Submitter : Mr. Stephen Harwell **Date:** 03/19/2007

Organization : Healthcare Association of New York State

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attached document

CMS-2258-P-306-Attach-1.DOC

#306

Healthcare Association
of New York State

March 19, 2007

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

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

Dear Ms. Norwalk:

The Healthcare Association of New York State (HANYS), on behalf of our more than 550 hospitals, nursing homes, home health agencies, and other health care providers, welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule. We strongly oppose this rule and request that CMS permanently withdraw it. These policy changes would severely compromise the health care safety net, jeopardizing essential health care services for our nation's most vulnerable populations.

The proposal would restrict funding for government operated public hospitals and nursing homes that are the primary source of services for many Medicaid and uninsured patients. New York public facilities are essential to this vulnerable population. Fifty-two percent of patients served by New York public hospitals are covered by Medicaid and an additional 26% are covered by Medicare. In additions, New York public hospitals incur over $500 million in uncompensated care costs annually.

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 contradicts stated Congressional intent. 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 reiterated that opposition, with 226 House members and 43 Senators having signed letters urging their leaders to stop the proposed rule from moving forward.

Intergovernmental Transfers

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program by imposing significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through intergovernmental transfers (IGTs). IGTs are a permissible source of State funding of Medicaid costs that allow units of local government to share in the cost of the state Medicaid program.

New York State uses IGT funds to help pay more of the cost of providing care to Medicaid beneficiaries and to maintain safety net providers that serve many of the 14.5% of New York residents who live in poverty. These funds are particularly important to New York due to the low Federal Medical Assistance Percentage that is provided under current law. These changes would cause major disruptions to our state Medicaid program and hurt providers and beneficiaries alike.

CMS states that they have found instances where states have taken advantage of IGT mechanisms to wrongly increase federal payments. In the proposed rule, CMS states that when these abusive state practices have come to light through the state plan amendment process, CMS has systematically required the States to eliminate these financing arrangements. If these abusive practices can be addressed through the state plan reviews, there is no need for CMS to propose these unauthorized new restrictions on IGTs.

Limiting Payments to Government Providers

The rule proposes to limit reimbursement for government hospitals to the cost of providing services to Medicaid patients. 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. New York and many other state Medicaid programs have adopted this method of hospital reimbursement, yet CMS is proposing to resurrect a cost-based limit that Congress long ago declared less efficient.

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. We are very concerned that, in CMS' zeal to reduce federal Medicaid spending, important costs such as graduate medical education (GME) and physician on-call services, or clinic services would not be recognized and therefore would no longer be reimbursed. This is particularly troubling given the President's federal fiscal year 2008 proposed budget which calls for the elimination of Medicaid payments for GME. Congress should have the opportunity to review any change to the Medicaid program's support for graduate medical education, and we urge CMS not to move forward with any proposed rule that would implement the president's budget proposal.

In addition, the proposal would impose a significant burden on both states and the providers by requiring implementation of a new, standard cost report to determine Medicaid allowable costs.

Upper Payment Limit

CMS also proposes to change Medicaid Upper Payment Limit (UPL) rules to incorporate provisions that would limit Medicaid reimbursement for State government operated and non-State government operated facilities to the individual provider's cost. This would replace the current UPL regulations which provide an aggregate limit for defined groups of providers, but leave the states considerable flexibility to allocate payment rates within those categories. The proposed rule would eliminate states' ability under the UPL system to target additional funds to individual providers as a means of achieving policy objectives.

In addition, the proposal directly contradicts the clear intent of Congress as stated in the Benefits Improvement and Protection Act of 2000 (BIPA). Section 705(a) of BIPA required CMS to issue

a final regulation modifying the UPL test applied to state Medicaid spending "by applying an aggregate upper payment limit to payments made to government facilities that are not state-owned, or operated facilities." Congress explicitly contemplated that CMS' final regulation regarding UPLs would apply an aggregate limit. CMS' proposed rule, which removes the aggregate UPL and imposes a limit based on the individual provider's costs, is precluded by the clear statement in BIPA that UPLs be based on an aggregate limit for each provider class.

Conclusion

We urge CMS to withdraw this proposed rule change in its entirety. If implemented, this proposal would jeopardize the health care safety net system that provides essential services to Medicaid beneficiaries as well as other vulnerable populations; disrupt long-standing state funding and reimbursement systems that have been fully vetted and approved through the state plan review process; and impose significant new burdens on states and providers. If CMS believes that specific IGT funding mechanisms are abusing the rules, they should be addressed during the state plan review process instead of through the imposition of burdensome and unauthorized new regulations that will interfere with the fully legitimate and approved IGT mechanisms that are used by many states.

Sincerely,

Stephen Harwell
Director, Economic Analyses

SH:lw

Submitter : **Ms. Nancy Hutchison** **Date: 03/19/2007**

Organization : **Department of Health Services**

Category : **State Government**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

CMS-2258-P-307-Attach-1.PDF

CMS-2258-P-307-Attach-2.PDF

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

MAR 19 2007

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

Dear Sir or Madam:

The California Department of Health Services (CDHS), on behalf of the State of California, appreciates this opportunity to comment on the proposed regulation changes. Please find attached California's comments in response to the Notice of Proposed Rule Making (NPRM) (CMS-2258-P) published at 72 Fed. Reg. 2236 (January 18, 2007). The NPRM proposes amendments to 42 C.F.R. Parts 433, 447, and 457.

Our comments cover a number of issues raised by the proposal. In addition to this letter, we have enclosed eight specific areas of comment for your consideration. The areas of comment include:

- The potential negative impact of the proposed regulations on public hospitals that provide safety net services for Medicaid beneficiaries and for the people of the United States, which puts this critical care in jeopardy. The proposed regulations are in violation of existing federal law, are overly prescriptive, unworkable, take away state flexibility, and infringe upon a state's ability to raise funds to support its Medicaid Program.

- The applicability of the proposed rules to current demonstration projects and waivers.

- Limiting the sources of the State's share of Medicaid payments funded by intergovernmental transfers and requiring hospitals to retain the full Medicaid payment.

- The disparate treatment of public and private providers of inpatient and outpatient services to Medicaid beneficiaries with respect to the limits to payments made to those providers.

- The definition of "unit of government."
- Undermining California's Selective Provider Contracting Program (SPCP) and placing new administrative burdens on CDHS to cost settle cost reports for SPCP contract hospitals that are not cost settled today.
- The administrative burden on State Medicaid agencies if the proposed regulations are adopted.
- The effective date of the regulations.

If you have any questions, or if we can provide further information, please contact me at (916) 440-7800.

Sincerely,

Stan Rosenstein
Deputy Director
Medi-Cal Care Services

Enclosure

cc: Mr. Toby Douglas
Deputy Director
Medical Care Services
Department of Health Services
1501 Capitol Avenue, MS 4000
P.O. Box 997413
Sacramento, CA 95899-7413

Mr. Tom McCaffery
Chief Deputy Director
Health Care Programs
Department of Health Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

cc: Mr. Keith Berger
Executive Director
California Medical
Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814

Mr. Joe Munso
Deputy Secretary
Office of Program and Fiscal Affairs
California Health and
Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

Mr. Bob Sands
Assistant Secretary
Office of Program and Fiscal Affairs
California Health and
Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

Sharon Stevenson, Esq.
Assistant Chief Counsel
Office of Legal Services.
Department of Health Services
1501 Capitol Avenue, MS 0010
P.O. Box 997413
Sacramento, CA 95899-7413

State of California

CMS's Proposed Regulations
Cost Limit for Providers Operated by Units of Government
and
Provisions to Ensure the Integrity of Federal-State Partnership
(CMS-2258-P)

COMMENTS FROM THE STATE OF CALIFORNIA

1. **The State of California strongly objects to these regulations based upon their potential negative impact on public hospitals that provide safety net services for Medicaid beneficiaries and for the people of the United States, which puts this critical care in jeopardy. The proposed regulations are in violation of existing federal law, are overly prescriptive, unworkable, take away state flexibility, and infringe upon a state's ability to raise funds to support its Medicaid Program.**

These regulations establish arbitrary, unnecessary and overly complex standards for state payments to public hospitals that inappropriately prevent states from paying public hospitals in the same manner that states pay private hospitals or Medicare pays both public and private hospitals. Public hospitals provide critical care to Medicaid beneficiaries as well as the general public providing much of the trauma, burn center and other specialty care in the nation. They are vital institutions to the county, especially in the time of emergency and these regulations unfairly discriminate against these critical safety net providers. At a time when the nation is focused on emergency preparedness, including preparation for a potential pandemic flu (including surge capacity), it is ill advised for CMS to establish these regulations that may undermine the nation's ability to prepare and respond to health emergences.

