The Safety Net Coalition of the Georgia Alliance of Community Hospitals

March 19, 2007

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

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

Dear Ms. Norwalk:

The Safety Net Hospital Coalition of the Georgia Alliance of Community Hospitals (the Safety Net Coalition), on behalf of its member hospitals,[1] respectfully submits these comments on the Proposed Medicaid Regulation, CMS-2258-P, published by the Centers for Medicare and Medicaid Services (CMS) on January 18, 2007 (the Proposed Rule).

In sum, we strongly oppose the issuance of the Proposed Rule. Its impact on the State of Georgia would be devastating. It would upend the delicate balance of safety net support that has been carefully constructed over more than fifteen years to ensure that safety net and rural hospitals in our state are healthy, viable and able to meet the ever-growing demands of their increasingly diverse patient populations. Most of the signatory hospitals are submitting individual comment letters to CMS to detail the particular impact that the Proposed Rule will have in their communities and on their patients. The sum total of these and other letters from Georgia paint a bleak picture of a healthcare system starved of essential funding sources on which it has relied for years if the Proposed Rule goes into effect. We urge you to withdraw the Proposed Rule immediately.

The Safety Net Coalition is comprised of Georgia's largest safety net hospitals and health systems, almost all of which are owned by hospital authorities, which are governmental entities under Georgia law. Together, the Coalition's member hospitals constitute Georgia's safety net hospital system, ensuring access to care for those with nowhere else

[1] Member hospitals are Archbold Health System, Columbus Regional Medical Center, Floyd Medical Center, Grady Health System, Medical Center of Central Georgia, Medical College of Georgia, Northeast Georgia Health System, Phoebe Putney Memorial Hospital, and University Hospital.

to turn, supporting communities with essential services such as trauma care, burn care and neonatal intensive care, and providing the backbone of the emergency response systems in our communities. Many, but not all, of our members are teaching hospitals, playing an important role in ensuring that Georgia has an adequate supply of physicians, nurses and other professionals in the years to come.

And we provide all of these services under very tight fiscal constraints. We do not have the luxury of a huge commercial payer base from which we can cross subsidize losses on the uninsured. We absorb substantial unreimbursed costs of caring for uninsured – and increasingly, underinsured – patients. Most of us do not receive local taxpayer subsidies to supplement our other revenues; we have learned to manage to very tight revenues. In essence, in the absence of universal coverage, it is the members of the Safety Net Coalition that ensure that every Georgian has access to the care that he or she needs.

A. Defining a Unit of Government (§ 433.50)

The Proposed Rule takes the extraordinary step of dictating to state governments how to define sub-units of government. The statutory definition of a "unit of government" under Title XIX of the Social Security Act is "a city, county, special purpose district, or other governmental unit in the State."[2] This broad definition allows states to determine which entities within their jurisdictions are "governmental." The Proposed Rule significantly narrows the statutory definition, allowing only those governmental units that have "generally applicable taxing authority" to be considered a unit of government for purposes of contributing to the non-federal share of Medicaid expenditures.

The consequence of this narrow, federally-mandated designation of units of government is that states will no longer be able to rely on funds provided by local governmental entities to support their Medicaid programs, and instead will be forced to rely much more exclusively on state general revenues. Title XIX, by contrast, envisions a very substantial role for localities in funding state Medicaid programs. Section 1902(a)(2) allows states to derive up to *sixty percent* of the non-federal share of Medicaid expenditures from local sources. In Georgia, sixty percent of the non-federal share would be approximately $1.9 billion,[3] but the total local funding provided by hospitals is only $235 million, well under the statutory cap. Yet even this relatively small amount of local funding would be jeopardized under the Proposed Rule.

The loss of this local funding source would result in a huge budget gap for the Medicaid program, for which we have no other readily available replacement funding. We estimate, conservatively, that this narrow definition of a unit of government could deprive the program of $ 235 million in non-federal share funding, for a potential loss of total

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[2] 42 U.S.C. § 1396b(w)(7)(G).

[3] According to the Kaiser Family Foundation, total Medicaid spending in Georgia in 2005 was $7,817,603,408. The non-federal share of this amount (at a 60.44% matching rate for FY 2005) is $3,092,643,908, and 60% of that amount is $1,855,586,345.

(state and federal) funds of $603,639,625. Our healthcare system is not large enough to absorb a cut of that magnitude without a significant impact on access, quality and safety.

The direct impact on the member hospitals of the Safety Net Coalition and on our communities is substantial. As described in more detail in our individual comment letters, the loss of this funding would severely compromise our unique role in Georgia's healthcare system in multiple ways. It would undermine our ability to provide needed access to care for low income Medicaid and uninsured patients; it would undercut our efforts to reach deep into communities to provide preventative, primary, outreach and health education services to avoid the need for costly inpatient and specialty care; it would make it more difficult for us to invest in new disease management programs to improve health status and quality; it would make it extremely difficult for us to make the necessary capital investments to provide modern facilities and technologies that our patients deserve and expect, including critical health information technology; it would place at risk our role as first responders in an emergency, compromising our standby trauma and other capabilities; our teaching programs would suffer, as our ability to provide the necessary training and supervision would be jeopardized. In short, this regulation threatens to undo all of the substantial progress that we have made in recent years to improve the quality and availability of healthcare services for our communities, undercutting health policy goals that the Administration has frequently cited as at the top of its own healthcare agenda. CMS should more carefully consider the consequences of its proposals on local communities.

CMS should also carefully consider the indirect impact of its Proposed Rule, and its philosophical underpinnings. CMS is narrowing the definition of a "unit of government" to a very small universe of providers that meet its proposed standards, reflecting a restrictive view of how state governments can or should create political subdivisions. The history of hospital authorities in Georgia, however, demonstrates how cramped a view this definition is.

The development of hospital authorities can be traced back to the Hill-Burton Act, which first made federal funds available for the construction of hospitals.[4] The prospect of federal money triggered a number of states and communities to begin construction of new hospitals and many state legislatures, including Georgia's, determined that the establishment and operation of these hospitals should be placed in the hands of an independent authority. The mechanism Georgia chose for filtering Hill-Burton dollars into local communities was the hospital authority.

In 1964, the Georgia General Assembly passed the Hospital Authorities Law, which authorizes the establishment of a hospital authority in every county and municipal corporation in the state.[5] The statute also governs operation of hospital authorities and represents Georgia's legislative determination of how the state's public healthcare ought

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[4] John O'Looney, *Public Hospital Authorities for Public Purposes?* 88(2) Nat. Civic Rev. 123-132 (1999). *See also, Hill-Burton Hospital Survey and Construction Act: History of the Program and Current Problems and Issues,* U.S Gov. Pr. Office: Washington, D.C. (1973).

[5] O.C.G.A. § 31-7-70 et seq; *see also Richmond Cty. Hosp. Auth. v. Richmond Cty.*, 255 Ga. 183, 185 (1985).

to be organized. In particular, although hospital authorities operate independently of local government, each hospital authority is governed by a board appointed by or in cooperation with the hospital authority's sponsoring county or municipal corporation.[6]

By statute, hospital authorities "exercise public and essential governmental functions," and are given all the powers necessary and convenient to carry out and effectuate the purposes and provisions of the Hospital Authorities Law.[7] These powers include, in addition to those necessary to operate a hospital, the authority to issue bonds (revenue anticipation certificates) for essential public and governmental purposes, and the authority to exercise certain powers of eminent domain. Hospital authorities qualify for exemptions from income and property taxation as governmental entities, and are subject to the state's sunshine laws applicable to governmental entities.[8]

The Proposed Rule undercuts Georgia's longstanding efforts to develop a model for delivering a core governmental function – the provision of local public healthcare services – through a governmental structure tailored to Georgia's unique needs. The creation of hospital authorities has allowed Georgia to deliver healthcare services efficiently and effectively but through a public structure that ensures responsiveness to local needs. In structuring its hospital authorities, it never occurred to Georgia that the federal government would second-guess the state legislature and decide that the authorities are not public. It never occurred to Georgia that, absent a significant modification of Title XIX, entities determined to be public under state law would be barred from participating in funding local Medicaid expenditures. Had the Georgia General Assembly known the consequences of this devastating new policy, the hospital authority law may have been structured differently. But it is now far too late to redo governmental structures that have been the framework through which complex local healthcare systems have evolved. CMS' Proposed Rule ignores the reality of the multiple ways through which local communities have structured the delivery of public healthcare services.

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

The Safety Net Coalition also opposes the imposition of a cost limit on providers determined to be public under the new regulation. The limit would cut supplemental Medicaid payments for hospitals in Georgia by at least $43,336,977 (and possibly significantly more depending on how restrictively CMS will determine which costs would be allowable). As explained above, cuts of this magnitude would be deeply felt by our patients and our communities, with far-reaching implications for local healthcare systems. Medicaid reimbursement is not excessive; we struggle on a daily basis to meet our needs with current reimbursement levels. We simply do not have the resources to absorb additional cuts.

