Submitter : Mr. Dennis Millirons **Date:** 03/19/2007

Organization : Condell Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

 #328

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

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

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

Submitter : Mr. Troy King **Date:** 03/19/2007

Organization : Alabama Attorney General's Office

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-329-Attach-1.PDF

#329

STATE OF ALABAMA
OFFICE OF THE ATTORNEY GENERAL

TROY KING
ATTORNEY GENERAL

ALABAMA STATE HOUSE
11 SOUTH UNION STREET
MONTGOMERY, AL 36130
(334) 242-7300
WWW.AGO.STATE.AL.US

March 19, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Post Office Box 4017
Baltimore, Maryland 21244-8017

Re: CMS-2258-P

To Whom It May Concern:

The purpose of this letter is to comment on, and to strenuously urge the reconsideration of, your agency's proposed changes to the Medicaid regulations, as described in your notice found at 72 FR 2236-01. In particular, I am concerned about the proposed revisions to the definition of "unit of government," which would, for the first time in the history of the Medicaid program, insert a requirement that a health care authority or similar entity have "generally applicable taxing authority" to be considered a "unit of government." This change is not legally appropriate for the reasons set forth below.

As you are no doubt aware, section 1903(w)(7)(g) of the Social Security Act provides, in pertinent part: "The term 'unit of government' means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State." Absent from this statutory definition is any mention of the requirement that the entity in question have generally applicable taxing authority. Indeed, the phrase "generally applicable taxing authority" does not appear in the section in question or anywhere else in title XIX of the Social Security Act. Clearly, if Congress had intended that this restriction to apply, it could have easily said so. In fact, Congress declined to include this language. *See:* H.R. Rep. No. 89-682, (1965)(Conf. Rep.), as reprinted in 1965 U.S.C.C.A.N. 228, 22444-45; Pub. L. No. 102-234, 105 Stat. 1793. Given this fact, this agency lacks the statutory authority to amend the definition of "unit of government"; to do so would violate the separation of powers between the legislative and executive branches. CMS should be mindful of the warning of the Supreme Court that "[a]gencies may play the sorcerer's apprentice but not the sorcerer himself." *Alexander v Sandoval*, 532 US 275, 291(2001).

The proposed changes raise serious federalism concerns. A federal agency is seeking to insert itself as the sole judge of the form and powers that a public entity created by a state (such as a public health care authority authorized by ALA. CODE § 22-21-310, *et seq.* (1975 as amended)) must have in order to be considered a governmental entity. While some may, no doubt, argue that the states are not literally coerced to alter the structure and/or powers of their public health care facilities to accommodate this new definition, such an argument ignores these facilities' and the states' dependence on Medicaid and, in turn, the dependence of local communities on these facilities. The states do not have a meaningful choice given the present structure of financing health care. The clear effect of this definition is, then, to intrude on the sovereignty of the State to decide for itself the structure and, more importantly, the powers of its health care authorities and similar entities. In so doing, CMS has apparently given no consideration to whether, consistent with the various state constitutions, arrangements such as it proposes to require can even be practicably accomplished. The position occupied by CMS and Medicaid make this decision uniquely and unduly coercive and an inappropriate intrusion on state sovereignty. Even if this intrusion may not rise to the level of violating the 10th Amendment, the nature and extent of the intrusion make the proposed changes inappropriate.

There is another federalism related concern raised by the proposal – namely, whether the proposed changes violate the Spending Clause of the U.S. Constitution. "The spending power [of the federal government] is of course not unlimited but is instead subject to several general restrictions articulated in our cases." *South Dakota v. Dole*, 483 U.S. 203, 207 (1987). One such restriction is that "if Congress desires to condition the States' receipt of federal funds, it 'must do so unambiguously ... enabl[ing] the States to exercise their choice knowingly, cognizant of the consequences of their participation.'" *Id.* (citing *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17 (1981).). The statutory language quoted above demonstrates that the condition CMS now seeks to impose was not one unambiguously imposed by Congress. Moreover, the Supreme Court has recognized that "in some circumstances the financial inducements offered by Congress might be so coercive as to pass the point at which pressure turns into compulsion." *Dole*, 483 U.S. at 211 (quoting *Steward Machine Co. v. Davis*, 310 U.S. at 590.). Such compulsion is not permitted.

For over forty years, the states have participated in the Medicaid program. The health care systems throughout this country are dependent on the states' participation. Indeed, the present structure of the health care delivery system is a direct result of the states' decision to participate in the system. Any substantial decrease in the level of funding provided by Medicaid will have far reaching and devastating consequences for the delivery of health care to pregnant women, children, and the disabled. In this instance, this change in the definition of "unit of government" will dramatically and

adversely affect the state's level of funding of Medicaid. Such a fundamental change in the program at this juncture may well run afoul of the Spending Clause. It cannot be assumed that the states would have participated in Medicaid to the extent that they have and/or would have created the system of public health care founded on this level of participation had they known that such a fundamental change would be, or even could be, altered by regulatory fiat.[1] Given the states' dependence on Medicaid monies, a change such as this, especially in light of the federalism concerns it raises, constitutes coercion that is prohibited by the Spending Clause.