As described below, the regulations attempt to define how payments to public hospitals can be made in a manner that will require extensive and unnecessary new accounting processes and in a way that cannot be administered by either the federal or state governments. The regulations make artificial and illogical distinctions between the source of funds that can be used in the Medicaid program ignoring the fact that governments, including the federal government, have many sources of funds that they use beyond taxes, including borrowing and litigation settlements, and they ignores the fact that funds are fungible.

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 narrow view of the Federal Government's role in contributing to public support of the Medicaid program.

The view that the Federal Government should only reimburse 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.

- ***Proposed Rule Violates Federal Law***

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 of quality of care and services under the plan. There is no requirement in this section of the law that such "funds" come from tax revenues or that the "sources" be federally determined to be "units of government."

Section 1903(d)(1) of the Act, which also has been a feature of Title XIX from the program's inception, also makes clear Congress' intention that the non-federal share may encompass public funds made available from "other sources" than the State and its political subdivisions. That subsection includes reporting requirements in order for a State to seek 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 explicit that sources of funds *in addition to* amounts appropriate by the State or its political subdivisions may supply the non-Federal share.

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* Sections 1903(w)(6)(A), which was added to Title XIX as part of the Provider Tax Amendments of 1991. 72 Fed. Reg. at 2240. 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.*

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

For all of the above reasons, California believes that these regulations are arbitrary, unnecessary and overly complex. They should not be adopted.

2. **The applicability of the proposed rules to current demonstration projects and waivers.**

The Preamble to the proposed regulations 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.*

Despite the language of the Preamble, California officials have been given assurances that it was CMS's intent that California's five-year Section 1115 Medi-Cal Hospital/Uninsured Care Demonstration (Demonstration) approved beginning September 1, 2005, would not be affected. These assurances appear to be inconsistent with both the Preamble and the terms and conditions of the Demonstration.

Under the Demonstration, California has made major commitments of funding that rely on certification of expenditures by governmental entities that may not satisfy the extremely restrictive definitions in the proposed rules of those entities that may certify expenditures.

Additionally, the governmental entities that certify expenditures, as agreed to by CMS, do not rely totally on state and local taxes to provide the non-federal share of those expenditures. Therefore, if the proposed rules were adopted and were determined to apply to existing demonstration projects, they could seriously impair the viability of such demonstration projects, including California's Demonstration, and be counter to the assurances made by CMS.

Further, because these programs are all subject to time-limited authorizations and require periodic renewal, California would have no assurance that it would obtain federal approval to renew the Demonstration when it expires without complying with the provisions of the proposed regulations that appear to seriously impact budget neutrality calculations. This would undermine the entire basis for the Demonstration, which is in large part dependent on prior federal funding that was based on what would be "over cost" under the proposed regulations.

For the reasons specified above, California requests that the regulations expressly be made inapplicable to any and all existing demonstration projects under Section 1115 that provide a specific method of reimbursing public hospitals, for as long as the demonstration remains in effect, and for the duration of subsequent renewal or extension periods.

3. **Limiting the sources of the State's share of Medicaid payments funded by intergovernmental transfers/retaining full payment in the hospital.**

In the Preamble to the proposed regulations, CMS states that when an intergovernmental transfer (IGT) from a governmentally operated health care provider is used as the non-Federal share of a Medicaid payment . . . *the State must be able to demonstrate: (1) that the source of the transferred funds is State or local tax revenue (which must be supported by consistent treatment on the provider's financial records); and (2) that the provider retains the full Medicaid*

payment and is not required to repay, or in fact does not repay, all or any portion of the Medicaid payment to the State or local tax revenue account.

- ***Source of Funds***

Governmental entities in California currently use many sources of funds when making an IGT to the State to be used as the non-Federal share of Medicaid payments. Those sources include, but are not limited to, tax revenue, tobacco litigation funds, foundation grants, charitable contributions, fees, bond proceeds, State General Fund monies that may have been transferred to the unit of government, and payments for both Medicaid services and non-Medicaid services. Many of these funding sources are placed in the local governmental entity's general fund, and are not "tracked" to any specific set of expenditures. Generally speaking, such funds when commingled are considered fungible. Assuming that the intent of the regulations is to ensure that tax revenues are equal to or greater than the IGT amount, we question whether this determination would serve any real purpose.

Narrowly restricting the source of funds used as an IGT to State or local tax revenue would be confusing and may unnecessarily limit the base of support for the Medicaid program by excluding appropriate sources that can help to achieve the goal of ensuring our nation's neediest have access to needed health care. We do not see how this element of the proposed regulations serves a public purpose or advances the broad purposes of Medicaid. Further, we do not understand the logic for excluding certain types of funds from being used to pay for Medicaid services. For example, tobacco settlement funds, excluded by the regulations, have been a traditional source of the non-Federal share of Medicaid payments. There is no logic to prohibit a government entity from using funds it has borrowed to pay for services. This level of prescription is misguided and misses many legitimate sources of funds. Further, it inappropriately restricts the ability of states to manage their Medicaid programs.

- ***Retaining the Medicaid Payment***

The provisions of the regulations that require that a provider retain the full Medicaid payment are not justified and would be almost impossible to track. Where a governmental provider is funded fully by a state or county agency, it would be entirely appropriate for the provider to return to its funding agency any revenues received from payers, whether Medicaid or any other payment source.

Because Medicaid is a reimbursement program, the governmental expenditure is always made prior to the receipt of the reimbursement, and, accordingly, there is no valid argument that the governmental provider should not return to the original source of its expenditures the portion of the payment that was provided in the first place. Additionally, once reimbursement is received and is deposited in

accounts containing other funds, as noted above, such funds cannot be tracked, segregated or separately identified; their identity is lost. Finally, it would appear that the regulations' provisions on facility-specific cost limits would make any kind of tracking unnecessary, even if it were logical to do. The cost limits alone would operate to eliminate any increase in the effective FMAP with respect to actual, allowable expenditures.

Therefore, California requests that CMS eliminate these requirements from the proposed regulations.

4. **The disparate treatment of public and private providers of inpatient and outpatient services to Medicaid beneficiaries with respect to the limits to payments made to those providers.**

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.* However, proposed § 447.272(b) provides that . . . *[f]or privately operated facilities, upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by* ***the group of facilities*** *under Medicare payment principles . . .* ***(Emphasis added.)***

These proposed regulations treat public providers of inpatient hospital services differently than private providers of inpatient hospitals services. There is no need for the upper payment limit rules to be stricter for public providers of these services than for private providers; to be applied on a provider-specific basis; and for this basis to be actual cost.

Further, the proposed regulation inappropriately limits a state's ability to pay public hospitals in the same manner and at the same rate as Medicare pays them. It is highly inappropriate to limit Medicaid reimbursement to this one class of hospitals. States should be free to pay public hospitals at levels that are permissible for other hospitals, or at levels that Medicare pays either public hospitals or other hospitals.

Therefore, California requests that CMS eliminate the requirement from the proposed regulations that payments to public providers of inpatient hospital services be held to actual cost in specific facilities.

5. **The definition of "unit of government."**

Proposed § 433.50(a)(1)(i) defines "unit of government" as a 'city, county, special purpose district, or other governmental unit in the State with generally applicable taxing authority." This definition is too narrow and does not include the

"governmental entities" approved by CMS under California's existing section 1115 Demonstration.

Specifically, Alameda County Health Authority is an entity approved by CMS to certify its expenditures which subsequently will be used to claim federal funding under the Demonstration. Yet, this entity would not appear to meet the definition of "unit of government," as proposed by CMS, because the Health Authority does not have "generally applicable taxing authority." Additionally five University of California (UC) hospitals have been approved by CMS to certify their expenditures which subsequently will be used to claim federal funding under the Demonstration. While the UC system is an "arm" of the State because it is established under Article IX, Section 9 of the California Constitution, the UC hospitals do not meet the definition of "unit of government," as proposed by CMS, because the UC system does not have "generally applicable taxing authority," most funding coming from fees, grants, endowments, bequests, enterprise income, patents, and many other sources.

