers. The rule proposes: a) limiting payments to the cost of providing care to Medicaid beneficiaries; b) the use of a vaguely defined standardized, nationally recognized cost report ; c) limitations on the determination of the Upper Payment Limit; and, d) limitation of intergovernmental transfers. The effect of all of these provisions is a de facto shift of the costs saved by the rule change to the states. This has the potential to cripple the state programs and climinate huge amounts of services to safety-net populations.
3. Unit of Government definition. The rule establishes a restrictive definition of unit of government in order for a hospital to certify expenditures to state programs. This change has no basis in existing federal statute. It is simply another means to unreasonably change the long-standing methods of jointly funding the Medicaid program in this country.

We strongly urge the permanent withdrawal of this rule change by CMS. We believe that it is poorly thought out, unworkable, and a threat to health care for millions of Americans.

Submitter : Dr. Rhonda Medows **Date:** 03/19/2007

Organization : Georgia Department of Community Health

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-304-Attach-1.DOC

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner

Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

#304

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:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule.

The department **opposes** this rule for the following reasons:

1. The state's loss of federal funds without alternative matching state funds sources threatens the financial viability of public providers who would be deemed private under the new rules.
2. Cost-based payment requirements will have an adverse financial effect on public providers who provide a health care safety net to the uninsured and indigent and who are the least able to deal with the loss of revenue.
3. The proposed rules eliminate the state's flexibility in targeting supplemental payments where they are most needed to support the state's healthcare infrastructure.
4. There is insufficient time for the state to obtain alternative matching fund sources or make other changes the proposed rules require.
5. The proposed rules are administratively burdensome for both the state and CMS.

Impact to the State of Georgia

Under this new rule scheduled to go into effect in less than 6 months:

- **HOSPITALS IMPACTED**:
  80 DSH HOSPITALS RECEIVING DISPROPORTIONATE SHARE FUNDING
  65 UPL HOSPITALS RECEIVING UPPER PAYMENT LIMIT PAYMENTS
  None of the non-state, public hospitals in the state of Georgia that currently provides an IGT as the state share of their supplemental payment would receive supplemental Medicaid funds (DSH/UPL) for indigent care.
  THIS INCLUDES GRADY MEMORIAL HOSPITAL IN ATLANTA.

- **NURSING HOMES IMPACTED:**
  78 PUBLIC NURSING HOMES (NON-STATE) RECEIVING UPL FUNDING AND
  12 INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED
  None of the public nursing homes in the state of Georgia would receive supplemental Medicaid funds.

- **PUBLIC HEALTH & MENTAL HEALTH IMPACT**
  159 PUBLIC HEALTH DEPARTMENTS FUNDING AND
  27 COMMUNITY MENTAL HEALTH CENTERS MAY BE SIGNIFICANTLY IMPACTED.

- **GEORGIA'S STATEWIDE HEALTHCARE SAFETY NET WOULD BE SEVERELY UNDERMINED AND IS ANTICIPATED TO COLLAPSE**

Georgia's DSH and UPL programs are primarily financed with intergovernmental transfers (IGTs) made to the state on behalf of non-state governmental hospitals and nursing homes. Under the proposed CMS rules, the state does not believe that any non-state facility previously considered public would be able to retain such a status based on the proposed rules. This is because IGTs are received from hospital and developmental authorities; units of local governments that have access to local tax revenue but do not have authority to levy taxes.

As a result, the state would need new state matching fund sources of approximately $204 million to replace intergovernmental transfers previously used to support the DSH Program ($138 m) and the Hospital ($31 m) and Nursing Home ($35 m) UPL programs. Without such new state matching funds, the state would stand to lose access to $236 million in federal DSH funds, $53 million in federal Hospital UPL funds, and $59 million in federal Nursing Home UPL funds.

While state owned and operated providers are not impacted by the new public provider definitions, they are impacted by that part of the rule that would limit their reimbursement to cost. The department estimates that state owned and operated nursing homes for the developmental disabled would lose federal matching funds of $8.9 million per year and state owned and operated hospitals would lose federal matching funds of $5.0 million per year due to the cost-based payment limits.

The state is additionally concerned about the reimbursement changes that would be necessary for non-institutional based providers who are state owned and operated that are currently paid on a fee-schedule basis. The state has identified the following other state owned and operated providers that would be impacted by the proposed rule: public health departments, community mental health centers, and local boards of education. In each case, the department treats these providers like any other private provider and pays on a fee-for-service basis. In the state, there are 159 public health departments, 180 local boards of education, and 27 community service boards with multiple mental health centers. There are currently no efforts to collect cost for these providers. The absence of cost reporting forms and cost definitions (to be determined by CMS at a later date) makes it difficult to determine the fiscal impact to the state or determine what administrative efforts will be necessary to conduct cost settlements for each and every public provider.

Questions for CMS

The state asks that CMS address the following questions when responding to public comment.