The concerns addressed in this letter are significant and, even if not fatal to the proposed changes, at a minimum, certainly counsel against their adoption. I respectfully, but strenuously, urge CMS to decline to adopt the proposed changes. Such a course of action would show appropriate deference to both Congress and the states.

Sincerely,

Troy King
Attorney General

[1] This is not to suggest that any state would have chosen not to participate in the Medicaid program - only that the level of participation and/or the public health care structure would, in all likelihood, have been significantly different had Congress enacted this proposed definition of "unit of government" at the outset of the program.

Submitter : **Mr. Dennis Millirons** **Date: 03/19/2007**

Organization : **Condell Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

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

Condell Medical Center appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule. We oppose this rule and would like to highlight the harm its proposed policy changes would cause to our local not-for-profit, hospital and the patients we serve.

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

CMS estimates that the rule will cut $3.9 billion in federal spending over five years, amounting to a budget cut for safety-net hospitals and state Medicaid programs. Condell Medical Center has consistently provided care to Medicaid patients, estimating a $15.7 million hard loss in 2006. Reducing the Medicaid funding would negatively impact our hospital s ability to invest in advanced technology, complex care services and community benefit programs.

We oppose the proposed rule and urge CMS to permanently withdraw it. Furthermore, for the past two years, Congressional members have voiced opposition having signed letters urging their leaders to stop the proposed rule from moving forward. If these policy changes are implemented, the nation s health care safety net will unravel, and the health care services for millions of our nation s most vulnerable people will be jeopardized.

Sincerely,

Dennis Millirons, CEO
Condell Medical Center

Submitter : Dr. Pascal Goldschmidt **Date:** 03/19/2007

Organization : University of Miami Miller School of Medicine

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-P-331-Attach-1.DOC

331

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 University of Miami Miller School of Medicine ("UMMSOM") 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 UMMSOM, which 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 UMMSOM is estimated to be $25 million - annually.

Faculty physicians employed by and under contract with the UMMSOM are the state's providers of primary and specialty services for vulnerable populations, including Medicaid and uninsured persons. Through this critical access, the UMMSOM trains and educates Florida's physician workforce, and the member Colleges of Medicine 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 UMMSOM 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 patient 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 UMMSOM 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 UMMSOM 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 presummably 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 UMMSOM urges CMS to reconsider the dictate that funds contractually obligated by a governmental entity to a health care provider cannot be used as IGTs; however, it is unclear if those funds would qualify as a CPE. For instance, a community in Florida has opted to tax itself to provide access to physician and hospital services, will the funds obligated and expended to pay faculty physicians qualify as a CPE for services approved and provided under the state plan.

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

II. Defining a Unit of Government (§ 433.50)

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

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

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

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

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

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

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

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

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

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.

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

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

11. The cost limit undermines important public policy goals.

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

For example, the 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. UMMSOM 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 UMMSOM urges CMS to reconsider the scope of the exception to the direct payment provision. The UMMSOM 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

[3] 42 C.F.R. §438.60.

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

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

II. Retention of Payments (§ 447.207)

The UMMSOM 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. UMMSOM 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 UMMSOM is concerned that CMS' new authority to examine "associated transactions" will jeopardize these arrangements, and that CMS may use its disallowance authority to pressure public providers to dismantle such arrangements. CMS' review and audit authority is limited to

[4] Proposed 42 C.F.R. § 447.207(a).

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 UMMSOM 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 University of Miami Miller School of Medicine relative to the direct impact on UMMSOM.

Sincerely,

Pascal J. Goldschmidt

Pascal J. Goldschmidt, MD
Senior Vice President for Medical Affairs and Dean
University of Miami Miller School of Medicine

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 University of Miami Miller School of Medicine ("UMMSOM") is submitting these comments on behalf of our teaching hospital partners. The UMMSOM urges the Centers for Medicare a nd M edicaid S ervices ("CMS") t o w ithdraw t he p roposed r ule e ntitled " 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 UMMSOM members but also on our teaching hospital affiliates, which will seriously compromise medical education, training a nd research as well as adversely affect access to care for Medicaid and uninsured patients in Florida. The impact on the UMMSOM 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 UMMSOM 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 ensured that Florida's poor and uninsured have access to a full range of primary and specialty care. If implemented, this regulation would be a severely compromise Florida safety net health system.