Therefore, California suggests the following amendments to proposed § 433.50(a)(1)(i) (proposed language underscored):

> *(i) A unit of government is a State, a city, a county, a special district, a health authority, or other governmental unit in the state that has generally applicable taxing authority, or is specifically established as a unit of government under the State's constitution.*

California also suggests the following amendments to proposed § 433.50(a)(1)(ii) by adding a new subsection (C), to read:

> *(C) The health care provider, although it does not meet the requirements of subparagraphs (A) or (B), is able to demonstrate to CMS that the sources of its funding are of a nature that would permit a finding that it is a unit of government for purposes of this section.*

California has additional concerns that involve public entities that are county educational agencies where the source of funding for Medicaid expenditures by those agencies is limited to tax revenue collected by a "unit of government."

The proposed regulations might exclude an unknown number of school districts or county offices of education (referred to as local educational agencies or "LEAs") from the definition of a unit of government.

It is not clear from the definition of a special purpose district whether LEAs that provide School Based Medi-Cal Administrative Activities (SMAA) or LEAs that provide medical assistance through the LEA Billing Option program would be considered a unit of government.

In addition, the degree to which each LEA, or Local Educational Consortium through which a LEA may certify its expenditures, meets the criteria in the proposed regulations is unknown. Those county educational agencies that are fiscally independent from the county board of supervisors may not qualify. Because these issues remain unclear, the proposed regulations place the SMAA and LEA Billing Option programs at risk. The proposed regulations may result in unintended consequences, not only for the State's schools, but also for other public entities.

The addition of a new subparagraph (C), as described above, would provide a means by which CMS would retain the flexibility to address situations that are currently uncertain.

6. **Undermining the Selective Provider Contracting Program (SPCP) and placing new administrative burdens on the State Medicaid agency to cost settle cost reports for SPCP contract hospitals that are not cost settled today.**

Proposed § 447.206(e) requires each provider to submit annually a cost report to the Medicaid agency that reflects the individual provider's cost of serving Medicaid recipients during the year. This requirement appears to apply to payments made to providers operated by units of government that are not funded by certified public expenditures or by IGTs. This subsection requires each provider to submit annually a cost report to the Medicaid agency that reflects the individual provider's cost of serving Medicaid recipients during the year. The Medicaid agency must review the cost report to determine that the 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. If the provider received an overpayment, amounts related to the overpayment must be properly credited to the Federal Government.

Currently, all hospitals that provide inpatient hospital services to Medicaid-eligible beneficiaries in California annually submit cost reports to the California Department of Health Services' Audits and Investigations (A&I) program. A&I reviews all cost reports to ensure that costs for providing inpatient hospital services are properly allocated to Medicaid, but cost settles only those cost reports where the hospital does not participate in the SPCP (authorized under the Demonstration). Cost reports for hospitals that participate in the SPCP are not cost settled because those hospitals agree to accept per diem rates of reimbursement and supplemental payments negotiated by the California Medical Assistance Commission (CMAC) on behalf of CDHS. Under the SPCP program, CMAC ensures that payments to contract hospitals do not exceed the hospital-specific charge limit for inpatient services. Currently, about 220 hospitals participate in the SPCP. Of that number 15 are providers that are operated by "units of government" that are not cost settled today. Many of these hospitals do

not receive disproportionate share hospital payments and are not subject to these provisions in federal law.

This proposed regulation would undermine the SPCP program by requiring that negotiated payments to these providers be limited to cost, rather than to charges. Over the last 23 years, the SPCP program has saved the State and Federal Governments hundreds of million annually by negotiating competitive rates of reimbursement.

Additionally, this proposed regulation increases the administrative burden on the State because cost reports for SPCP contract hospitals currently are not cost settled.

For the reasons specified above, California requests that the proposed requirement to limit payments to providers not funded by certified public expenditures be eliminated.

7. Administrative burden on State Medicaid agencies.

California currently has several approved State Plan Amendments and State statutes that will require changes and/or repeal if the proposed regulations are adopted. This creates an administrative burden on California and will put an inordinate strain on existing staffing resources.

8. Effective date of regulations.

CMS plans to promulgate the proposed regulations with an effective date of September 2007. Because of the number of changes states must make to approved SPAs and other authorities and the amount of time needed to make those changes, these regulations cannot be effective any earlier than September 1, 2008, and there needs to be appropriate phase-in processes for the requirements that are ultimately contained in the regulations.

Submitter : **Ms. Paula G. Sanders** **Date: 03/19/2007**

Organization : **Post & Schell P.C.**

Category : **Attorney/Law Firm**

Issue Areas/Comments

GENERAL

GENERAL

See attached.

CMS-2258-P-308-Attach-1.PDF

#308

Re: CMS-2258-P: Comments on Proposed Rule *Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Endure the Integrity of Federal-State Financial Partnership,* 72 Federal Register 2236 (January 18, 2007)

We are counsel to The County Commissioners Association of Pennsylvania (CCAP) and the Pennsylvania Association of County Affiliated Homes (PACAH). We appreciate the opportunity to comment on the proposed rule *Medicaid Program: Cost Limit for Providers Operated by Units of Government and Provisions to Endure the Integrity of Federal-State Financial Partnership,* CMS-2258-P, 72 Fed. Reg. 2236 (January 18, 2007).

CCAP is a statewide, nonprofit, bipartisan association representing the commissioners, chief clerks, and solicitors of Pennsylvania's sixty-seven (67) counties. The Association serves to strengthen Pennsylvania counties' ability to govern their own affairs and improve the well-being and quality of life of their constituents. The Association strives to educate and inform the public, administrative, legislative and regulatory bodies, decision makers, and the media about county government. CCAP also has contractual agreements with a number of independent associations and organizations having ties to county government. PACAH is an affiliate of CCAP and represents the interests of county and county-affiliated nursing homes as well as private nursing homes in Pennsylvania. The overall intent of this affiliation process is to have mechanisms whereby these groups and CCAP can arrive at common policy positions.

Since 1995, qualified local government units, through CCAP, have participated in intergovernmental transfers (IGTs) with the Commonwealth of Pennsylvania. Additionally, many of CCAP's constituent county members have made certified public expenditures (CPEs) on behalf of their county nursing facilities. The proposed regulations contain numerous provisions that would enact significant modifications to the Medicaid program, many of which would require fundamental changes in the way county governments and their constituent health and social service organizations operate.

CCAP respectfully requests that the Centers for Medicare and Medicaid Services (CMS) withdraw the proposed rule, or in the alternative, delay the implementation date and revise the proposed rule to recognize the flexibility and self-determination that states and local governments have traditionally exercised to define units of government and to establish appropriate funding mechanisms for the Medicaid program. CCAP urges CMS to remove barriers created in the rule that would significantly burden local government in the delivery of health care services to our country's most vulnerable citizens.

CMS has indicated that they have reviewed and processed over 1,000 State plan amendments related to State Medicaid payments to providers. Of those, approximately 10 percent have been disapproved by CMS or withdrawn by the States after review by CMS. CMS, in the Preamble to the proposed rule, goes on to state that they believe the proposed rule "strengthens accountability to ensure that statutory requirements within the Medicaid program are met." Proposed Rule at 2237. CCAP respectfully suggests that CMS has overstated its case and that there is no need for the proposed rule, CMS already has sufficient safeguards under the existing review system and

State plan approval process, as evidenced by the 10 percent rejection rate, to protect the integrity and accountability of the Medicaid program without overreaching and disturbing the delicate balance between federal, state, local governments and the public health care providers.

Proposed Regulation Section 433.50(a)(1): Redefining "Unit of Government"

The proposed rule is inconsistent with the definition of a "unit of local government" as set forth in Title XIX of the Social Security Act:

> A unit of local government is a city, a county, a special purpose district, or other governmental unit in the State.

42 U.S.C. § 1396b(w)(7)(g). CMS's proposal restricts this definition to require, that for purposes of determining eligibility to contribute to Medicaid financing through intergovernmental transfers or certified public expenditures, a "unit of government" must be:

> [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 42 C.F.R. § 433.50(a)(1)(i) (emphasis added). Even more troubling is CMS's attempt to further limit the number of eligible contributors by the imposition of the following restrictive requirement:

> A health care provider may be considered a unit of government only when it is *operated by a unit of government* as demonstrated by a showing of the following:
>
> (A) The health care provider has generally applicable taxing authority; or
>
> (B) The health care provider is able to acces funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities and deficits, so that a *contractual arrangement* with the State or local government *is not the primary or sole basis for the health care provider to receive tax revenues.*

Proposed 42 C.F.R. § 433.50(a)(1)(ii)(A)(B) (emphasis added).