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[6] O.C.G.A. § 31-7-72(a).
[7] O.C.G.A. § 31-7-75.
[8] *Id.*

Moreover, CMS has not demonstrated the need for these cuts. If the agency's goal is simply to save federal dollars, it has chosen an odd means for doing so – cutting funds to governmental providers who are at the very core of the healthcare safety net in most states and who have the least financial capacity to absorb cuts. If the agency's goal is to improve the "fiscal integrity" of the Medicaid program, it has not explained how cutting funds to governmental providers will achieve this goal. Nor has it explained why its current efforts to more closely scrutinize state financing mechanisms are insufficient.

Georgia is a perfect example of why the cost limit is *not* needed to improve fiscal integrity. Georgia has relied on intergovernmental transfers (IGTs) from hospital authorities for years to help fund the Medicaid program. In 2005, however, CMS, through its administrative oversight of the program, raised concerns about the structure of our IGTs. Georgia appeared on various CMS lists of states whose IGTs potentially contained "recycling" mechanisms. Working with CMS, Georgia's Department of Community Health worked to restructure its IGTs to address the concerns CMS raised. As a result, the amount of our IGTs has been reduced to no greater than the non-federal share of the supplemental payments they support. In addition, CMS requested detailed information about the structure of the hospital authorities. Georgia responded by fielding a lengthy survey to all hospitals whose authorities were providing IGTs requesting information on their organizational structure. It is our understanding that these responses were shared with CMS, and CMS has allowed the hospital authorities to continue to contribute funds to the Medicaid program. As a result of this detailed review of Georgia's program, Georgia has been removed from the most recent CMS list of states with problematic IGTs and is now characterized as one of the states using IGTs appropriately. (In fact, there are only three states listed as having potential recycling problems on the latest CMS chart.)

Georgia, therefore, has clearly responded to CMS' concerns and now has an appropriate IGT program that does not compromise the fiscal integrity of the Medicaid program. Yet our hospital authorities would still be subject to the restrictive provisions of the proposed rule, either being deemed to be private and incapable of providing IGTs or being deemed public and therefore subject to a restrictive, hospital-specific cost limit. Either way, the members of the Safety Net Coalition will be subject to deep funding cuts that will impose deep pain on our patients and communities with no measurable improvement in fiscal integrity. We oppose the imposition of a cost limit on governmental providers.

Direct Payments for Medicaid Managed Care Patients

As you may know, Georgia Medicaid recently implemented a managed care program through which Medicaid recipients are being enrolled in Care Management Organizations (CMOs). Hospitals contract with the CMOs to provide care to their enrollees. Because of CMS' regulation prohibiting states from making direct payments to providers for services available under a managed care contract,[9] our supplemental Medicaid payments have been drastically reduced as CMO enrollment has gotten underway.

[9] 42 C.F.R. § 438.60.

There is an exception to this prohibition on direct provider payments for payments for graduate medical education (GME), provided capitation rates have been adjusted accordingly. Given the extreme funding cuts that will be imposed on many governmental providers by the imposition of the cost limit, the Safety Net Coalition urges CMS to reconsider the scope of the exception to the direct payment provision. We recommend that states be allowed to make direct Medicaid fee-for-service payments to providers for all unreimbursed costs of care for Medicaid managed care patients (not just GME costs). To avoid double dipping, states could be required to similarly adjust capitation rates to account for the supplemental payments. If reimbursement to governmental providers is going to be restricted to cost, it should include costs for all Medicaid patients, not just those in the declining fee-for-service population.

* * *

If you have any questions about these comments, please contact Rhonda Perry at perry.rhonda@mccg.org. We appreciate your consideration of our concerns.

Sincerely,

Rhonda Perry/cdh

Rhonda Perry
On Behalf of the Safety Net Coalition

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Regional Medical Center at Memphis

March 19, 2007

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

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

Dear Administrator Norwalk:

The Regional Medical Center at Memphis (The MED) is pleased to submit the attached comments expressing our serious concern about the impact of the above-referenced Proposed Rule on the nation's health system and The MED. Our Hospital serves as a regional tertiary care and safety net hospital for a one-hundred and fifty (150) mile radius, one of the poorest regions in the nation. In the wake of changes to the TennCare program, The MED has seen its percentage of charity go from a monthly average of around 24% to a monthly average of over 30%, with reductions to commercially insured/managed care patients in addition to those resulting from the TennCare cuts.

The attached comments on behalf of The MED detail many specific concerns about the Proposed Rule. However, please be aware that our primary recommendation is that CMS withdraw the Proposed Rule and work with the Congress and with state and local stakeholders to develop policy alternatives that would strengthen—not undermine—the nation's health safety net.

The MED appreciates the opportunity to submit these comments. If you have any questions, please contact me at (901) 545-8223.

Very truly yours,

Mary E. Whitaker

Mary E. Whitaker
Vice-President Legal and Governmental Affairs
Regional Medical Center at Memphis
877 Jefferson Avenue
Memphis, TN 38103

March 19, 2007

COMMENTS BY THE REGIONAL MEDICAL CENTER AT MEMPHIS ON PROPOSED RULE: CMS-2258-P-Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership

INTRODUCTION

The Regional Medical Center at Memphis urges the Centers for Medicare and Medicaid Services (CMS) to withdraw Proposed Rule CMS-2258-P (the Proposed Rule). The Proposed Rule is not grounded in law and is contrary to the will of the majority of Members of Congress. The State of Tennessee's TennCare program would suffer greatly if the proposed rule is to become final, as it is anticipated that the applicable losses of only one hospital in the group of thirty-one (31) hospitals would be eligible for federal matching money as certified public expenditures (CPE). This would result in a huge gap in funding for the TennCare program, with no proposed substitution in funding. In addition, The MED's regular TennCare reimbursement of $72,472,435 in fiscal year 2006, and its Essential Access Hospital funding of $29,160,634 in fiscal year 2006 would be jeopardized. The MED's continued participation in the Arkansas and Mississippi supplemental Medicaid programs would likewise be threatened since both programs rely upon Intergovernmental Transfers (IGT's). The loss of these funding sources would create a devastating blow to the entire health care delivery system in the Mid-South region, one of the poorest regions in the country.

COMMENTS RELATED TO SPECIFIC PROVISIONS

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

The MED objects to the new cost limit on Medicaid payments to government providers under the Proposed Rule as being contrary to law and public policy. Congress has already determined that federal support is needed and that states may use their Medicaid programs to provide it. Above-cost Medicaid payments based on Medicare rates have been part of the Medicaid payment system for years. Congress has specifically rejected CMS's proposals to impose provider-specific cost-based payment limits during its

budgetary deliberations in Fiscal Years 2005 and 2006. The cost limits would violate federal law in at least four respects. First, it will prevent states from adopting payment methodologies that are economic and efficient and that promote quality and access in contravention of Section 1902(a)(30(A) of the Social Security Act (SSA); second, it defies simplicity of administration and ignores the best interests of Medicaid recipients that states are required to safeguard pursuant to Section 1902(a)(19); third, it would violate Section 705(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 by adopting upper payment limits that are not based on the proposed rule announced on October 5, 2000; and fourth, it would prohibit states from adopting prospective payment systems for their governmentally-operated federally qualified health centers and rural health clinics as required by Section 1902(b) of the SSA. CMS should not modify the current upper payment limits.

B. Defining a Unit of Government (Section 433.50)

The MED urges CMS to reconsider its proposed new definition of a "unit of government." The proposal would usurp the traditional authority of states to identify their own political subdivisions and exceed the authority provided in the Medicaid statute.

The most onerous requirement in the proposed law relates to taxing authority. CMS has exceeded its statutory authority in adopting a definition of a "unit of government" more restrictive than that established in Title XXI of the SSA. Section 1903(w)(7)(G) defines a "unit of local government," in the context of contributing to the non-federal share of Medicaid expenditures, as "a city, county, special purpose district, or other governmental unit in the State." 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.*" (Proposed 42 C.F.R. section 433.50(a)(1)(i) (emphasis added). Congress never premised qualification as a unit of government on an entity's access to public tax dollars. Rather, Congress' formulation, which includes an "other governmental unit in the State," provides appropriate deference to the variety of governmental structures into which a state may reorganize itself. Moreover, Section 1903(d)(1) of the SSA requires states to submit quarterly reports wherein the states must identify "the amount appropriated or made available by the State and its political subdivisions." Nowhere in this provision is the requirement that the referenced political subdivisions must have taxing authority. In creating a new federal regulatory standard to

determine which public entities within a state are considered to be "units of government" and which are not, CMS is encroaching on a fundamental reserved right of states to organize their governmental structures as they see fit. This federal intrusion into the operation and administration of state government violates the very basis of the Medicaid program—the federal-state partnership and the federalism principles on which it rests. Accordingly, The MED urges CMS to defer to states regarding the definition of a unit of government.