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 UMMSOM 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 over-hauled 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 UMMSOM 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."[5] 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.

[5] 72 Fed. Reg. at 2239.

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.*

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 UMMSOM 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[6] 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.*"[7] Congress never premised qualification as a unit of government on an entity's access to public tax dollars. Rather, the definition Congress has adopted for "other governmental units in the State," provides appropriate deference to the variety of governmental structures into which a state may organize

[6] 42 U.S.C. § 1396b(w)(7)(G).
[7] Proposed 42 C.F.R. § 433.50(a)(1)(i) (emphasis added).

itself. In narrowing this statutory definition, without instruction by Congress, CMS has unilaterally eliminated the deference to states underlying the statutory formulation.

Section 1903(w)(7)(G) is not the only section of Title XIX which evidences a Congressional intent to allow states to determine which entities are political subdivisions capable of participating in Medicaid financing. The absence of any requirement that units of government have taxing authority in order to contribute to the non-federal share of Medicaid expenditures is supported by the language elsewhere in the Medicaid statute. Section 1903(d)(1) requires states to submit quarterly reports for purposes of drawing down the federal share in which they must identify "the amount appropriated or made available by the State and its political subdivisions." The reference to the participation of political subdivisions in Medicaid funding does not include a requirement that the subdivisions have taxing authority.[8] In fact, funds made be made available through direct appropriation or through contract - and it is not limited funds paid to only those providers operated by governmental entities.

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

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

10. *A federally-imposed restriction on state units of government violates Constitutional principles of federalism.*

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

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

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

More than a century ago, state and local governments began establishing public hospitals to provide health care services to their residents, including their most needy residents. As the health care system matured, commercial insurance evolved and the Medicare and Medicaid programs were established, public hospitals filled a unique role in serving the poor and uninsured

[8] 42 U.S.C. § 1396b(d)(1).

in their communities -- patients who were often shunned by other providers. The public hospitals were typically operated as a department of the state or local government, with control over hospital operations in the hands of an elected legislative body, funding appropriated to plug deficits, surpluses reverting into the general fund of the government, public agency procurement requirements, civil service systems, and specific to Florida open government and public records laws. These unique public entity state laws are generally designed with the operations of traditional monopolistic governmental agencies such as libraries, police, fire and public schools in mind.

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

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

These restructurings have taken a wide variety of forms. Some local governments in Florida have created hospital authorities, with a separate governing board, appointed by elected officials and dedicated solely to governing the hospital. Other Florida public hospitals have elected boards, which are autonomous from the county or municipality. And, some public hospitals have been sold or leased to private entities but retain obligations to provide services to the community for which the local government provides financial support.

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

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

* Public Health Trust of Miami-Dade County (the "Trust") is the umbrella organization which owns and operates Jackson Memorial Hospital, which is a public hospital under Florida law. Miami-Dade County imposes an optional sales for the benefit of the Trust and hospital; however, neither the trust nor the hospital has taxing authority, and so it is not clear if the Proposed Rule would allow those funds to be used as Medicaid match - particularly since the County does not operate the hospital or include the hospital in its consolidated financials. In the case of the physician supplemental payments, Trust dollars which are paid the affiliated private university are used as CPEs – and again it is uncertain if these funds will continue to be eligible under operation of the Proposed Rule.

* The North Broward Hospital District own and operate hospitals in Broward County, Florida and has taxing authority, and so it seems to meet the definition of "unit of government" as proposed.

* Shands at the University of Florida is a formerly public hospital leased to private entity as is Tampa General Hospital. Many formerly public hospitals in Florida are leased to private entities for a number of reasons, and these facilities would be leery to be considered "public" for federal purposes while maintaining their private status under state laws. Shands receives a state appropriation which may qualify as IGT; Tampa General is contractually obligated to fulfill the former public hospital's obligation to the uninsured in Hillsborough County and the hospital is also the statutory recipient of sales tax dollars raised in the County. The Proposed Rule appears to negate the funding for contractually obligated services, and it is unclear as to the treatment of the statutorily appropriated tax revenues.

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

One very common feature of all of the restructurings that has occurred in Florida is to establish a separate and independent budget and accounting system for the hospital, in which revenues earned by the hospital are retained in a separate enterprise fund controlled by the governing board dedicated solely to the hospital rather than automatically reverting to the government's general fund. Such fiscal independence has been viewed as critical to establishing the necessary incentives and accountability for hospital administrators to operate efficiently, to maximize patient care revenues and to invest in new initiatives widely. Similarly, many restructured hospitals are not granted unlimited access to taxpayer support but are forced to manage within a fixed budget, which again has been viewed as furthering the goals of economy and efficiency. In short, the governmental entities that previously owned and operated these hospitals have restructured them deliberately to be both governmental and autonomous. They are governmental

under state law and they remain fully accountable to the public. But they are autonomous governmental entities in that the local or state government with taxing authority is no longer legally responsible for their liabilities, expenses and deficits. For this reason, they likely would not meet CMS' new unit of government definition, even though they have retained several governmental attributes and may be considered governmental under the laws of the state.