The proposed regulatory definition ignores the realities facing many public health care providers, who, for a variety of reasons, have chosen to restructure their organizational and legal compositions. Some may have undergone restructuring to protect the public fisc from the vagaries and threats from plaintiff negligence suits, which are being brought against long term care providers with increasing frequency, while others may have restructured to assure increased

efficiencies and economies. Such restructurings should not, however, disqualify such public providers and units of government from being allowed to participate in Medicaid funding arrangements through IGTs and CPEs.

Pennsylvania has always recognizes that local governments have many reasons for structuring their health care providers in different ways depending upon the needs of the specific localities. Toward that end, the Pennsylvania Medicaid program identifies a county nursing facility as a licensed long term care nursing facility that is enrolled in the Medicaid program as a provider of nursing facility services and is "*controlled by the county* institution district or by county government if no county institution district exists." 55 Pa. Code § 1187.2 (emphasis added). The fact that the public health care provider is an independent entity does not negate its existence as a unit of government that fulfills the legal obligations of the local government to meet the health care needs of Pennsylvania citizens. Pennsylvania looks beyond form to substance and intent.

By ignoring the characteristic of public control of county nursing facilities that forms the hallmark of Pennsylvania's definition of a county nursing home, the proposed regulations would severely restrict the number of entities in Pennsylvania which would qualify as units of government for purposes of the Pennsylvania Medicaid program. The consequences of this result are addressed further in these comments. By adopting such a narrow definition of "unit of government," CMS has exceeded its regulatory authority and ignored both the language of Title XIX of the Social Security Act as well as long-established principles of comity between the federal government on the one hand, and state and local governments on the other.

Proposed Regulation Section 433.51(B): Limiting Sources of State Share and Increasing Documentation of CPEs

The proposed rule seeks to limit the number of previously recognized "public agencies" that can participate in the financing of the non-Federal share by CPEs. To accomplish this objective, CMS proposes to replace the terms "public" and "public agency" with the much more narrowly defined term, units of government. CCAP respectfully requests that CMS rescind this proposal for the reasons set forth above. The proposed rulemaking ignores the fact that local governments financially support their "public" health care providers even though those providers may not necessarily fit the confines of the proposed regulatory definition of a unit of government. States and local governments should be able to continue to participate in IGT and CPE expenditures under the existing definitional structure, and the public should be adequately protected from alleged abuses as long as CMS continues to exercise its review of State plan amendments appropriately.

The proposed rule would require an enormous amount of documentation from governmental entities to support CPE expenditures. In many instances, the burden on such entities will be excessive. It does not appear that CMS has adequately researched this issue or assessed the fiscal impact. Under the proposed rule, governmental entities must submit a certification statement to the State Medicaid agency which must in turn submit it to CMS within two years from the date of expenditures attesting that the expenditures are in fact eligible for federal financial participation. To prove that this requirement is met, States will be required to submit

auditable documentation in a form approved by the Secretary that will: (1) identify the expenditure category under the State plan; (2) justify the provider's status as a unit of government that falls within the exception to the provider-related tax and donations limitations; (3) demonstrate actual expenditures incurred; and (4) be subject to audit and review. Costs that are certified by units of government cannot include the costs of providing services to the non-Medicaid population or costs of services that are not covered by Medicaid. Proposed Rule at 2241.

CCAP respectfully submits that these new requirements will prove unworkable.

Proposed Regulation Section 447.206: Cost Limitations

The proposed rule attempts to limit public Medicaid providers to payment of costs, whereas all other classes of private providers remain subject to the more flexible and appropriate upper payment limit (UPL). The proposed regulations will limit the nature of reimbursable costs for governmental providers as well, creating further inequities. In addition, by limiting payment to an "individual provider's cost of providing Medicaid services to eligible Medicaid recipients" (Proposed 42 C.F.R. 447.206(c)), CMS refuses to recognize the marginal costs associated with treating such patients, leaving public health care providers uncompensated for a range of costs. This will become even more acute as the impact of the asset transfer provisions of the Deficit Reduction Act of 2005 (Public Law 109-171) (S 1932) (Feb. 8, 2006), begin to play out. CCAP anticipates that county nursing homes, in particular, will be hard hit by the uncompensated costs of caring for patients who become Medicaid ineligible for a period of time after they have been admitted to the facility. Moreover, by requiring facility-specific costs rather than permitting aggregation by class of provider, for example, county nursing homes, the proposed rule would supersede existing Medicaid UPL regulations. *See,* Proposed Rule at 2242; Proposed 42 C.F.R. 447.321.

Pennsylvania's county nursing homes have been receiving supplemental payments funded by the IGT. These payments help to keep these public health care providers solvent and able to provide the safety net coverage for the most frail and needy of their citizens. These payments are authorized under the current Medicaid UPL standards, pursuant to the transition provisions of the BIPA statute (Public Law 106-554, §705), through September 2008. The proposed rule contains no reference to the regulations that authorize this transition period (42 C.F.R. §§447.272 and 447.321). CCAP respectfully requests that any regulation that CMS adopts incorporate reference to the transitional UPL provisions of the BIPA law to remove any unintended confusion about the cost-limitations inapplicability to Pennsylvania.

Proposed Regulation Section 447.207: Retention of Payments

The proposed regulations would require 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, if applicable.)" Proposed Rule at 2242. CMS has apparently overlooked the funding realities that face public health providers, including Pennsylvania county nursing facilities, where revenue cycles are often beyond their control. Requiring providers to retain payments may have the unintended consequence of preventing the efficient and economical flow of funding streams within and between governmental entities. CCAP respectfully believes that here again, CMS has more effective mechanisms at its disposal to limit the potential for abuse involving the re-direction of Medicaid payments by IGTs. The proposed regulation is overly-broad and it is likely that there will be many unintended and harmful consequences.

CCAP respectfully requests that the Proposed Rule be withdrawn in its entirety. To the extent that CMS determines to move forward with the rulemaking process, CCAP further requests that CMS work closely with representatives of State and local governments to assure that considerations of comity are respected and that effective, efficient and economical governmental operations are preserved without threatening the existence and fabric of the public health care safety net upon which so many citizens rely.

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

Organization : Truman Medical Centers

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-309-Attach-1.PDF

#309

TMC
TRUMAN MEDICAL CENTERS

Department of
Corporate Finance
2301 Holmes
Kansas City, MO 64108

816-404-3528

March 19, 2007

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

Re: Comments for CMS-2258-P, Medicaid Program; Cost Limit for Providers Operated by Units of Government

Dear Ms. Norwalk:

On behalf of Truman Medical Centers ("TMC"), I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes $37 million in Medicaid funding that has been essential to TMC's ability to survive as Western Missouri's safety net hospital system.

Comprised of TMC Hospital Hill, TMC Lakewood, and TMC Behavioral Health, about three in four of TMC's patients are Medicaid-eligible or uninsured. TMC serves almost 100,000 individual patients each year. In FY 06, TMC provided $92 million in uncompensated care services, and over $140 million in Medicaid services. TMC treats our community's most vulnerable, such as the elderly, low-income families, and those with chronic illness such as diabetes, asthma, HIV/AIDS, sickle cell, and mental illness. In addition, TMC delivers about one-third of the babies born yearly in Kansas City, Missouri and operates one of the community's busiest neonatal intensive care units.

HOSPITAL HILL

LAKEWOOD

BEHAVIORAL HEALTH NETWORK

TMC is Western Missouri's Tier I trauma center, staffed to accept critically ill and injured patients 24/7. TMC is the community's lead partner in ensuring homeland security and monitoring disease trends. TMC is the primary teaching hospital for the medical school of the State's University of Missouri-Kansas City, and trains large numbers of resident and students, the main source of physicians in this region.

As you probably know, the Missouri House of Representatives has adopted House Concurrent Resolution 25, specifically asking CMS to withdraw the portion of the Proposed Rule that would eliminate TMC's current status as a public hospital.

We, too, strongly oppose the Proposed Rule. Following, we comment on specific aspects of the Rule.