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

The MED opposes the restrictions related to the source of the public funds used for the state share of Medicaid funding. Traditionally, states have been able to rely on the public funds contributed by governmental entities, regardless of the source of the public funds. The Proposed Rule rejects the idea that all funds held by a unit of government are governmental. Rather, the preamble to the proposed rule would establish a hierarchy of public funds, and only funding derived from taxes would be allowed to fund Medicaid expenditures while those derived from other governmental functions (such as providing patient care services through a public hospital) would be rejected. The preamble states that, with respect to intergovernmental transfers, "the source of the transferred funds (must be) State or local tax revenue (which must be supported by consistent treatment on the provider's financial records)." (72 Fed. Reg. at 2238). While the proposed regulatory language itself refers only to "funds from units of government" without specifying the source of those funds, the preamble language clearly indicates CMS' intent to further restrict funding for state Medicaid programs by imposing the additional requirements that local funds be derived from tax revenues.

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

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Association of
American Medical Colleges
2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0400 **F** 202 828 1125
www.aamc.org

March 19, 2007

Via Hand Delivery

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-2258--P**

Dear Administrator Norwalk:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership."* 72 Fed. Reg. 2236 (January 18, 2007). The Association represents nearly 300 general acute nonfederal major teaching hospitals and health systems. The Association also represents all 125 accredited U.S. allopathic medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation's medical students and residents.

We agree with the American Hospital Association (AHA) and the National Association of Public Hospitals and Health Systems (NAPH) that the proposed rule should be withdrawn. Its sweeping changes, many of which are not authorized under the Medicaid statute, would seriously compromise an already fragile safety net system—of which teaching hospitals are key participants—that ensures access and quality care for Medicaid beneficiaries and uninsured persons. The proposed rule estimates that the changes would result in $3.9 billion in federal savings over five years, although the President's FY 2008 budget proposal estimates the savings at $5 billion. While such numbers are daunting in and of themselves, based on conversations with our members we believe the actual overall reduction in Medicaid payments would be much higher.

The proposed rule provides neither data nor rationales justifying the restrictions the Agency seeks to impose. We urge CMS to work with Congress to determine whether, and to what extent, policy changes to the Medicaid program are needed. If

notwithstanding the widespread opposition CMS moves forward with a final rule, the Agency should allow for a sufficient transition period that allows both states and providers to adjust their long-standing approved practices to ensure that the needs of Medicaid and other patients are met during the adjustment period.

In the remainder of this letter, we discuss the important relationship between state Medicaid programs and teaching hospitals and their clinical faculties. We then provide comments on specific aspects of the proposed rule.

MEDICAID AND TEACHING HOSPITALS AND THEIR CLINICAL FACULTY

Major teaching hospitals and their clinical physician faculty take seriously their commitment to treating the nation's poor by providing a disproportionate amount of healthcare to Medicaid recipients and uninsured patients while maintaining their core missions of education, research and innovative patient care. While they represent only 6 percent of all hospitals, about 25 percent of Medicaid discharges are from major teaching hospitals. In 2004, these institutions provided nearly half of all hospital charity care in the country. Medicaid accounts for 16 percent of the healthcare provided by faculty practice groups, compared to only 10 percent provided by community-based multi-specialty groups.

In addition to being important participants in the nation's health care "safety net," teaching hospitals have unique roles that extend beyond the normative patient care services. These include being sites for the clinical education of all types of health professional trainees; providing environments in which clinical research can flourish; and being sources of specialized, unique, and referral/standby services. Because of their education and research missions, teaching hospitals typically offer the newest and most advanced treatments and technologies, and often care for the nation's sickest and most complex patients. Today, major teaching hospitals also are looked to as front-line responders in the event of a biological, chemical or nuclear attack and they are constantly refining their capabilities to fulfill this role.

Undertaking these missions has important financial consequences. Thus, it is not surprising that the aggregate total margin for the nation's major teaching hospitals is consistently and significantly below that of other hospital groups. In some years, the margins have hovered near zero. In 2004, the most recent and most complete data available, the aggregate total margin for major teaching hospitals (those with an intern/resident-to-bed (IRB) ratio of 0.25 or more) was only 3.4 percent; the average and median total margins were 1.5 percent and 2.4 percent respectively. By contrast, the aggregate total margin for other teaching hospitals was 5.0 percent, and 4.7 percent for nonteaching hospitals.

State Medicaid programs and the academic medical community have worked together over many years to ensure that the health care needs of Medicaid patients are met while allowing teaching hospitals and their faculty to also fulfill their other missions.

Consequently, it is important that changes to the Medicaid program are viewed within this context. We are concerned that the totality of the changes in the proposed rule, if finalized, would significantly upset the delicate balance of resources that teaching hospitals rely on to fulfill their patient care and other missions.

THE PROPOSED COST LIMIT ON MEDICAID PAYMENTS TO PUBLIC PROVIDERS

The proposed rule would limit reimbursement for government-operated hospitals to each entity's cost of providing Medicaid services to Medicaid recipients. Currently, state Medicaid programs have "upper payment limits (UPLs)" which, for government-operated providers, are based on what Medicare would pay for the same services and are calculated at an aggregate level. This allows states the flexibility to vary the amount paid to hospitals within the category, so long as the aggregate limit is not exceeded.

Over time, Medicaid has moved away from cost-based reimbursement because it does not provide incentives for efficient performance. Increasingly, states have followed the Medicare model and established prospective payment systems for their Medicaid programs. This approach encourages efficiency by rewarding hospitals that constrain their costs below the payment amount. Returning to cost-based limits would be returning to an ineffective policy that has been soundly rejected not only by Medicare but by many private payers as well.

CMS asserts in the proposed rule that facility level cost limits are necessary because providers "use the excess of Medicaid revenue over cost to subsidize health care operations that are unrelated to Medicaid, or they may return a portion of the supplemental payments to the State as a source of revenue." (72 Fed. Reg. at 2241). However, the proposed rule presents no data or other facts to support its assertion. Moreover in court filings, the Agency has explicitly recognized the value of allowing states flexibility to direct higher payments to certain hospitals having special needs (See AHA Comment Letter at 5-6).

The proposed rule position also is at odds with the current policy that establishes an aggregate UPL for private hospitals. The policy is the right policy for private hospitals and there is no reason to establish a separate and unequal policy for government providers.

Finally, section 705(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) directed CMS to apply an "aggregate upper payment limit to payments made to government facilities that are not state-owned or operated facilities." The proposed rule is in direct contradiction to this Congressional mandate and thus this proposal must be rescinded.

DEFINITION OF "COSTS" FOR PURPOSES OF APPLYING A FACILTY-SPECIFIC LIMIT

The proposed rule does not address specifically what costs would be included in the determination of the facility specific-cost limits. We assume, but would like CMS to confirm, that such costs include all those costs necessary to operate the hospital. For teaching hospitals, such costs include those associated with graduate medical education.

The President's fiscal year 2008 budget request includes an administrative proposal to eliminate federal Medicaid matching payments for graduate medical education (GME) funding . Along with Medicare, Medicaid is a key contributor in helping to offset some of teaching hospitals' GME costs. As of 2005, Medicaid programs in 47 states and the District of Columbia provided funds for GME costs.[1]

We strongly oppose this budgetary proposal. We also question whether the Administration can implement such a proposal without explicit statutory direction. If the Administration does choose to raise this as a regulatory issue, we believe it would be necessary for CMS to issue a distinct and explicit notice and comment rulemaking process.

THE PROPOSED RE-DEFINITION OF "UNIT OF GOVERNMENT"

The proposed rule would redefine the phrase "unit of government" by requiring that:

- The health care provider has generally applicable taxing authority; or
- The health care provider is able to access funding as an integral part of a governmental unit with taxing authority (that is legally obligated to fund the governmental 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.

Source: 72 Fed. Reg. at 2240.

We agree with comments by the AHA and NAPH that this redefinition is both incompatible with and contrary to the Medicaid statute.

Such a narrow redefinition would drastically limit the number of providers that may participate in the state financing of Medicaid through allowable intergovernmental transfers (IGTs) or certified public expenditures (CPEs). It also would pre-empt long-standing state authority to define governmental entities.

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[1] Henderson, Tim. "Medicaid Direct and Indirect Graduate Medical Education Payments: A 50 State Survey (November, 2006).

Perhaps most importantly, this proposal runs counter to the trend of states and their associated hospitals to identify ways that maintain important state-provider relationships while allowing such providers to pursue enhanced efficiencies that are unobtainable under traditional state relationships. By reorganizing the governance structures, a number of public teaching hospitals have been given the autonomy and flexibility to implement efficiency and cost-containment measures that yield hospital and program savings, and often result in improved access and higher quality care for patients.