1. Under what regulatory authority can CMS move to more narrowly define a unit of government when the Social Security Act has already defined it in Section 1903(w)(7)(G)?

2. Why does CMS believe it necessary to require statutorily recognized local units of government to have taxing authority before they can be considered public entities?

3. Can CMS' policy objectives be met if a state could demonstrate that a local unit of government had access to local tax revenues?

4. Please address the concern that it appears public providers who are able to operate without local tax subsidies are being penalized.

5. What is the policy basis for limiting reimbursement to cost for public providers? Supplemental payments are already limited to the lesser of charges or what Medicare will pay. Are Medicare rates believed by CMS to be excessive?

6. Why does CMS wish to limit states' flexibility in distributing supplemental payments by requiring provider-specific, cost-based payment limits for public providers?

7. Is CMS aware of the administrative burden that will be created by requiring that no public provider can be paid more than cost-an administrative burden for both the state and CMS? How will this burden be minimized?

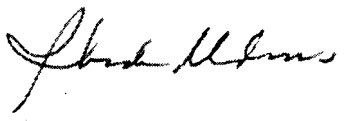
8. How does CMS expect states to make alternate financing arrangements to replace the use of intergovernmental transfers or certified public expenditures in less than 6 months? Please describe how time to transition will address the time required for state legislative sessions to meet regarding policy and budgetary changes and the time required for state rule making processes.

9. How does CMS plan to authorize the significant number of required state plan changes that will be necessary to convert to cost-based reimbursement for all public providers before September 1, 2007?

In summary, Georgia's healthcare infrastructure is in danger of the collapse of its health care safety net and of losing $348 million in federal funds without new state matching funds of $204 million. The state expects to lose an additional $13.9 million in federal funds for state owned and operated providers due to cost-based payment limitations and there is an unknown impact on local boards of education, community mental health centers, and public health departments.

On behalf of the department, I respectfully oppose the implementation of these proposed rules and look forward to CMS' response to my questions. Should additional time and consideration be granted to address the federal objectives prompting this rule, its impact on states and our safety nets, and the needs of the people served in the Medicaid program, we are more than willing to work with you on creating a viable alternative.

Sincerely,



Rhonda M. Medows, M.D.

Submitter : **Ms. Teena Keiser** **Date: 03/19/2007**

Organization : **United HealthGroup**

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-305-Attach-1.PDF

#305

UnitedHealth Group

March 19, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8017

Dear Sir/Madam:

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

We have reviewed the proposed Medicaid rule on the Cost Limit for Providers Operated by Units of Government and provide the following comments on behalf of UnitedHealth Group. Please note that, for the purposes of this letter, "United" includes all parts of our organization that serve Medicaid including Evercare, Oxford and AmeriChoice.

Covering the uninsured through federal programs is important, and for years, states have been permitted by Congress and the Centers for Medicare and Medicaid Services (CMS) to use funds to help offset the costs of uncompensated care through special payments to safety net hospitals. In many states, safety net hospitals provide the only source of health care for the uninsured. In doing so, they are an important part of our health care system. We support ensuring that hospitals that offer significant uncompensated care services remain financially solvent as CMS proposes rules on these payments.

Any proposals to eliminate special payments for providers affiliated with units of government must consider options to redirect funds to provide health care coverage for the uninsured. States and providers use these payments to help offset the costs of the uninsured. Low income adults that cannot qualify for Medicaid because they do not meet categorical eligibility, compose a large part of the uninsured population. Redirecting special federal payments to states to provide coverage for these individuals will reduce the number of uninsured and cost shifting for uncompensated care.

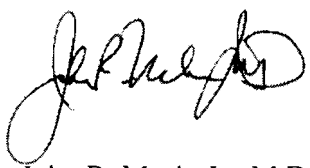
Finally, we are concerned that the proposed regulation does not address a disincentive for states to offer or expand coordinated care programs for Medicaid Beneficiaries. By

treating payments for services provided to Medicaid beneficiaries enrolled in health plans differently than those under Fee-for-Service (FFS) Medicaid, the Upper Payment Limits (UPL) policy prevents states from moving from a costly, unmanaged system of care to a model that provides coordinated care for beneficiaries through Medicaid health plans.

We urge CMS to create a level playing field between FFS and managed care by including inpatient days provided to Medicaid health plan enrollees in UPL calculations similar to the treatment of DSH & GME calculations. In order to improve cost and quality outcomes, financial incentives must be better aligned between the state and federal government.

We greatly appreciate the opportunity to comment, and we look forward to continuing to work with CMS to develop successful products and services for Medicaid beneficiaries. If you have any questions or concerns on our comments, please contact myself at 952/936-6833 or Teena Keiser at 507/663-1844 or via email teena_keiser@uhc.com.

Sincerely,



John R. Mach, Jr., M.D.
CEO, Evercare