Defining a Unit of Government (§ 433.50)

The Proposed Rule would impose a new definition of "unit of government" that would prohibit entities without independent taxing authority from contributing funding to the non-federal share of Medicaid expenditures.

TMC should be viewed and treated as a public entity, among other things, because it has direct access to tax funds through its interdependent relationship with Kansas City and Jackson County. TMC today receives approximately $25 million from the Kansas City health levy tax, which authorized a "tax levy for . . . Truman Medical Center . . . and other public health programs and facilities." An increase in that tax levy was funneled to TMC in 2005 by a public ballot which determined that the City could act "by increasing the existing tax levy by 22 cents per $100.00 assessed valuation [distributing] . . . the revenue derived from 15 cents of the levy to Truman Medical Center." In other words, TMC has an absolute right to specified revenues from the City tax. [Emphasis added above.]

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

Though in corporate form a not-for-profit corporation, TMC looks and acts like a public entity in at least the following additional ways: three members of the TMC Board of Directors are appointed by the County, three by Kansas City and two by the State's University of Missouri-Kansas City; the County owns the land and buildings of both hospitals; TMC has the responsibility to operate the County Health Department, health services at the County Jail and transportation of the medically indigent to health facilities; and TMC construction and equipment have been financed by over $76 million dollars in Jackson County special obligation bonds since 2001 alone.

On the basis of these facts, Missouri sought confirmation from CMS in 2001 that TMC should be treated as a "non-state government-owned or operated" facility. In a letter from the US DHHS Regional Office to the Missouri Department of Social Services, dated May 11, 2001, HHS stated that "[c]onsultation with HCFA Central Office has provided concurrence that the new category 'non-State Government-owned or operated' hospital as defined in the revised UPL regulations is applicable to TMC." Now the government proposes to move the target again.

Medicaid has always recognized our funding as public, and has allowed our funds to be used as the non-federal share of Medicaid expenditures. The matching of our funds is essential to our ability to carry out the safety net role described above.

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

TMC certifies over $150 million annually in expenditures for services provided to Medicaid patients and the uninsured. Those expenditures have earned a federal match.

We object to the discussion in the preamble of the regulation (not repeated in the text) that units of government that are providers may only certify their expenditures if they are paid on a cost basis. The preamble acknowledges that units of government that are **not** providers may certify their payments to providers even if the state plan payment methodology is not cost-based. The same should apply to the provider itself. Please rescind the preamble discussion requiring providers to be paid on a cost basis in order to certify expenditures as the non-federal share.

TMC is also a nominal charge provider. Due to the population we serve, we keep our charges well below market rates. By eliminating § 447.271, which waives the lower of cost or charge provision for nominal charge entities, CMS would penalize nominal charge entities for maintaining affordable charge structures.

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

CMS proposes to implement the Proposed Rule as of September 1, 2007 – an astonishingly ambitious schedule given the sweeping nature of the changes proposed. Assuming that a final regulation is not issued until this summer, states will have little time to analyze the rules and adopt the changes necessary to come into compliance. Nor would our Medicaid agency have time to develop and obtain approval for any state plan amendments that may be required or to adopt changes to state rules and provider manuals. Establishing appropriate cost-reporting mechanisms as envisioned in the Proposed Rule will, in and of itself, require months of work.

CMS should provide a generous transition period for states and providers to adjust to these enormous changes. We would recommend at least ten years.

* * *

Given the devastating impact the Proposed Rule would have on the TMC, our patients and our community, we request that you withdraw the regulation.

If you have any questions about this letter, please contact Gerard Grimaldi at (816) 404-3505.

Sincerely,

Allen M. Johnson
Chief Financial Officer
Truman Medical Centers

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

Organization :

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachments

CMS-2258-P-310-Attach-1.PDF

CMS-2258-P-310-Attach-2.PDF

CMS-2258-P-310-Attach-3.PDF

#310

March 19, 2007

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

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

Dear Ms. Musotto:

These comments by the Council of Medical School Deans (the "Council") are directed solely at the Tool to Evaluate the Governmental Status of Providers[1] (the "Tool"), which was released by the Centers for Medicare and Medicaid Services ("CMS") in conjunction with the proposed rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership," CMS-2258-P (the "Proposed Rule"). The Council believes that the Proposed Rule, as well as the Tool, exceed the agency's legal authority, defies the bipartisan opposition of a majority of the Members of Congress, and would dismantle the Florida's intricate Medicaid-based safety net system, which will seriously compromise access for Medicaid and uninsured patients. As noted in our comments on the Proposed Rule, the effect on Florida's safety net physicians and hospitals is devastating – over $950 million reduction in Medicaid payments annually.

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

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

A provider (or presumably the provider's practice plan) is not required to be included on the unit of government's consolidated financial report to be considered a "health care provider operated by a unit of government" pursuant to the Proposed Rule. However, it is not clear based on the Tool whether the statement above is actually true and accurate. Based on the reading of the Proposed Rule, a provider might believe that they are still a unit of government, but the same conclusion cannot be drawn by completing the form. Likewise, the unit of government is not required to be liable for a provider's operations, expenses, liabilities, and deficits in order for the provider to be considered a "health care provider operated by a unit of government under the

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

language of the Proposed Rule. However, again, it is unclear when reviewing responses to the Tool what the outcome is. The disconnect between the Proposed Rule and the Tool will make it very difficult for states, governmental entities, and providers to determine whether they qualify as a "unit of government" under the regulation.

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

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

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

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

Once CMS makes a decision using the Tool, there is no mechanism in place for challenging that decision or amending the information once provided. A "Tool" of this importance should only be implemented with procedural checks and balances.

Recommendation: CMS should provide a procedure for challenging a decision made using the Tool and should also provide the means for amending the information provided should there be a change in circumstances.

This concludes the comments submitted by the Council regarding the "Tool."

Sincerely,

Anthony J. Silvagni, D.O.
Chair

March 19, 2007

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

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

Dear Ms. Norwalk:

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

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

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

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

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

I. Certified Public Expenditure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. State and Local Tax Revenue

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

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

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

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

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

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

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

II. Defining a Unit of Government (§ 433.50)

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

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

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

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

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

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

Cost-based methodologies are particularly inappropriate for physician services. Moreover, given the difficulties of calculating costs for professional providers, the additional administrative

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

burden on states and the impacted professionals would far exceed the value of the cost limit. This is issue should subsequently be resolved as to CPEs for physician payments, which are not typically conducive to cost-based methodologies. Further, if physicians are forced to convert to a cost-based reimbursement methodology, the costs associated with the reconciliation processes will be significant.

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

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

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

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

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

11. The cost limit undermines important public policy goals.

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

For example, the Colleges of Medicine have invested millions of dollars in adopting electronic medical records and other new information systems that have a direct impact on quality of care, patient safety, and long-term efficiency, all goals promoted by HHS and AHCA. HHS has

focused on expanding access to primary and preventative services, particularly for low-income Medicaid and uninsured patients, and reducing inappropriate utilization of emergency departments. Council members have been engaged in this effort, establishing networks of off-campus, neighborhood clinics with expanded hours, walk-in appointments, assigned primary care providers, and access to appropriate follow-up and specialty care. These initiatives require substantial investments of resources. CMS does not appear to have considered the impact of the cut imposed by the cost limit on shared policy initiatives that HHS itself has established as key goals of America's complex health care system. The only goal achieved by the Proposed Rule would be the dismantling of Florida's safety net.

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

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

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

Because the payments would be based on costs pursuant to the new regulation, there would not be the danger of "excessive payments" that has concerned CMS in the current system. Moreover, to avoid double dipping, states could be required to similarly adjust capitation rates to account for the supplemental cost-based payments. If reimbursement to faculty physicians is going to be restricted to cost, it should include costs for all Medicaid patients, not just those in the declining fee-for-service population. This adjustment would be critical in states like Florida, where there has been a significant shift to managed care organizations, particularly under operation of Florida's 1115 waiver.

[3] 42 C.F.R. §438.60.

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

II. Retention of Payments (§ 447.207)

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

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

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

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

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

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

[4] Proposed 42 C.F.R. § 447.207(a).

arrangements, and that CMS may use its disallowance authority to pressure public providers to dismantle such arrangements. CMS' review and audit authority is limited to payments made under the Medicaid program. It does not have authority over providers' use of Medicaid payments received.

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

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

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

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

This concludes the comments submitted by the Council of Florida Medical School Deans relative to the direct impact on Council members.