NAPH's comments eloquently and articulately describe such restructuring arrangements. They also discuss how these reconfigurations enhance the fiscal viability of the health care safety net, as well as improve access, quality, program responsiveness and public accountability. While perhaps not fully contemplated by the Agency, we believe CMS's proposal would result in an operational retrenchment of no benefit to states, hospitals and, most importantly, Medicaid beneficiaries.

We urge the Agency to withdraw the proposed redefinition.

PROPOSED LIMITATIONS ON INTERGOVERNMENTAL TRANSFERS (IGTS) AND CERTIFIED PUBLIC EXPENDITURES (CPEs)

If finalized, in combination with its redefinition of "unit of government," the proposed rule would drastically restrict states' abilities to use allowable IGTs to finance the non-federal share of Medicaid payments. Specifically, the proposed rule preamble states that where a governmentally operated health care provider has transferred the non-Federal share in order to receive matching federal payments, the state must be able to demonstrate that "the source of the transferred funds is State or local tax revenue (which must be supported by consistent treatment on the provider's financial records)." (72 Fed. Reg. at 2238).

In the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234), Congress modified the use of provider taxes and donations to finance the non-federal share of Medicaid payments, but explicitly made clear that those restrictions did not affect IGTs (see Social Security Act 1903(w)(6)(A)). Given Congress' clear intent to protect states' uses of IGTs and CPEs as financing mechanisms, such direction must come from Congress and should not be unilaterally implemented through regulation.

We also have serious concerns on the proposed rule's treatment of CPEs, specifically the proposal to impose new documentation standards including the limitation to cost-based policies. We believe that there are less burdensome ways to ensure the accuracy of Medicaid claims submitted for purposes of CPEs.

EFFECTIVE DATE AND TRANSITION PERIOD

As stated above, we believe the prudent course of action is for CMS to withdraw this proposed rule and work closely with the Congress and the health care community to address Agency concerns about current Medicaid policies. However, if CMS decides to move forward with some form of final regulation, we believe that a) the effective date for the new cost limit, unit of government definition, and limitations on IGTs and CPEs must be extended beyond September 1, and b) the final rule must be accompanied by a significant transition period. Both states and providers will need time to accommodate to the new policies and find alternative funding sources to minimize access and financing problems. We support NAPH's recommendation that such a transition period be 10 years.

CONCLUSION

The Medicaid program and teaching hospitals have a long history that has helped to ensure that poor and uninsured patients have access to high quality care. The proposed rule runs the grave risk of unraveling this fragile structure. We urge the Agency to rescind the proposed rule and work with states and providers alike to initiate improvements to the Medicaid program that both strengthen it and ensure its long term financial viability.

If you have questions concerning these comments, please do not hesitate to contact me or Karen Fisher, Senior Associate Vice President. We both may be reached at (202) 828-0490.

Sincerely,

Robert M. Dickler
Senior Vice President
Division of Health Care Affairs

Indiana Hospital&Health Association

One American Square ▪ P.O. Box 82063
Indianapolis, Indiana 46282
317/633-4870 ▪ 317/633-4875 fax

MAR 19

Timothy W. Kennedy
E-Mail: tkennedy@hallrender.com

March 19, 2007

VIA HAND DELIVERY

Centers for Medicare & Medicaid Services ("CMS")
Department of Health and Human Services
Attn: CMS-2258-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-2258-P: 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:

The Indiana Hospital and Health Association ("IHHA") understands the importance of ensuring the financial viability and integrity of the Medicaid program. Over the years, the IHHA has worked collaboratively with Indiana's Office of Medicaid Policy and Planning to implement CMS's (and HCFA's) numerous Medicaid funding reforms. The IHHA believes that, by any objective measure, Indiana has historically taken a conservative approach to funding the non-federal share of its Medicaid expenditures. With this in mind, we appreciate this opportunity to comment upon the above-referenced proposed rule and the serious consequences it may have for many Indiana hospitals.

Background

Indiana has thirty-six (36) "county hospitals" and one (1) "municipal" hospital.[1] Most of these hospitals are located in rural areas – all of them provide health care to underserved populations. Since 1998, these hospitals have received annual Medicaid disproportionate share payments. In addition, since 2003 these hospitals have received annual "upper payment limit" payments for non-state governmental hospitals. These annual payments are the lifeblood of a number of these hospitals.

[1] These numbers do not include the municipal corporation known as the "Health and Hospital Corporation of Marion County".

More to the point, each hospital, based upon its status as a unit of government under Indiana statutory law, funds the non-federal share of its own disproportionate share payment and upper payment limit payment. The funding of the non-federal share of these payments, and the hospitals' receipt and retention of these payments, occurs without the abusive practices that CMS seeks to stop through the proposed rule.

Even though these hospitals do not engage in the abusive practices targeted by CMS, it appears that the proposed rule may nevertheless penalize the hospitals by prohibiting them from funding the non-federal share of their disproportionate share payments and upper payment limit payments. Such an outcome, for all practical purposes, will result in the hospitals losing those crucial payments forever.[2] In an effort to help safeguard these hospitals, the IHHA respectfully submits the comments set forth below.

Comments

1. Why Must a Unit of Government Have Taxing Authority?

The proposed rule defines a "unit of government" as a governmental unit that has generally applicable "taxing authority". Under the proposed rule, a health care provider may be a unit of government only if it is operated by a unit of government (as evidenced by the provider's taxing authority or by the provider's status as an integral part of a governmental unit with taxing authority).

In contrast to the approach taken in the proposed rule, Indiana's county hospitals and municipal hospital are not operated by units of government. Instead, under Indiana statutory law, they are units of government. The following points, which are supported by Indiana statutory provisions, confirm the hospitals' status as units of government:

- Although a county hospital is established by an order of the county's commissioners, the governing board of a county hospital is separate from the county government itself. As stated in statute, the governing board of a county hospital is, itself, "a body corporate and politic". Similarly, the governing board of the municipal hospital is recognized under statute as "a separate legal entity" from the city government that authorized the establishment of the municipal hospital.

- The members of a county hospital's governing board are appointed by publicly elected officials, typically county commissioners and the county council. For some county hospitals, the applicable state statute requires the county commissioners to serve on the hospitals' governing boards. The members of the municipal hospital's

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[2] If the hospitals are prohibited from funding the non-federal share of their disproportionate share payments and upper payment limit payments, it is reasonable to assume that the State of Indiana will not step in and fund the non-federal share on the hospitals' behalf.

governing board are appointed by the mayor, a member of the county council, and one of the county commissioners.

- In all material respects, the activities of the county hospitals and the municipal hospital are governed by Indiana statutes.

- The employees of the county hospitals and the municipal hospital are public employees entitled to public employee benefits.

- The county hospitals and the municipal hospital are subject to Indiana's tort claims act, which only applies to units of government.

- The county hospitals and the municipal hospital are subject to Indiana's "open records" and "open meetings" laws, which govern access to public records and public meetings.

- Perhaps most importantly for purposes of these comments, the funds of the county hospitals and the municipal hospital are "public funds" and such hospitals are subject to annual audits by Indiana's State Board of Accounts.

The indicia listed above (which is not exhaustive) clearly satisfy the most commonly held notions of a "unit of government". With respect to the proposed rule, however, the county hospitals and the municipal hospital do not have taxing authority. Furthermore, for purposes of these comments, the IHHA is taking the position (but not conceding) that the independent status of these hospitals will make it difficult for CMS to determine that they are sufficiently integrated within a unit of government that possesses taxing authority. All of this begs an important question: why must "taxing authority" be dispositive of whether an entity is a "unit of government" under the proposed rule?

A. The Applicable Statutes Do Not Require Taxing Authority

The IHHA respectfully contends that none of the applicable statutes requires a unit of government to have taxing authority in order fund the non-federal share of Medicaid payments. Clearly, Section 1902(a)(2) of the Act does not require the States to use only funds transferred from units of government with taxing authority. A review of the various funding-related regulations promulgated under Section 1902(a)(2) throughout the years quickly reveals that Section 1902(a)(2) has never been given such a narrow interpretation.[3]

Regarding Section 1903(w) of the Act, it appears that its provisions have little application concerning whether the non-federal share of Medicaid payments must be funded by local units of government with taxing authority. To be sure, Section 1903(w) of the Act addresses taxes – but only health care related taxes. Also, Section 1903(w)(6)(A) prevents the Secretary from restricting the States' use of tax proceeds transferred from units of

[3] See 42 C.F.R. § 446.185; 42 C.F.R. § 432.60; 42 C.F.R. § 433.45; 42 C.F.R. § 433.51.

government – but the fact that the Secretary does not have the authority to restrict the States' use of tax proceeds transferred from units of government does not mean that the Secretary *does* have the authority to restrict the States' use of public funds transferred from units of government without taxing authority (at the very least, nothing in Section 1903(w) compels the Secretary to restrict the States' use of public funds transferred from units of government without taxing authority).[4]

In sum, it is fair to question the policy underpinnings of the proposed rule's restriction on the States' use of public funds transferred from units of government that do not have taxing authority, especially given the resulting serious and unwarranted financial losses that may befall hospitals such as those described above.