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

In Florida, 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***."[9] 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***."[10] 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.[11] For example, courts in Florida have

[9] Proposed 42 C.F.R. § 433.50(a)(1)(i).
[10] Proposed 42 C.F.R. §433.50(a)(1)(ii).
[11] *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.").

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 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 UMMSOM 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 UMMSOM 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 rates 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.[12] 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).[13] 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.[14]

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

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

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[12] Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits*, December 2006.
[13] H.R. 5661, 106th Cong., enacted into law by reference in Pub. L. No. 106-554, § 1(a)(6) ("BIPA").
[14] 42 U.S.C. § 1396a(a)(30)(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 ...."[15] By contrast, the UPL regulations are carefully drafted to limit their scope to "rates set by the agency,"[16] and they include an explicit exemption for DSH payments.[17]

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.

[15] Proposed 42 C.F.R. § 447.206(a)
[16] 42 C.F.R. § 447.272(a), § 447.321(a).
[17] 42 C.F.R. § 447.272(c)(2).

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

- costs incurred by the hospital for physician and other professional services (e.g. salaries for employed professionals, contractual payments to physician groups for services provided to hospitals, physician on-call and standby costs);
- capital costs necessary to maintain an adequate physical infrastructure;
- medical education costs incurred by teaching hospitals 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 UMMSOM 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[18]) and the dozens of approved state plan provisions authorizing such payments, the UMMSOM 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.

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.

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

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 UMMSOM on behalf of the UMMSOM's teaching hospital partners.

Sincerely,

Pascal J. Goldschmidt

Pascal J. Goldschmidt, M.D.
Senior Vice President for Medical Affairs and Dean

March 19, 2007

Melissa Musotto
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Re: Proposed Tool Comments; File Code CMS-2258-P

Dear Ms. Musotto:

These comments by the University of Miami Miller School of Medicine ("UMMSOM") are directed solely at the Tool to Evaluate the Governmental Status of Providers[19] (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 UMMSOMbelieves 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 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 UMMSOM regarding the "Tool".

Sincerely,

Pascal J. Goldschmidt

Pascal J. Goldschmidt, M.D.
Senior Vice President for Medical Affairs and Dean

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

Organization : Kentucky Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment which corrects typographical errors in comments we previously submitted. These are our final comments.

CMS-2258-P-333-Attach-1.DOC

#333

March 19, 2007

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

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

Dear Ms. Norwalk:

On behalf of all hospitals in the Commonwealth of Kentucky, the Kentucky Hospital Association (KHA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals.

With respect to the use of IGTs and CPEs, KHA concurs with the proposed rule's requirement that providers must keep 100% of payments made through use of an IGT, without any rebate of a portion of those payments to the state. We also concur that all states should be held to the standard that IGTs and CPEs cannot be used to fund non-Medicaid costs, but rather, only Medicaid covered services provided to Medicaid recipients. However, KHA is strongly opposed to application of a cost-based reimbursement limit to government-operated providers. Imposition of this limit would reduce payments by more than $20 million annually to several safety net hospitals in Kentucky, including the hospital which provides the largest volume of services to Medicaid patients in the state.

Cost-Based Limit for Public Hospitals

The proposed rule would limit reimbursement for government-operated hospitals to the cost of providing Medicaid services to Medicaid recipients. However, the rule does not even specify how "cost" would be determined - only that the Secretary will set forth a reasonable method. The regulation references use of Medicare cost finding principles only "as appropriate", leaving open the potential for imposing additional payment reductions on the basis of restricting the definition of "cost." The cost limit would also be imposed on payments to governmental hospitals that do not involve CPEs

to finance those payments. Finally, the rule changes the upper payment limit for governmental hospitals by limiting payment to each individual provider's cost, whereas the current UPL regulations provide an aggregate limit based on the UPL facility group. KHA is opposed to the disparate treatment of governmental, safety net hospitals since the use of an aggregate UPL for privately operated facilities would remain unchanged.

Currently, Medicaid reimbursement for all hospitals is constrained by the upper payment limit, which prohibits a state Medicaid agency from paying more than what Medicare would pay for the same services, or a hospital's charges. Since Medicare has implemented payment rates and systems designed to achieve economy and efficiency, Kentucky's Medicaid agency has generally adopted hospital payment methodologies that are the same as or are similar to Medicare. Imposing a payment limit at cost will reduce payments to governmentally operated critical access hospitals in Kentucky and the University of Kentucky Medical Center.