Sincerely,

Anthony J. Silvagni, D.O.

Anthony J. Silvagni, D.O.
Chair

#310-2

March 19, 2007

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

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

Dear Ms. Norwalk:

The Council of Florida Medical School Deans (the "Council") is submitting these comments on behalf of our teaching hospital partners. The Council urges the Centers for Medicare and Medicaid Services ("CMS") to withdraw the proposed rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership," CMS-2258-P (the "Proposed Rule"). The Proposed Rule will have profound impact not only on the Council members, but also on our teaching hospital affiliates, which will seriously compromise medical education, training and research, as well as adversely affect access to care for Medicaid and uninsured patients in Florida. The impact on the Council members and hospitals in Florida is estimated to be in excess of $950 million annually.

Faculty physicians, along with our affiliate hospitals, are Florida's safety net for vulnerable populations, including Medicaid and uninsured persons. The teaching hospitals and Council members are committed to maintaining access and training the next generation of practitioners; however, this regulation will have a profound impact on our ability to continue the level and breath of services currently available.

Further, we believe the Proposed Rule exceeds the agency's legal authority, defies the bipartisan opposition of a majority of the Members of Congress, and would dismantle the Florida's intricate Medicaid-based safety net system, which will seriously compromise access for Medicaid and uninsured patients. Further, without any plan for replacement funding, CMS would eliminate $25 million in payments to Florida's faculty physicians and over $900 million to hospitals annually. These payments have been used to ensure that Florida's health workforce needs are met, as well as ensure that Florida's poor and uninsured have access to a full range of primary and specialty care. If implemented, this regulation would severely compromise Florida safety net health systems.

Florida has never been identified by CMS as abusive; on the contrary, CMS has repeatedly reviewed in detail the hospital, physician, and nursing home payment and financing programs in Florida and approved them as legitimate. Despite the recent review and approval of Florida's program by CMS, the Proposed Rule would undermine Florida's Low Income Pool ("LIP") program and will cut payment rates and eliminate approved sources of non-federal share funding. As a result, Florida's safety net health systems' ability to serve Medicaid and uninsured patients will be severely compromised, and state Medicaid programs will face substantial budget

shortfalls with no apparent gain in fiscal integrity. All of the state's teaching hospitals and Council members are part of that safety net, and medical education in Florida will be undermined by the Proposed Rule.

Moreover, CMS would impose these cuts immediately, effective September 1, 2007, providing no time for Florida legislators to overhaul program financing to come into compliance with the new requirements. The Florida Legislature regularly meets one time each year for a 60-day session; the 2007 Regular Session began March 6, 2007, and the Legislature has until May 4, 2007, to conduct the state's business. Therefore, if the Proposed Rule goes into effect September 1, 2007, Florida's budget would need to be overhauled after the fact since the Proposed Rule affords no transition period or replacement funding.

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

- Applicability of the Rule on Waiver States;
- Limit on payments to governmental providers to the cost of Medicaid services;
- Definition of a unit of government and health care provider operated by a unit of government; and
- Restriction on sources of non-federal share funding.

The Council's legal and policy comments are presented according to the sections of the Proposed Rule.

I. Intergovernmental Transfer (IGT)

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

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

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

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

Florida's hospital Upper Payment Limit ("UPL") and now LIP program are dependent upon IGTs voluntarily provided by municipalities and counties; the Proposed Rule should not override local communities' ability to support safety net and teaching hospitals by disallowing those funds to be used as the non-Federal share of approved Medicaid expenditures.

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

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

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

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

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

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

Recommendation: CMS should not alter the method for determining DSH payments or DSH payment financing.

I. State and Local Tax Revenue

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

The Proposed Rule states that "[I]n order for state and/or local tax dollars to be eligible as the non-federal share of Medicaid expenditures, that tax revenue cannot be committed or earmarked for non-Medicaid activities."[1] By stating this in the negative, it is unclear what, if any or all, tax-derived funds may be used as match. In Florida, many local communities raise local tax dollars expressly for health care services, but not necessarily for Medicaid-only purposes (just as the state derives little or no direct tax dollars in express support of Medicaid), and these funds should be eligible as IGTs under the Medicaid program.

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

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

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

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

[1] 72 Fed. Reg. at 2239.

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

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

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

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

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

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

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

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

Recommendation: Existing DSH statutes and regulations should stand.

II. Defining a Unit of Government (§ 433.50)

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

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

CMS has exceeded its statutory authority in adopting a definition of a "unit of government" more restrictive than that established in Title XIX of the SSA. Section 1903(w)(7)(G) of the SSA[2] defines a "unit of local government," in the context of contributing to the non-federal share of Medicaid expenditures, as "a city, county, special purpose district, or other governmental unit in the State." The Proposed Rule narrows the definition of "a unit of government" to include, in addition to a state, "a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) *that has generally applicable taxing authority.*"[3] Congress never premised qualification as a unit of government on an entity's access to public tax dollars. Rather, the definition Congress has adopted for "other governmental units in the State," provides

[2] 42 U.S.C. § 1396b(w)(7)(G).
[3] Proposed 42 C.F.R. § 433.50(a)(1)(i) (emphasis added).

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

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

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

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

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

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

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

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

The Proposed Rule would permit only units of government to participate in financing the non-federal share of Medicaid expenditures. The regulatory text then goes on to define a unit of government as "a State, a city, a county, a special purpose district or other governmental unit in the State (including Indian tribes) ***that has generally applicable taxing authority.***"[5] A provider can only be considered to be a "unit of government" if it has taxing authority or it is an "***integral part of a unit of government with taxing authority.***"[6] It is clear from this proposed definition that, unless a provider has direct taxing authority, CMS will only consider it a "unit of government" if it is an integral part of a unit of government with taxing authority.

State courts, typically look beyond the presence of taxing authority to other indicia of public status to determine whether an entity is governmental.[7] For example, courts in Florida have looked to whether an entity enjoys sovereign immunity, to whether its employees are public employees, to whether it is governed by a publicly-appointed board, to whether it receives public funding, to whether its enabling statute declares it to be a political subdivision or a public entity, or to whether it is subject to specific state laws that govern public entities. There are a wide

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

variety of factors that go into determining public status beyond whether the provider or the unit of government of which it is an integral part has taxing authority. The Council urges CMS to eliminate the caveat that units of government must have taxing authority and allow any governmental entity so designated under state law to be treated as public and capable of participating in Medicaid financing.

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

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

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

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

Rather than adopting a narrowly-tailored solution to address identified concerns with inappropriate Medicaid financing practices, CMS proposes to impose a cost limit on governmental providers that is simply a straightforward funding cut of over $950 million per year to hospitals and physicians in Florida. The limit purports to target Medicaid financing practices that CMS has publicly asserted are no longer a problem. Further, CMS recently completed a review of Florida's sources and uses of IGT and deemed them to be appropriate, and yet the Proposed Rule ignores the due diligence that has already been undertaken . To the extent abuses remain, the cost limit would not eliminate them; it would simply limit the net funding for governmental, safety net providers.

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

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

A payment limit based on Medicaid costs represents a sharp departure from CMS' efforts to bring cost-effective market principles into federal health programs. Prospective payment systems are structured to encourage health care providers to eliminate excess costs by allowing them to keep payments above costs as a reward for efficiency. As CMS considers new payment

models, which would include incentives for providing high quality care as a means to better align payment and desired outcomes, it seems regressive to take steps that would cause all states to revert to a cost based system. The Proposed Rule would require a return to cost-based reporting and reimbursement that is inconsistent with efforts over the last twenty years by Congress and CMS to move away from cost-based methodologies. Furthermore, a cost-based reimbursement system for physicians would need to be created.

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

15. Providers cannot survive without positive margins.

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

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

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

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

It is unclear why CMS believes the agency would continue to allow states to pay private providers under the Proposed Rule are excessive as compared to government providers. The needs of governmental providers are often significantly greater than those of private providers as they typically provide a disproportionate share of care to the uninsured and offer critical, yet under-reimbursed, community-wide services (such as trauma care, burn care, neonatal intensive care, first response services, standby readiness capabilities, etc.). A report issued in December by the Congressional Budget Office confirmed that governmental hospitals provide significantly more Medicaid and uncompensated care and other community benefits than private hospitals.[8] Moreover, governmental providers' payer mix is markedly different from that of private providers, with greater reliance on Medicaid revenues to fund operations and a lower share of commercially insured patients on which uncompensated costs can be shifted. By cutting Medicaid reimbursement for governmental providers, the Proposed Rule would slash their primary funding source.