B. Public Funds, Not Taxing Authority

CMS can surely realize its policy aims without penalizing governmental hospitals such as those described above. It is not clear to the IHHA how permitting the States to use public funds transferred from units of government without taxing authority (including governmental hospitals) would thwart any of CMS's stated goals – especially given the proposed rule's provisions regarding the retention of payments, as well as the long standing prohibition in 42 C.F.R. § 433.51(c) against using federal dollars to match other federal dollars. Thus, the IHHA respectfully urges CMS to forgo using taxing authority as a limiter on which units of government can transfer funds to the States. Instead, CMS should continue to permit the States to use public funds transferred from units of government, even those without taxing authority (such as governmental hospitals), as the non-federal share of Medicaid payments.

2. Imposing a Cost Limit On Government Providers Will Undermine Economy and Efficiency

Contrary to CMS's position, limiting governmental providers' reimbursement to cost will not improve the economy and efficiency of the Medicaid program. The limitation would remove the States' flexibility to maximize the impact of their limited Medicaid funds when they direct greater payments to providers in selected underserved or impoverished areas. Many States also maximize the benefits of their limited Medicaid DSH dollars by carefully coordinating their DSH payments with an allocation of funds available under the States' upper payment limits for non-state governmental hospitals. The proposed rule's limit will effectively preclude the States from pursuing these efforts, and similar efforts, all of which are undertaken in order to make the best use of limited Medicaid dollars. It necessarily follows that the limit will undermine the Medicaid program's economy and efficiency.

[4] HCFA essentially confirmed this fact in its preamble to the rules implementing Section 1903(w), where it said that States may continue to use funds transferred from any government source, except funds derived from taxes or donations made impermissible by Section 1903(w). See 47 FR 55118, 55119 (November 24, 1992).

It is also fair to question whether the limit is needed to protect the financial integrity of the Medicaid program. In the IHHA's view, the proposed rule's provisions regarding the retention of payments should sufficiently safeguard the program's financial integrity, so that limiting the reimbursement to governmental providers in not necessary.

3. "Nonpublic Providers" In Section 1903(w)

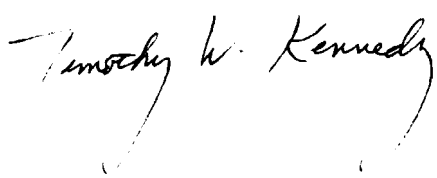
Section 1903(w) refers to "nonpublic providers". If CMS adopts the proposed rule's definition of a "unit of government", the IHHA respectfully requests that CMS clarify its interpretation of "nonpublic provider".

4. Effective Date of Final Rule

If CMS proceeds with the material aspects of the proposed rule, the IHHA respectfully requests that the final rule's effective be set at least one year following the publication of the final rule. The rule would no doubt require substantial work at the state level, including remedial state legislative action. At least one year will be required to accommodate properly the changes brought about by the rule.

Sincerely,

INDIANA HOSPITAL&HEALTH ASSOCIATION



Timothy W. Kennedy
Counsel

cc: Kenneth G. Stella, President
Indiana Hospital&Health Association
Allison D. Wharry, Director of Health Policy
Indiana Hospital&Health Association
John C. Render, Esq.

MOREHEAD
MEMORIAL·HOSPITAL

March 8, 2007

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

Re: (CMS-2258-P) Medicare Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (Vo. 72, NO. 11), January 18, 2006

Dear Ms. Norwalk:

I am writing on behalf of the 600+ employees of Morehead Memorial Hospital in strong opposition to the proposed CMS rule CMS-2258-P which will impose new restrictions on how states fund their Medicaid programs.

The proposed rule represents a substantial departure from long-standing Medicaid policy and will result in devastating reductions in Medicaid funding to our state's hospitals, totaling $313,738,388. The effect on Morehead Memorial Hospital alone is estimated to be $434,170. To put this into perspective, our operating margin for FY 2006 was $1,054,997. The proposed reduction would reduce our profits by 41%. We cannot sustain our hospital long term on such slim margins.

The proposed rule puts forward a new and restrictive definition of "unit of government." In order for a public hospital to meet this new definition, it must demonstrate that it has generally applicable taxing authority or is an integral part of a unit of government that has generally applicable taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Nowhere in the Medicaid statute, however, is there any requirement that a "unit of government" have "generally applicable taxing authority." This new restrictive definition would disqualify many long-standing truly public hospitals from certifying their public expenditures. There is no basis in federal statute that supports this proposed change in definition.

Existing federal Medicaid regulations allow North Carolina hospitals to receive payments to offset a portion of the costs incurred when caring for Medicaid patients. Even with these payments, however, hospital Medicaid revenues for most North Carolina hospitals still fall significantly short of allowable Medicaid costs. If the proposed rule is implemented and, as a result, this important hospital funding stream is eliminated, those losses would be exacerbated. Hospitals would be forced either to raise their charges to insured patients or to reduce their costs by eliminating costly but under-reimbursed

117 East Kings Highway
Eden, North Carolina 27288-5201
TEL 336.623.9711
www.morehead.org

services. The first choice would raise health insurance costs by an estimated four percent. The second would eliminate needed services, not just for Medicaid patients but also for the entire community. Eliminating those services likely would result in the elimination of almost 3,000 hospital jobs. That reduced spending and those lost jobs would be felt in local economies and the resulting economic loss to the State of North Carolina has been estimated at over $600 million and almost 11,000 jobs.

We strongly oppose the proposed rule and urge CMS to permanently withdraw it. If these changes are implemented on September 1, 2007 as proposed, we would have no time to react and plan in order to even partially manage such a significant loss of revenue. The result would have a long lasting negative impact on our continued ability to provide high quality care to all of our citizens. We depend on adequate funding from Medicaid and all other government payers to continue our mission.

Thank you for your attention to this important matter.

Sincerely,

Robert A. Enders, Jr.
President

RAEjr:www

cc: Senator Elizabeth Dole
Senator Richard Burr
Congressman Brad Miller

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ahca
American Health Care Association

1201 L Street, NW, Washington, DC 20005-4046
Main Telephone: 202-842-4444
Main Fax: 202-842-3860 2nd Main Fax: 202-289-4253
Writer's Telephone: 202-898-2858
Writer's E-Mail: byarwood@ahca.org
www.ahca.org

March 15, 2007

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

MAR 14 2007

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

Dear Ms. Norwalk: Leslie

The American Health Care Association (AHCA) appreciates the opportunity to comment on the proposed rule, *Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure The Integrity of Federal-State Financial Partnership*, CMS-2258-P, 72 Fed. Reg. 2236 (January 18, 2007).

AHCA is the nation's leading long term care organization. AHCA and its membership are committed to performance excellence and Quality First, a covenant for healthy, affordable and ethical long term care. AHCA represents more than 10,000 non-profit and proprietary facilities dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to more than 1.5 million of our nation's frail, elderly and disabled citizens who live in nursing facilities, assisted living residences, subacute centers and homes for persons with mental retardation and developmental disabilities.

Background On The Proposed Rule

In the proposed rule, the Centers for Medicare and Medicaid Services (CMS) addresses problems that the agency has identified in the Medicaid federal financial matching process. The proposed rule would restrict the way states are permitted to generate funding for their share of Medicaid costs. CMS is targeting certain current practices that use intergovernmental transfers (IGTs) and certified public expenditures (CPEs) in a manner that, according to CMS, draws down more federal matching dollars than warranted.

According to CMS, the rule is designed to ensure that Medicaid payments to governmentally operated health care providers are based on actual costs and that the financing arrangement supporting those payments is consistent with the statute. CMS indicates that as it has examined Medicaid financing arrangements across the country, it has found that many States make supplemental payments to governmentally operated providers that are in excess of cost. These providers, in turn, use the excess of Medicaid revenue over cost to subsidize health care operations that are unrelated to Medicaid, or they may return a portion of the supplemental payments to the state as a source of revenue.

The proposed rule would clarify that entities involved in the financing of the non-federal share of Medicaid payments must be a unit of government; clarify the documentation required to support a certified public expenditure; limit reimbursement for health care providers that are operated by units of government to an amount that does not exceed the provider's cost; require providers to receive and retain the full amount of total computable payments for services furnished under the approved State plan; and make conforming changes to provisions governing the State Child Health Insurance Program (SCHIP).