Critical Access Hospitals

Kentucky Medicaid pays critical access hospitals using Medicare rates. In recognition of the importance of maintaining the viability of critical access hospitals, which have a small volume of patients that are predominately on government programs, Medicare pays CAHs at 101% of their cost. Likewise, Kentucky Medicaid payments to all critical access hospitals are at 101% of cost. IGT and CPEs are not used to finance payments to any Kentucky critical access hospital, yet the proposed cost limit would require Kentucky Medicaid to reduce payments to the few governmentally operated critical access hospitals from 101% of cost (consistent with Medicare) to 100% of cost, while continuing to pay other critical access hospitals at the higher rates. Reducing payments to these safety net hospitals merely undermines their safety net mission, reduces access, and creates a financial strain on the sponsoring governmental entities that could ultimately result in their inability to maintain operation of these hospitals which serve a vital role in their rural communities.

State Teaching Hospitals

The proposal to limit governmental hospital payments to the facility's "costs" rather than to the amount they would be paid by Medicare will result in substantial harm to Kentucky's largest Medicaid hospital provider, the University of Kentucky Medical Center by reducing payments by approximately $20 million annually. Under the current UPL, the hospital can receive payments based on the amount Medicare would pay, including payment for graduate medical education, indirect medical education, organ transplant costs, and disproportionate share. The Medicare program provides these additional payments in recognition of the added costs incurred by hospitals for medical education and training, operating a transplant program, and service to a disproportionate number of low income patients. This facility serves the largest number of Medicaid patients – with more than 20,000 inpatient days annually, and serves as a referral center for the transfer of Medicaid patients from other hospital throughout the state. The University of Kentucky Medical Center trains the majority of the state's future physicians

and serves as the tertiary referral center for the Eastern half of the state. University Hospital is also one of the largest safety net hospitals for the uninsured and medically indigent, providing more than $30 million in indigent care costs annually. Approximately thirty percent of these costs are not covered by Medicaid DSH payments, which are capped under federal law to Kentucky hospitals. Limiting Medicaid payment to cost, rather than Medicare payment levels, will eliminate vital funding used to support the hospital's safety net mission, including indigent care, a Level I trauma center (of which Kentucky only has three), and the training of physicians and other allied health care practitioners. The hospital will be unable to recoup from other patients the magnitude of losses resulting from imposition of a Medicaid cost limit due to the extremely high volume of Medicaid and indigent patients that it serves.

There is simply no rationale basis for requiring state Medicaid agencies to reduce payments to governmentally operated hospitals, while paying private hospitals at higher levels. In fact, the policy to limit governmental hospital payment to cost is contrary to those hospitals having higher unpaid costs due to the fact that, as governmentally operated facilities, they serve a higher proportion of governmental and indigent patients and have higher uncompensated care costs that cannot be recovered from privately insured patients.

KHA concurs with the comments submitted by the American Hospital Association pertaining to the cost limit and the lack of statutory authority for CMS to adopt regulations to impose this limit. We also support AHA's comments that CMS's proposal to apply a different, hospital specific UPL to governmentally operated hospitals, as opposed to an aggregate limit, is contrary to the requirement of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).

In summary, the cost limit would be damaging to several governmentally owned hospitals in Kentucky. The loss of Medicaid funding, coupled with significant unfunded indigent care, will subject these hospitals with substantial losses that will detrimentally impact on patient access to care. The federal government should be concerned with protecting the viability of safety net providers who are necessary to provide care to the Medicaid and uninsured population. States should be allowed to use IGTs and CPEs to pay these governmentally operated providers up to the current upper payment limit. For these reasons, KHA urges CMS to eliminate its proposed cost-based limit changes for governmental hospitals and retain the existing upper payment limit rule if it continues forward with other regulatory changes that address states' use of IGTs and CPEs.

Sincerely,

Nancy C. Galvagni
Senior Vice President

Submitter : **Ms. Lisa Waukau** **Date: 03/19/2007**

Organization : **Menominee Indian Tribe of Wisconsin**

Category : **Health Care Provider/Association**

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-336-Attach-1.DOC

#336

Monday, March 19, 2007

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

Subject: (CMS-2258-P) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (72 Federal Register 2236), January 18, 2007

Dear Ms. Norwalk:

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

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

Criteria for Indian Tribes to Participate

The proposed rule attempts to make clear that Indian Tribes may participate by specifically referencing them in proposed section 433.50(a)(1). However, as currently proposed, an Indian Tribe would only be able to participate if it has "generally applicable taxing authority," a criteria applied to all units of government referenced here. Although in principle Indian Tribes do enjoy taxing authority, as with all other matters about Indian Tribes, the law is complex and fraught with exceptions. To impose this requirement will burden each State with trying to understand the specific status of each Indian Tribe and to

make decisions about the taxing authority of the Tribe – a complex matter often the subject of litigation between Indian Tribes and States. A requirement to make such determinations will almost certainly negatively affect the willingness of States to enter into cost sharing agreements with Indian Tribes since an error in the determination regarding this undefined term could have potentially negative effects for the State.