17. The proposed cost limit violates federal law.

The proposed cost limit violates both section 1902(a)(30)(A) of the Social Security Act (SSA) and section 705(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).[9] CMS is therefore without legal authority to impose the limit by regulation.

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

> to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.[10]

Florida will be unable to meet the requirements of this provision given the restrictive limits imposed by CMS. By incentivizing providers to maximize costs in order to secure a higher reimbursement limit, the proposal clearly does not promote efficiency or economy. By removing tools to promote efficiency (such as through prospective payments systems that encourage providers to reduce costs), CMS has hampered states' ability to provide the assurances required

[8] Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits*, December 2006.
[9] H.R. 5661, 106th Cong., enacted into law by reference in Pub. L. No. 106-554, § 1(a)(6) ("BIPA").
[10] 42 U.S.C. § 1396a(a)(30)(A).

by the statute. Similarly, the cost limit thwarts states' efforts to ensure quality of care by eliminating flexibility to provide targeted above-cost incentives to promote and reward high quality care, particularly for providers identified by the state as having particular needs or faced with unique challenges. Finally, to the extent that the cost regulation prohibits states from paying rates that they have determined are necessary to ensure access for Medicaid recipients, CMS's proposed regulation undermines the statutory requirement that states assure access to care and services at least equal to that available to the general population.

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

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

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

Proposed 42 C.F.R. § 447.206(c)(1) provides that "[a]ll health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider's cost of providing ***covered Medicaid services to eligible Medicaid recipients***." By its terms, this provision would prohibit *any* Medicaid reimbursement to governmental providers for costs of care for patients who are *not* eligible Medicaid recipients, or for services that are not covered under the state Medicaid plan. Taken literally, states could no longer pay public hospitals for unreimbursed costs for uninsured patients or for non-covered services to Medicaid patients

through the disproportionate share hospital program. Similarly, Florida's authority to make payments to public providers pursuant to expenditure authority received through its section 1115 demonstration projects to pay for otherwise unreimbursable costs to the uninsured, for infrastructure investments and for other purposes not covered under the state plan would be called into question. The cost limit could also extend to Medicaid reimbursement received by governmental providers from managed care organizations (despite CMS' disavowal of any such intent in the Preamble). The problem is exacerbated because the regulation defines its scope as applying broadly to all "payments made to health care providers that are operated by units of government ...."[11] By contrast, the UPL regulations are carefully drafted to limit their scope to "rates set by the agency,"[12] and they include an explicit exemption for DSH payments.[13]

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

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

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

The calculation of cost for purposes of applying the cost limit is not well-defined under the Proposed Rule. Since the magnitude of the cut imposed by the cost limit will depend on which costs CMS will and will not allow states to reimburse, the Council requests that CMS provide

[11] Proposed 42 C.F.R. § 447.206(a)
[12] 42 C.F.R. § 447.272(a), § 447.321(a).
[13] 42 C.F.R. § 447.272(c)(2).

further guidance on how Medicaid costs would be determined and in particular clarify that any determination of Medicaid "costs" will include all costs necessary to operate a governmental facility. For governmental hospitals, these costs must, at a minimum, include:

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

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

In addition, the Council strongly believes that allowable costs should also include Medicaid's share of costs for the uninsured (beyond costs directly reimbursable through the limited available DSH funding). Absent universal coverage or full reimbursement of uninsured costs, hospitals must continue to rely on cross-subsidization from other payers, including commercial payers,

Medicare and Medicaid, to pay for this care. CMS should allow state Medicaid programs to shoulder their fair share of such costs rather than placing the full burden on Medicare and commercial payers. We therefore urge CMS to include uninsured costs among reimbursable Medicaid costs.

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

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

The President's FY 2008 budget request includes an administrative proposal to eliminate Medicaid reimbursement for graduate medical education (GME) costs. Given the long-standing policy to permit GME payments (as of 2005, 47 states and the District of Columbia provided explicit GME payments to teaching hospitals, according to the Association of American Medical Colleges[14]) and the dozens of approved state plan provisions authorizing such payments, the Council which partners with the Florida's teaching hospitals, was surprised to see this proposal described as an administrative rather than legislative initiative. We question CMS' authority to adopt such a policy change without statutory authorization. To the extent that CMS intends to change the policy administratively, however, we assume that the agency would undertake a full notice and comment rulemaking process. In particular, we assume that CMS will allow governmental providers to include all of the costs of their teaching programs in the cost limits under the Proposed Rule unless and until the law is changed to prohibit Medicaid payments for GME. Please confirm our understanding that full GME costs will be includable as reimbursable costs.

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

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

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

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

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

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

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

This concludes the comments submitted by the Council of Florida Medical School Deans on behalf of the Council's teaching hospital partners.

Sincerely,

Anthony J. Silvagni, D.O.

Anthony J. Silvagni, D.O.
Chair

#310-3

March 19, 2007

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

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

Dear Ms. Norwalk:

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

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

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

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

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

I. Certified Public Expenditure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. State and Local Tax Revenue

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

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

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

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

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

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

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

II. Defining a Unit of Government (§ 433.50)

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

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

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

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

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

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

Cost-based methodologies are particularly inappropriate for physician services. Moreover, given the difficulties of calculating costs for professional providers, the additional administrative

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

burden on states and the impacted professionals would far exceed the value of the cost limit. This is issue should subsequently be resolved as to CPEs for physician payments, which are not typically conducive to cost-based methodologies. Further, if physicians are forced to convert to a cost-based reimbursement methodology, the costs associated with the reconciliation processes will be significant.

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

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

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

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

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

11. The cost limit undermines important public policy goals.

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

For example, the Colleges of Medicine have invested millions of dollars in adopting electronic medical records and other new information systems that have a direct impact on quality of care, patient safety, and long-term efficiency, all goals promoted by HHS and AHCA. HHS has

focused on expanding access to primary and preventative services, particularly for low-income Medicaid and uninsured patients, and reducing inappropriate utilization of emergency departments. Council members have been engaged in this effort, establishing networks of off-campus, neighborhood clinics with expanded hours, walk-in appointments, assigned primary care providers, and access to appropriate follow-up and specialty care. These initiatives require substantial investments of resources. CMS does not appear to have considered the impact of the cut imposed by the cost limit on shared policy initiatives that HHS itself has established as key goals of America's complex health care system. The only goal achieved by the Proposed Rule would be the dismantling of Florida's safety net.

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

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

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

Because the payments would be based on costs pursuant to the new regulation, there would not be the danger of "excessive payments" that has concerned CMS in the current system. Moreover, to avoid double dipping, states could be required to similarly adjust capitation rates to account for the supplemental cost-based payments. If reimbursement to faculty physicians is going to be restricted to cost, it should include costs for all Medicaid patients, not just those in the declining fee-for-service population. This adjustment would be critical in states like Florida, where there has been a significant shift to managed care organizations, particularly under operation of Florida's 1115 waiver.

[3] 42 C.F.R. §438.60.

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

II. Retention of Payments (§ 447.207)

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

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

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

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

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

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

[4] Proposed 42 C.F.R. § 447.207(a).

arrangements, and that CMS may use its disallowance authority to pressure public providers to dismantle such arrangements. CMS' review and audit authority is limited to payments made under the Medicaid program. It does not have authority over providers' use of Medicaid payments received.

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

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

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

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

This concludes the comments submitted by the Council of Florida Medical School Deans relative to the direct impact on Council members.

Sincerely,

Anthony J. Silvagni, D.O.

Anthony J. Silvagni, D.O.
Chair

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

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-311-Attach-1.DOC

#311

March 19, 2007

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

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

Dear Ms. Norwalk:

On behalf of Boston Medical Center, ("BMC"), I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes $77 million in critical Medicaid support payments for the *BMC*, funding that has been essential to our ability to serve as a major safety net health care system in our community. BMC is a 581 licensed bed, safety net academic medical center located in Boston's historic South End. BMC employs a diverse work force; with 4,429 fulltime equivalent employees. The hospital is the primary teaching affiliate for Boston University School of Medicine. Emphasizing community based care, BMC, with its mission to provide consistently accessible health services to all, is the largest safety net hospital in New England. The breadth of this commitment is best exemplified by the amount of free care BMC provides. Last year BMC provided more than $294 million in free care to uninsured populations.