Executive Summary

AHCA acknowledges and respects the government's responsibility to enforce the fiscal integrity of all federal programs. Public programs that spend public dollars should operate with transparency, integrity, and accountability. We do not support subsidizing health care operations that are unrelated to Medicaid or returning a portion of supplemental payments to the state as a source of revenue. However, in seeking fiscal integrity, and without adequate analysis of the problem or supporting data, the proposed rule rips a considerable amount of funding away from states. Indeed, the proposed rule is an unsupportable piecemeal fix that could have a disastrous effect on **all** health care providers by removing considerable funds from the system -- an act which can prolong and worsen Medicaid fiscal problems.

Fiscal integrity is crucial and must be maintained. However, it is a concept that must be integral to every aspect of a public program such as Medicaid. Fiscal integrity is missing when Medicaid funds are diverted for non-Medicaid purposes, but it is also missing when Medicaid program payments to providers of services are driven for the most part -- or solely -- by state budgets; and fiscal integrity is also missing when CMS approves a state plan amendment that will result in inadequate Medicaid rates and under-funding of the program. The problems with Medicaid, including fiscal integrity, are systemic.

The proposed rule "fix" does not address systemic problems and will create more difficulties than it will solve. AHCA has several major concerns. CMS estimates this proposed rule will result in $3.87 billion in savings over five years. That is an enormous loss to the system, but the impact may be even worse. From the perspective of the long term care sector, a key weakness in this proposed rule is CMS's demonstrable uncertainty of the impact of the rule. CMS does not know the extent of the potential harm to the government nursing facilities **nor to the overall system** since it lacks data and information as to the impact of piecemeal fix set forth in the proposed rule.

In short, CMS' impact analysis is fatally flawed and cannot support the legitimacy of the proposed rule. It is simply gutting the program without a reasonable basis for the nature or extent of the fix. As an illustration of the potential harm of such an action, we offer, later in the letter, information and supportive data on the precarious nature of Medicaid reimbursement for nursing facilities -- a state of affairs that could precipitously worsen as states struggle to cope with lost funds.

Lastly, CMS insists that private providers will generally be unaffected by the proposed rule. As we have already indicated, all providers will be affected by the loss of funds, but in addition, CMS itself admits that states may have to change reimbursement or financing methods which would affect all providers. There is considerable uncertainty as to the overall effect CMS' proposed directive regarding cost limited reimbursement and UPLs would have on state Medicaid reimbursement models. This question is particularly relevant to those models following a growing trend toward pricing systems now prevalent in Medicare or utilizing an incentive system for high quality services known as pay for performance.

In light of the forgoing, AHCA respectfully requests withdrawal of the proposed rule. Rather, CMS should work with state government representatives and nursing home and hospital providers to work out a broad regulatory framework that would help to ultimately provide consistency and stability to the Medicaid program, assure adequate payment for Medicaid providers, provide access to quality health care, and meet the highest standards of fiscal integrity.

The following are details regarding our concerns expressed above.

Discussion

CMS' Impact Analysis is Flawed

As indicated above, CMS estimates this proposed rule will result in $3.87 billion in savings over five years. However, CMS clearly is uncertain about this impact estimate and admits a lack of adequate data to support the proposed regulation. CMS provides a brief explanation of how it estimated the reduction in federal Medicaid outlays resulting from the proposed rule. The estimates were broad in the extreme, and CMS itself acknowledged this:

> There is uncertainty in this estimate to the extent that the projections of IGT spending may not match actual future spending and to the extent that the effectiveness of this policy is greater than or less then assumed. 72 Federal Register at page 2245.

In order for CMS to conduct an adequate impact analysis for this proposed rule, it should examine cost report information on the governmental providers that make up the group on which IGT dollars are claimed in each state to quantify the impact of the difference between the UPL and cost. In addition, CMS should collect state and conduct an adequate impact analysis before the rule goes into effect. However, CMS made no attempt to provide acceptable impact estimates -- state by state -- and place these

estimates in the context of the overall budget and funding problems. In response to an AHCA request for state data, CMS indicated that it did not have state data.[1]

Proceeding with a proposed rule -- the effectiveness of which may be greater or less than assumed -- indicates that the problem to be addressed by the regulation (the very basis of the regulation) is not understood and has not been adequately analyzed and quantified. This is not good policy. In addition, it is not good law.

Indeed, the Administrative Procedure Act's standard of review, 5 U.S.C. §706, provides that before an agency finalizes a rule it "must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made." *Motor Vehicle Manufacturers Ass'n. v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29, 43, 103 S.Ct. 2856, 77 L.Ed.2d 443 (1983), quoting *Burlington Truck Lines, Inc. v. United States,* 371 U.S. 156, 168, 83 S.Ct. 239, 9 L.Ed.2d 207 (1962), emphasis added. In the present circumstances, CMS lacks the relevant data and thus lacks a reasonable basis for the rule.

In addition, while referencing the applicability of Executive Order 12866, it has paid scant attention to its imperatives. The Executive Order 12866 directs agencies:

> to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). 72 Federal Register at page 2243.

We do not believe that CMS assessed all the costs of the proposed rule, especially the cost of the ensuing sudden administrative nightmare of dismantling mechanisms and gutting programs or services. Further, it did not select a regulatory approach that considered potential economic, environmental, public health and safety effects, distributive impacts and equity. It did not assess the economic impact on states and their Medicaid programs. It did not consider public health and safety effects resulting from drastically altering modes of financing care for Medicaid beneficiaries. In terms of equity, it did tout the fact that all providers would be paid the same which is equitable and desirable – but only when achieved in a reasonable and rational fashion that does not precipitate a crisis resulting in harm to all providers and to the beneficiaries in their care.

In the preamble, CMS fails to acknowledge the larger financial issues facing states and their Medicaid programs. In short, the proposed rule does not provide a reasonable roadmap to the desired end of fiscal integrity.

The fiscal integrity of programs such as Medicaid and Medicare is crucial. However, fiscal integrity applies to an entire program, including its overall financial stability, adequacy and consistency. Given the fact that Medicaid is a shared federal/state

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[1] In response to AHCA's request, CMS explained that it used an actuarial formula to estimate impact. CMS basically took a percentage of government facilities in each state that they assumed might be affected by the rule and then multiplied that number by estimated savings per facility. CMS staff would not share this data and indicated in effect that that they would not know the actual state impact of the proposed rule until it had gone into effect, giving CMS a count of providers who met the proposed rule definition of a unit of government.

program, it is imperative that financial integrity have the same meaning for both parties and that both parties apply the same standards.

On November 1, 2005, the National Academy for State Health Policy (NASHP) convened a Medicaid Fiscal Integrity Work Group. The goal of the NASHP fiscal integrity project was to bring participants with different perspectives together to find common ground and generate ideas about improving Medicaid fiscal integrity. The resulting report made several critical points which are germane to the issue of the viability and soundness of the proposed rule.[2]

The report states that:

> Fiscal integrity in Medicaid means a fiscal relationship between the states and the federal government that is sound. Integrity has a moral meaning; fiscal integrity in Medicaid implies a standard of appropriateness from the perspective of both parties to the relationship.

However, from the perspective of both parties, such a standard has apparently been missing. For at least the last 25 years, state governments and federal regulators have been involved in a high-stakes struggle about how Medicaid programs are financed. According to the report, given the essential nature of Medicaid as a federal-state matching program, and the lack of a clear overall regulatory framework about what states may use for their portion of the pie, disputes over state funding practices have arisen regularly.

Inconsistency between state and federal views has resulted in a policy environment that can be characterized as a "tug-of-war," with states discovering, expanding, or changing legal mechanisms in the financing of the program, and the federal government eventually reacting by restricting these practices through legislative or regulatory actions.[3] Without a more comprehensive set of policies and practices coupled with a broader fiscal integrity regulatory framework, this tension will continue.

Indeed, many participants in the NASHP work group were concerned that fiscal integrity problems are distracting policymakers from resolving the program's other fundamental financing issues. According to the report, these fundamental issues include:

- The lack of federal matching funds to cover key low-income populations such as childless adults and legal immigrants,
- Finding sustainable funding streams for the program, and

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[2] *Moving beyond the Tug of War: Improving Medicaid Fiscal Integrity*, Sonya Schwartz, Shelly Gehshan, Alan Weil, Alice Lam, August 2006, funded by the Robert Wood Johnson Foundation. The group of fourteen people included Congressional staff, state Medicaid officials, health financing experts, a hospital executive, representatives of the National Conference of State Legislatures and the National Governors Association, and current and former federal health officials.

[3] For example, the report indicates that in order to serve certain federal policy goals, the federal government has allowed and even encouraged state fiscal practices that it later determines are problematic. The rules about what is acceptable often change in midstream – a state can be told one year that its practices are fine, while the next year the state is told that its actions are not permitted.

- **The funding of long-term care.**[4]

Participants recognized that the failure to address these larger fiscal problems is part of what is fueling states' use of financial schemes that have come under federal scrutiny.