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

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

Criteria for Tribal Organizations to Participate

We oppose this rule as currently written because we believe it will negatively affect the participation of tribal organizations to perform Medicaid State administrative activities. The CMS TTAG spent over two years working with CMS and Indian Health Service (IHS) resulting in an October 18, 2005, State Medicaid Director (SMD) letter clarifying that tribes and tribal organizations, under certain conditions, could certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services provided by such entities. However, the proposed rule does not reflect that the criteria approved by CMS recognizing tribal organizations as a unit of government eligible to incur expenditures of State plan administration eligible for Federal matching funds. As part of these comments, we have enclosed a copy of the SMD's letter of October 18, 2005, and clarifying SMD letter dated June 9, 2006. [1]

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

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

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

section 447.206.[2]

Most tribal organizations will not meet the proposed standard for criteria (1). The basic participation requirement in proposed 433.50(a)(1) sets a new standard for the eligibility of the unit that will exclude many tribal organizations by imposing a requirement that there be "taxing authority" or "access [to] funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities, and deficits . . .." The new proposed rule at 433.50(a)(1) provides:

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

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

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

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

The proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). Furthermore, we believe there is no authority in the statute for CMS to restrict cost sharing to funds generated from tax revenue. CMS has inexplicably attempted to use a provision in current law that *limits the Secretary's authority to regulate* cost sharing as the source of authority that *all* cost sharing must be made from state or local taxes. The proposed change is inconsistent with CMS policy as outlined in the October 18, 2005 and the June 9, 2006 SMD letters.

Based on the comments made by Leslie Norwalk during the TTAG meeting February 22, 2007, it is clear that the proposed rule regarding conditions for inter-governmental transfers was not intended by the Department to overturn any part of the SMD letters of October 18, 2005, and June 9, 2006, regarding Tribal participation in MAM. This was further confirmed by Aaron Blight, Director Division of Financial Operations, CMSO, on a conference call held with the CMS TTAG policy subcommittee as well as the second day of the CMS TTAG meeting held on February 23.

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

> (C) The health care provider is an Indian Tribe or a Tribal organization (as those terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (ISDEAA); 25 U.S.C. 450b) and meets the following criteria:
>
> (1) If the entity is a Tribal organization, it is—
>
> (aa) carrying out health programs of the IHS, including health services which are eligible for reimbursement by Medicaid, under a contract or compact entered into between the Tribal organization and the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, and
>
> (bb) either the recognized governing body of an Indian tribe, or an entity which is formed solely by, wholly owned or comprised of, and exclusively controlled by Indian tribes.
>
> (2) The cost sharing expenditures which are certified by the Indian Tribe or Tribal organization are made with Tribal sources of revenue, including funds received under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, provided such funds may not include reimbursements or payments from Medicaid, whether such reimbursements or payments are made on the basis of an all-inclusive rate, encounter rate, fee-for-service, or some other method.

The caveat to paragraph (2) above regarding the source of payments was added to expressly address a new limitation that CMS proposed on February 23, 2007, with regard

to approving the Washington State Medicaid Administrative Match Implementation Plan to exclude any "638 clinics that are reimbursed at the all-inclusive rate from participation in the tribal administrative claiming program." No such exclusion was ever contemplated by CMS when it sent the SMD letters referred to earlier. Such an exclusion would swallow the rule that allows Indian Tribes and Tribal organizations to participating in cost sharing.

This new requirement could be interpreted as undermining the commitment made in the SMD letters, which had no such limitation, notwithstanding hours of discussion among CMS, Tribal representatives, and IHS about how reimbursement for tribal health programs is calculated. There was an understanding that the all-inclusive rate does not include expenditures for the types of activity covered by Administrative Match Agreements and therefore avoids duplication of costs. CMS well knows that most Indian Health Service and tribal clinics are reimbursed under an all-inclusive rate. We have to hope that instead this is another instance in which the individuals responding to Washington State were simply "out-of-the-loop" regarding the extensive discussions with the TTAG prior to the issuance of the SMD letter.