- Over 50% of BMC's Patient are Uninsured or are covered by the States Medicaid program.
- Over 73% of BMC's Patients are classified as a minority.
- Over 25% of the entire States Uninsured population receive their services at BMC
- Over 80% of BMC's revenue is from Governmental sources.

Patient Care
With more than 28,035 admissions and 975,301 patient visits annually, BMC provides a comprehensive range of inpatient, clinical and diagnostic services in more than 70 areas of medical specialties and subspecialties, including cardiac care and surgery, hypertension, neurological care, orthopedics, geriatrics and women's health.
With the largest 24hour Level I trauma center in New England BMC had over 128,005 emergency room visits last year.

Interpreter Services
BMC values its diverse patient population and is committed to honoring their ethnic, religious and cultural differences. The Interpreter Services program at BMC is the most extensive in New England. In addition to providing person to person interpreters onsite in more than 30 languages, 24 hours a day, the department utilizes the latest advances in technology such as telephonic and video interpreting. Our interpreters help to break language barriers as well as serve as cultural brokers to patients and staff. Last year they assisted in more than 162,000 interactions with patients and visitors.

Teaching
As the principal teaching affiliate of Boston University School of Medicine, BMC is devoted to training future generations of health care professionals. Every member of the hospital's medical and dental staff holds an academic appointment at the Boston University School of Medicine or at the Goldman School of Dental Medicine. BMC operates 44 residency training programs with more than 620 resident and fellowship positions.

Research
BMC is a recognized leader in groundbreaking medical research. BMC received more than $86 million in sponsored research funding in 2006, and oversees over 400 research and service projects separate from research activities at Boston University School of Medicine. The world renowned researchers at BMC conduct both basic, laboratory based biomedical research, and clinical research programs, including the Sickle Cell Center, infectious disease, cardiology, vascular biology, Parkinson's Disease, geriatrics, endocrinology and hematology/oncology.

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

Defining a Unit of Government (§ 433.50)

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

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

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

Under current regulations, states are permitted to provide Medicaid reimbursement to hospitals and other providers up to the amount that would be payable using Medicare payment principles. The Proposed Rule would reduce that limit to Medicaid costs for governmental providers only, resulting in significant cuts for our institution. We oppose the cost limit for public providers.

We currently receive supplemental Medicaid payments of approximately $77 million annually, based on the upper payment limit. These payments are critical to our ability to serve as a health care safety net in our community, as described above. If these supplemental payments are subject to the cut envisioned in the Proposed Rule, we will be forced to drastically scale back the scope of these activities, as they are not fully reimbursed and we do not have unlimited access to other sources of funding to replace the Medicaid cuts.

Limiting Medicaid payments to cost for safety net providers such as the *BMC* is, in our view, extremely short-sighted public policy. CMS asserts that the cost limit is necessary because public providers "use the excess of Medicaid revenue over cost to subsidize health care operations that are unrelated to Medicaid, or they may return a portion of the supplemental payments to the State as a source of revenue." (72 Fed. Reg. 2241) First, the *BMC* does not return Medicaid payments to *Massachusetts* as a source of revenue To the extent that the cost limit is intended to prevent such refunds, it is unnecessary in our case. CMS has overreached in imposing this limit on us when we do not engage in these practices.

Second, to the extent that the *BMC* uses Medicaid reimbursement to support the financial viability of the critical services described above, we submit that such activities *are* integrally related to Medicaid, and we are mystified at CMS' assertion to the contrary. A viable and financially stable Level I trauma center is absolutely essential to our community's health care system and in particular to Medicaid recipients. Similarly, our Medicaid program has a keen interest in ensuring that there is a strong emergency response capability in our region so that Medicaid beneficiaries can be assured of the care they need when they need it (even if stand-by capacities are not directly billable to Medicaid in and of themselves). Medicaid, just like Medicare, should be permitted to support a strong and vibrant medical education system so that there are sufficient doctors to provide care to Medicaid patients in the future. And our efforts to invest in accessible community-based clinics with hours that are compatible with the busy schedules of working families, doctors providing a "medical home," and staff that provides culturally and linguistically competent care are absolutely consistent with the goals of the Medicaid program.

We do not understand why CMS believes that these kinds of activities are not related to Medicaid. Nor do we understand why, when they are so clearly in the best interest of Medicaid recipients, CMS deems them not worthy of Medicaid's support. Governmental providers have a special role in our health care system, one that is entirely compatible with the goals of the Medicaid program. CMS should not single out governmental providers for such a particularly harsh and rigid reimbursement limit. We urge you to retain the current regulatory upper payment limits.

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

The cost limit contained in the Proposed Rule does not specify whether it applies only to institutional providers or also to professional providers. If it applies to professional providers, it is unclear how to determine whether such providers are an "integral part" of a unit of government or are "operated by" a unit of government. A cost limit would be particularly inappropriate for professional services. We request that CMS clarify that the provisions of the Proposed Rule do not apply to professionals.

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

We object to the discussion in the preamble of the regulation (that is not repeated in the text of the regulation) that units of government that are providers can only certify their expenditures if they are paid on a cost basis. There is no reason to impose this limitation on the use of CPEs. The preamble acknowledges that units of government that are *not* providers may certify their payments to providers even if the state plan payment methodology is not cost-based. The same should apply to the provider itself. We would, of course, not be able to certify any costs that are in excess of the payment that would result from the state plan methodology. But the costs that we incur in connection with services to Medicaid patients are no less real than the costs a non-provider unit of government would incur if they paid us for providing Medicaid services. Please confirm that the regulatory text stands on its own and rescind the preamble discussion requiring providers to be paid on a cost basis in order to certify expenditures as the non-federal share.

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

The preamble to the Proposed Rule states that "all Medicaid payments ... made under ... Medicaid waiver and demonstration authorities are subject to all provisions of this regulation." (72 Fed. Reg. 2240). In 2006, our state negotiated an extremely complex Section 1115 demonstration program with CMS that we have been working hard to implement. The underpinning of this demonstration project is *Safety Net Care Pool funding and* Expanded Coverage for which CMS has authorized through its authority under Section 1115(a)(2) of the Social Security Act to provide federal financial participation for expenditures that are not otherwise matchable.

Because the Special Terms and Conditions on the demonstration project require CMS to incorporate any changes in federal law into the budget neutrality

expenditure cap for the program, we request clarification as to whether implementation of the Proposed Rule will reduce available funding for the demonstration. Such an outcome would be unthinkable, given the enormous time, effort and resources that have been devoted to implementing the demonstration as approved by CMS. Our state negotiated the waiver in good faith for a *three*-year term in full expectation that CMS would honor the painstakingly negotiated agreement. We hope and expect that the Proposed Rule will not undo that agreement, but given the unconditional preamble statement that payments made under waiver and demonstration authorities are subject to the provisions of the Rule, we are concerned. Therefore, we request that CMS state unequivocally that the funding provided for the Safety Net Care Pool and Expanded Coverage will not be reduced or eliminated.

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

CMS proposes to implement the Proposed Rule as of September 1, 2007 – an astonishingly ambitious schedule given the sweeping nature of the changes proposed. Assuming that a final regulation is not issued until this summer, states will have very little time to adopt the changes necessary to come into compliance. It would not be able to properly consider the changes in our program that may be required under the regulation in time to meet the deadline. Nor would our Medicaid agency have time to develop and obtain approval for any state plan amendments that may be required or to adopt changes to state rules and provider manuals. Establishing appropriate cost-reporting mechanisms as envisioned in the Proposed Rule will, in and of itself, require months of work.

Moreover, given the longstanding payment policies and financing arrangements that would be disrupted by the Proposed Rule, CMS should provide a generous transition period for states and providers to adjust to these enormous changes. We would recommend a minimum transition period of at least ten years.

* * *

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

If you have any questions about this letter, please feel free to contact Thomas P. Traylor at 617-638-6730

Sincerely,

Elaine Ullian

Submitter : Mr. Ravi Shetty **Date:** 03/19/2007

Organization : St. James PHO

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

The impact of the proposed rules would represent a serious financial blow to Illinois hospitals and nursing hiomes providing healthcare for thousands lo-income, elderly, and disabled peoplle throughout the state.

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-313-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

#313

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 : Mr. Ervin Brinker **Date:** 03/19/2007

Organization : Summit Pointe

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

#314

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.