AHCA agrees wholeheartedly with these insights from the report. While AHCA does not condone mechanisms that might ultimately prove to be violative of the governing law, it believes that the proposed rule is an example of the inappropriate piecemeal approach deplored by the NASHP Medicaid Fiscal Integrity work group. CMS is not able to assess the impact of the rule and fails to provide a comprehensive set of policies and practices coupled with a broad fiscal integrity regulatory framework. The proposed rule will not help but rather will exacerbate the financing and funding problems facing the states – and will do so swiftly.

CMS Should Address The Fundamental Issues Facing Medicaid

As indicated above, fiscal integrity problems are distracting policymakers from resolving the program's other fundamental financing issues. These fundamental issues included finding sustainable funding streams for the program and the funding of long-term care.

The Medicaid program is the nation's major source of public financing for long-term care, which many people with disabilities need to function daily. States have limited budgets and most have balanced budget requirements that create pressure to contain Medicaid spending, which accounts for approximately 18 percent of state spending. It is universally acknowledged that fiscal pressures threaten Medicaid's ability to finance long-term care services.

Policy thinkers and scholars have consistently reported on the growing problems and analyzed approaches to solving these problems inherent in cost containment efforts and the federal matching structure.[5] And Congress, in the Deficit Reduction Act of 2005 (S. 1932), signed February 8, 2006, Public Law 109-71, made several changes to long-term services policies including creating state option for states to provide all home and community-based (HCBS) waiver services without needing to get a waiver for seniors and people with disabilities up to 150% of poverty.

AHCA supports reform and the provision of care in the most appropriate environment. We have developed principles and policies that support consumer choice, foster policies to achieve more sustainable financing for long term care and allow for varied and viable operating environments for long term care providers. One such principle is that there must be a sufficient investment in federal and state governmental infrastructure so as to ensure long term care delivery systems provide an adequate array of services

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[4] Id. at page 3 (emphasis added).

[5] For example, *Toward Real Medicaid Reform*, John Holahan and Alan Weil, Health Affairs 26, no. 2, published online February 23, 2007. The authors argue that there is a real need for Medicaid reform primarily because of the large differences among states in coverage and benefits and because of the program's high and rising costs. The authors develop several options for Medicaid reform that would expand coverage, provide fiscal relief to states, shift responsibility for some or all of the care of dual eligibles to the federal government, and eliminate or restructure disproportionate-share hospital (DSH) payments.

administered by knowledgeable providers – who are committed to quality – across the entire long term care spectrum. Thus, a key component of any reform is preserving access to nursing facilities for those who will need them. This is becoming increasingly difficult as demonstrated by statistics on nursing home Medicaid rates. For the last five years, AHCA has published information on the shortfall between Medicaid reimbursement and allowable Medicaid costs in as many states as feasibly possible.[6]

Reimbursement rate increases for nursing facilities in 2005 and 2006 have still not kept pace with projected nursing home cost inflation. The average shortfall in Medicaid nursing home reimbursement was projected to be $13.10 in 2006. The projected daily reimbursement shortfall for 2006 represents a 4% increase from 2004. Extrapolating to all 50 states, the projected shortfall in Medicaid reimbursement to nursing facilities was projected at nearly $4.5 billion in 2006, an increase of 3.1% from the estimated shortfall in 2004. Taken together, in the years that BDO Seidman has compiled this study, the shortfall in Medicaid nursing home funding has increased 45%, from $9.05 per patient day in 1999 to a projected $13.10 in 2006. If all costs of operations were considered, not just Medicaid allowable costs, the shortfall would be significantly greater.

It is clear on its face that ripping out $3.9 billion through 2011 by virtue of the proposed rule will very quickly have a disastrous cascading effect. It will force states to make extremely difficult decisions that could have very adverse economic, environmental, public health and safety effects. It also will cause inequitable and deleterious distributive impacts that may harm the overall health care infrastructure and cause irreversible loss of access to nursing homes and hospitals in general.

CMS Should Reconsider Cost-Based Reimbursement Limits

Mandating cost as the upper limit for reimbursement may sound reasonable – on its face. Such a mandate has a moral connotation with which it would seem hard to argue, especially if the excess revenue were returned to the state or used for non-Medicaid purposes. However, from a technical perspective, this standard, with its emphasis on cost limited reimbursement and cost limited UPLs for government providers may require changes in reimbursement methodologies not conceived of by CMS. While CMS itself admits that states may have to change reimbursement or financing methods, CMS does not concern itself with the possible incompatibility of the standard and emerging Medicaid "pricing" models -- those payment systems that look more to the current Medicare SNF PPS system than to the old cost-based model. Thus, the proposed rule may very well impact private providers if the proposed rule precipitates dual state reimbursement systems -- one for government entities and one for private entities – or pushes the states back towards more cost-based systems. In addition, CMS should examine the viability of state pay for performance programs under a federally imposed cost-based limits.

In addition, the Medicaid statute does not appear to require on its face cost-limited reimbursement, permitting as it does state prospective payment systems. CMS makes clear that it does not find that Medicaid payments in excess of cost to governmentally

[6] Each year AHCA publishes a report on shortfalls in Medicaid funding for Nursing Home Care. The report is produced for the American Health Care Association by BDO Seidman, LLP, Accountants and Consultants. The last report was issued in June of 2006.

operated health care providers are consistent with the statutory principles of economy and efficiency as required by section 1902(a)(30)(A) of the Act. However, while payment cannot and should not be used for costs not connected with the provision of services under the particular program, it is a given that, from a technical perspective, under prospective payment (i.e., pricing) systems, payment can be in excess of cost for a given patient or utilization group.[7] There are state prospective payment systems, and they have not been determined to be in violation of Section 1902(a)(30)(A).

Thus, the proposed rule may not be the only or the most effective way to halt what the federal government considers egregious state fiscal behavior. Further, at a minimum, superimposing cost limited reimbursement on other payment models in existence might cause administrative confusion and excessive and unreasonable expenses for states and for providers whose cost reporting mechanisms fail to meet CMS' new requirements.

CMS Should Withdraw The Proposed Rule

In sum, as we have stated above, AHCA recommends that CMS withdraw the proposed rule. CMS should work with state government representatives and providers to work out a broad regulatory framework that would help to ultimately provide consistency and stability to the Medicaid program, assure adequate payment for Medicaid providers, and meet the highest standards of fiscal integrity.

Sincerely,

Bruce Yarwood
President and CEO

[7] For example, we believe that seven states use some version of the Medicare Resource Utilization Group (RUG) to adjust nursing facility rates for patient case mix under a pricing model.

DUPLIN GENERAL HOSPITAL
A University Health Systems Affiliate

March 19, 2007

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

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

Dear Ms. Norwalk:

Duplin General Hospital is appreciative of the opportunity to comment on the Centers for Medicare and Medicaid Services' proposed rule. We oppose this rule and will highlight the harm its proposed policy changes would cause to our hospital and patients we serve.

Duplin General Hospital is a 101 bed hospital located in Kenansville, North Carolina, serving Duplin County in the southeastern part of the state. Acute care, long-term care and behavioral medicine are included in its bed capacity. Duplin General is affiliated with and managed by University Health Systems of Eastern Carolina.

It is estimated that the proposed rule would decrease reimbursement by about $1 million, exacerbating an already negative operating margin. The elimination of services and a loss of jobs resulting from these decreases has been estimated to result in an economic loss of almost $1.5 million. This cut would dramatically impact Duplin General and would severally jeopardize patient care, possibly leading to closing our doors. Duplin is a poor county with local government unable to locate funds to supplement a negative margin at our hospital.

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

The proposed rule puts forward a new and restrictive definition of "unit of government." In order for a public hospital to meet this new definition, it must demonstrate that it has generally applicable taxing authority or is an integral part of a unit of government that has generally applicable taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Nowhere in the Medicaid statute, however, is there any requirement that a "unit of government" have "generally applicable taxing authority." This new restrictive definition would disqualify many long-standing truly public hospitals from certifying their public expenditures. There is no basis in federal statute that supports this proposed change in definition.

Existing federal Medicaid regulations allow North Carolina hospitals to receive payments to offset a portion of the costs incurred when caring for Medicaid patients. Even with these payments, however, hospital Medicaid revenues for most North Carolina hospitals still fall significantly short of allowable Medicaid costs. If the proposed rule is implemented and, as a result, this important hospital funding stream is eliminated, those losses would be exacerbated. Hospitals would be forced either to raise their charges to insured patients or to reduce their costs by eliminating costly but under-reimbursed services. The first choice would raise health insurance costs by an estimated four percent. The second would eliminate needed services, not just for Medicaid patients but also for the entire community. Eliminating those services likely would result in the elimination of almost 3,000 hospital jobs. That reduced spending and those lost jobs would be felt in local economies and the resulting economic loss to the State of North Carolina has been estimated at over $600 million and almost 11,000 jobs.