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

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

Sincerely,

_____

Lisa S. Waukau, Chairman
Menominee Indian Tribe of Wisconsin

LSW:dab

Cc: National Indian Health Board
Mr. Jerry Waukau, Clinic Administrator, Menominee Tribal Clinic
File

Submitter : **Ms. Shawna Gavin** **Date: 03/19/2007**

Organization : **Yellowhawk Tribal Health Center**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

GENERAL

GENERAL

See Attachment

CMS-2258-P-337-Attach-1.DOC

CMS-2258-P-337-Attach-2.TXT

CMS-2258-P-337-Attach-3.DOC

CMS-2258-P-337-Attach-4.PDF

#337

YELLOWHAWK
TRIBAL HEALTH CENTER
P.O. Box 160
Pendleton, Oregon 97801
(541) 966-9830

March 15, 2007

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

SUBJECT: (CMS-2258-P) MEDICAID PROGRAM; COST LIMIT FOR PROVIDERS OPERATED BY UNITS OF GOVERNMENT AND PROVISIONS TO ENSURE THE INTEGRITY OF FEDERAL-STATE FINANCIAL PARTNERSHIP, (72 FEDERAL REGISTER 2236), JANUARY 18, 2007

Dear Ms. Norwalk:

My name is Shawna Gavin, I am the Chairperson for the Confederated Tribes of the Umatilla Indian Reservation (CTUIR) Health Commission. We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule published on January 18, 2007 at 72 Federal Register 2236. As currently written, we oppose the proposed rule and would like to offer suggested regulatory language that we believe will address tribal concerns consistent with existing CMS policy.

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

Criteria for Indian Tribes to Participate

The proposed rule attempts to make clear that Indian Tribes may participate by specifically referencing them in proposed section 433.50(a)(1). However, as currently proposed, an Indian Tribe would only be able to participate if it has "generally applicable taxing authority," a criteria applied to all units of government referenced here. Although in principle Indian Tribes do enjoy taxing authority, as with all other matters about Indian Tribes, the law is complex and fraught with exceptions. To impose this requirement will burden each State with trying to understand the

specific status of each Indian Tribe and to make decisions about the taxing authority of the Tribe – a complex matter often the subject of litigation between Indian Tribes and States. A requirement to make such determinations will almost certainly negatively affect the willingness of States to enter into cost sharing agreements with Indian Tribes since an error in the determination regarding this undefined term could have potentially negative effects for the State.

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

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

Criteria for Tribal Organizations to Participate

We oppose this rule as currently written because we believe it will negatively affect the participation of tribal organizations to perform Medicaid State administrative activities. The CMS TTAG spent over two years working with CMS and Indian Health Service (IHS) resulting in an October 18, 2005, State Medicaid Director (SMD) letter clarifying that tribes and tribal organizations, under certain conditions, could certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services provided by such entities. However, the proposed rule does not reflect that the criteria approved by CMS recognizing tribal organizations as a unit of government eligible to incur expenditures of State plan administration eligible for Federal matching funds. As part of these comments, we have enclosed a copy of the SMD's letter of October 18, 2005, and clarifying SMD letter dated June 9, 2006. 1

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

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

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

2/ The language in proposed 447.206(b) that provides an exception for IHS and tribal facilities from limits on the amounts of contributions uses language consistent with the October 18, 2005, State Medicaid Director Letter ("The limitation in paragraph (c) of this section does not apply to Indian Health Service facilities and tribal facilities that are

Most tribal organizations will not meet the proposed standard for criteria (1). The basic participation requirement in proposed 433.50(a)(1) sets a new standard for the eligibility of the unit that will exclude many tribal organizations by imposing a requirement that there be "taxing authority" or "access [to] funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities, and deficits . . .." The new proposed rule at 433.50(a)(1) provides:

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

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

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

The proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). Furthermore, we believe there is no authority in the statute for CMS to restrict cost sharing to funds generated from tax revenue. CMS has inexplicably attempted to use a provision in current law that *limits the Secretary's authority to regulate* cost sharing as the source of authority that *all* cost sharing must be made from state or local taxes. The proposed change is inconsistent with CMS policy as outlined in the October 18, 2005 and the June 9, 2006 SMD letters.

Based on the comments made by Leslie Norwalk during the TTAG meeting February 22, 2007, it is clear that the proposed rule regarding conditions for inter-governmental transfers was not

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funded through the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638").

intended by the Department to overturn any part of the SMD letters of October 18, 2005, and June 9, 2006, regarding Tribal participation in MAM. This was further confirmed by Aaron Blight, Director Division of Financial Operations, CMSO, on a conference call held with the CMS TTAG policy subcommittee as well as the second day of the CMS TTAG meeting held on February 23.

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

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

This new requirement could be interpreted as undermining the commitment made in the SMD letters, which had no such limitation, notwithstanding hours of discussion among CMS, Tribal representatives, and IHS about how reimbursement for tribal health programs is calculated. There was an understanding that the all-inclusive rate does not include expenditures for the types of activity covered by Administrative Match Agreements and therefore avoids duplication of costs. CMS well knows that most Indian Health Service and tribal clinics are reimbursed under an all-inclusive rate. We have to hope that instead this is another instance in which the individuals responding to Washington State were simply "out-of-the-loop" regarding the extensive discussions with the TTAG prior to the issuance of the SMD letter.

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

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

Sincerely,

Shawna M. Gavin
CTUIR Health Commission Chairperson

Cc: National Indian Health Board

Submitter : Mr. Reed Ernstrom **Date:** 03/19/2007

Organization : Bear River Mental Health

Category : Other Health Care Professional

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

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

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

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

Submitter : Ms. Rebecca Miles **Date:** 03/19/2007

Organization : Nez Perce Tribe

Category : Other Government

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2258-P-339-Attach-1.PDF

#339

Nez Perce

TRIBAL EXECUTIVE COMMITTEE
P.O. BOX 305 • LAPWAI, IDAHO 83540 • (208) 843-2253

March 19, 2007

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

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

Dear Ms. Norwalk:

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

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

We oppose this rule as currently written because we believe it will negatively affect the participation of tribal organizations to perform Medicaid State administrative activities. The CMS TTAG spent over two years working with CMS and Indian Health Service (IHS) resulting in an October 18, 2005, State Medicaid Director (SMD) letter clarifying that tribes and tribal organizations, under certain conditions, could certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services provided by such entities.

However, the proposed rule does not reflect that the criteria approved by CMS recognizing tribal organizations as a unit of government eligible to incur expenditures of State plan administration eligible for Federal matching funds.

Thank you for this opportunity to comment on this important matter.

Sincerely,

Rebecca A. Miles
Chairman

Submitter : Mr. Konrad Capeller **Date:** 03/19/2007

Organization : Michael R. Bell & Company, PLLC

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-P-340-Attach-1.PDF

#340

MICHAEL R. BELL & COMPANY, PLLC

CERTIFIED PUBLIC ACCOUNTANTS & CONSULTANTS

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March 19, 2007

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

Re: Proposed Rule RIN 0938-A057

Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership

To Whom It May Concern:

We are pleased to participate in the public comment on the proposed rule identified above. Following is our comment:

Issue and Comment

The proposed rule amends Medicare regulations at §447.271, §447.272, and §447.321. The regulations in those sections do not, however, differentiate between a "hospital" and a "critical access hospital."

CMS has made a concerted effort to use the term "hospital" separately from the term "critical access hospital". As far as CMS is concerned, a critical access hospital is not a hospital and the Medicare regulations have clearly made that distinction.

The current and proposed upper payment limit regulations clearly use the term hospital. In accordance with the Medicare and other federal regulations, hospital regulations do not apply to critical access hospitals. Therefore, since the customary charge limit applies to hospitals and does not specify critical access hospitals, inpatient and outpatient payment limits should not be applicable to the critical access hospitals.

We have successfully made this argument with the State of Washington when working with them to develop their critical access hospital payment methodology.

In our opinion, a distinction between "hospitals" and "critical access hospitals" should be written as part of the upper payment regulations for both inpatient and outpatient services. This distinction can be included with either §447.271 as a clarification, or as an exemption with the inpatient and outpatient exemptions at §447.272 and §447.321, respectively.

Furthermore, in our opinion, the critical access hospital regulations should be amended to prohibit States from imposing an upper payment limit on critical access hospital Medicaid payments. Although many states reimburse critical access hospitals utilizing a cost-based reimbursement methodology, they often place a lesser of cost-to-charge limitation or other forms of limitations on the reimbursement. This is inconsistent with Medicare reimbursement methodology and we believe the two methods should be consistent.

If you have any questions or require additional information, feel free to contact either myself or Michael R. Bell, CPA.

Sincerely,

MICHAEL R. BELL & COMPANY, PLLC

Konrad Capeller, CPA

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

Organization : svrd

Category : Physician Assistant

Issue Areas/Comments

GENERAL

GENERAL

see attachment

 #341

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

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

Submitter : Mr. Edward Fox **Date:** 03/19/2007

Organization : Squaxin Island Tribe

Category : Health Care Professional or Association

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

We support the position of the National Indian Health Board and the Northwest Portland Area Indian Health Board on this rule. We want CMS to understand that the NPAIHB is tribal organization that has authority, through its council appointed delegates, to take positions for the Portland Area of the Indian Health Service.

CMS-2258-P-343 **Cost LImit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership**

Submitter : Mr. F. Jerome Doyle **Date & Time:** 03/19/2007

Organization : EMQ Children and Family Services

Category : Other Health Care Provider

Issue Areas/Comments

Collection of Information Requirements

Collection of Information Requirements

See Attachment

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

#343

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

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