The proposed effective date for this rule is Sept. 1, 2007. If this devastating rule is not withdrawn, North Carolina hospitals will lose approximately $340 million immediately. The results of that would be disastrous, as we have shared in this comment letter. State Medicaid agencies and hospitals would need time to react and plan in order to even partially manage such a huge loss of revenue. The immediate implementation of this rule would result in major disruption of hospital services in our state.

Sincerely,

W. Harvey Case
President

cc: Senator Elizabeth Dole
Senator Richard Burr
Congressman Walter B. Jones
Congressman Mike McIntyre

Coos County Public Health

Healthy People in Healthy Communities

Frances Hall Smith, Administrator

1975 McPherson, # 1 ◆ North Bend, Oregon ◆ 97459 ◆ Tel: (541) 756-2020 ext 510 ◆ Fax: (541) 756-5466 ◆ E-Mail: fsmith@co.coos.or.us

March 15, 2007

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

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

Dear Mr. Leavitt:

I am writing in response to the proposed rule changes which would allow only state and/or local taxes for match for Medicaid and SCHIP. Our local health department serves a county of about 63,000 people, where we have a higher rate of poverty, unemployment, and other risk factors than the state as a whole. In 2005/2006, Medicaid funded 28% of our local Health Department's budget. In our maternal child health program, Medicaid funded 51% of our program. The following statistics represent the pregnant women (n=89) who received case management services from our local public health nurses:

- 79% were unplanned pregnancies
- 99% had nutritional risks
- 62% were unmarried
- 24% had less than a high school education
- 35% were victims of domestic violence
- 44% had current or a past history of mental illness
- 43% used tobacco
- 20.5% admitted to using or having used drugs

Our public health nurses provided these pregnant women with expert interventions and guidance. We served an additional 471 families with infants and young children. We identified and monitored children's health problems, and linked medically fragile children to needed services; we trained parents on how to interact appropriately with their children, thus preventing child abuse; and we helped parents change behaviors to improve their health and the health of their families.

This rule change will drastically cut these services.

Our county does not have the funds to pay all of this match from local tax revenue. We are one of the counties facing severe budget shortfalls due to the discontinuance of federal payments to replace lost timber revenue. We will have to rely on fees and the generosity of donors and foundations to help pay this match. If this is not allowed, then many of these vulnerable families will go without services. Please consider this as you make your decision.

Respectfully submitted,

Frances Smith

Frances Smith
Public Health Administrator

cc Oregon Department of Human Services
Association of Oregon Counties
Senator Ron Wyden
Senator Gordon Smith
Representative Peter De Fazio

Conference of Local Health Officials

Public Health
Prevent. Promote. Protect.

March 11, 2007

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

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

Dear Mr. Leavitt:

The Oregon Conference of Local Health Officials (CLHO), representing Oregon's thirty-four county health departments, respectfully submits this comment letter in response to the above proposed rule changes. CLHO agrees with the intent of the proposed rules, which seek to provide clean (non-recycled) sources of funds for Medicaid and the State Children's Health Insurance Program (SCHIP) match. However, the broad stroke of the proposals would have an adverse impact on our ability to provide Medicaid services to the residents of our communities, especially medically at-risk infants and children.

We do not understand the rationale for changing the use of clean public funds to allow only State and/or local taxes for match. Currently counties use other funds, not necessarily tax revenues, as match. These funds might include fees, contributions, non-profit grants, etc., and are not recycled Federal funds. To not be able to use these funds, significantly limits counties' ability to secure Medicaid funds. Medicaid funds are critical to the retention of professional staff and sustainability of services to vulnerable populations. This rules change appears to be a direct contradiction to national domestic policy objectives that strive to expand health services throughout the nation.

Currently 11% of (all) county revenues come from Medicaid. The actual rate is much higher in some counties. To reduce this level of revenue for public health services jeopardizes services our communities have come to rely upon and acknowledge as being critical to the continuum of care needed for healthy families.

As this proposal reads, there will be considerable increases in reporting which could amount to an unfunded administrative burden. The burden could well exceed the benefits of providing services, especially in rural areas where the reporting requirements would be (in proportion) well beyond the scope of their operations.

Contact Us: Linda Fleming, Executive Director, Conference of Local Health Officials
PO Box 428 Fossil, OR 97830 541-763-3740 541-763-3579 (*fax*)

Paying the matching portion prior to receiving reimbursement from the Oregon Department of Human Services (DHS) will be a change in current practice. While we understand the intent of the procedural requirement, we are advised by DHS that this may cause conflicts with Oregon's Prompt Payment Act, which requires interest to be paid to the provider of goods and/or services if requests for reimbursement are not paid within forty-five days of receipt. It definitely would add an additional accounting burden to track which entities had paid and were, therefore, eligible for reimbursement.

We encourage you to take these concerns, and the concerns of our member counties, into full consideration as you move forward with this rule making process. When we revise rules and impact revenue streams and add additional administrative burdens, we are in reality unduly impacting and burdening those who can afford it the least – the users of our services.

Sincerely,

Linda K. Fleming EHW

Linda K. Fleming
Executive Director

cc: Oregon Department of Human Services
Association of Oregon Counties
Senator Ron Wyden
Senator Gordon Smith
Representative Greg Walden
Representative Earl Blumenauer
Representative Darlene Hooley
Representative Peter DeFazio
Representative David Wu

BAY
SPECIAL CARE HOSPITAL

March 14, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1529-P
P.O. Box 8015
Baltimore, Maryland 21244-8015

Re: Comments on Medicare Program; 2008 Proposed Update Rule
Published at 72 Federal Register 4776 *et seq.*

Dear Ms. Norwalk:

Bay Special Care Hospital (BSCH) submits these comments on proposed rules published on February 1, 2007 at 72 *Fed. Reg.* 4776 et seq. This rulemaking seeks to make significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies.

Bay Special Care Hospital was established on June 30, 1994 and is located at 3250 E. Midland Road, Bay City, MI 48706. Its location is approximately five miles from its host hospital, Bay Regional Medical Center (BRMC), which is located at 1900 Columbus Avenue, Bay City, MI 48708. BSCH has been deemed a Hospital within a Hospital (HwH) by CMS due to an inpatient rehabilitation unit owned and operated by BRMC being located within the same West Campus facility. BSCH was granted grandfathered status by the BBA of 1997, a status which we feel we should maintain to be excluded from the proposed expansion of the 25% rule. The proposal to expand the 25% rule to grandfathered hospitals violates the statutory protection given to our hospital by Congress in recognition of our unique status.

Our hospital serves an average of 295 patients per year, and a significant percentage of Medicare patients reside in Bay County, Saginaw, Midland and surrounding counties. We are located in a small city of approximately 40,000 residents and have only one acute care hospital in our community. Outlying cities and their hospital systems are located approximately 15-20 miles or more away from our city and location. To shift patients outside of one community to another is not customary as physicians prefer to provide care through the entire episode of care/continuum. In our location, it would be nearly impossible to obtain 75% of our Medicare patients from a source other than the only hospital located in our community. We have outcomes that we are proud of and have successfully discharged 48% of our Medicare patients to their homes over the past three fiscal years. These discharge outcomes are similar to prior years. We feel that these, as well as other quality initiatives, demonstrate a successful outcome for our patients who have multiple co-morbid conditions requiring extended hospital level care.

CMS' proposed expansion of the 25% rule to freestanding and grandfathered hospitals, and its "consideration" of a policy to expand the short stay outlier ("SSO") payment policy to allow "extreme" SSO cases to be paid comparable to IPPS cases, both are unfair and unsupported by facts, and contrary to the clinical and financial data available. The two proposals would drastically reduce payments to Bay Special Care Hospital in fiscal year 2008 by approximately 47% percent, forcing BSCH to operate at a significant loss when treating Medicare patients. BSCH urges CMS to not adopt the proposed expansion of the 25% rule and to reject its consideration of the extreme SSO policy because the continued operation of BSCH and the patients it serves will be placed in jeopardy if they are adopted.

In the preamble to the update rule CMS repeatedly justifies both of its proposals by making the generalized, unsupported, and incorrect statements that in the situations the proposals are intended to address the LTCH is behaving like a ACH, or that the LTCH is acting like a step-down unit for a ACH, or that the patient presumably was discharged by the ACH to the LTCH during the same episode of care and the LTCH is not providing complete treatment. CMS points to the statutory difference between LTCHs and ACHs that was intended to pay LTCHs

based upon "the different resource use" of LTCHs as compared to ACHs. In fact, LTCHs do provide different services to patients, and patients in LTCHS do utilize different resources than ACHs, making it inappropriate to pay LTCH discharges under the IPPS, and CMS has presented no data to the contrary to support its proposals other than presumptions and beliefs. CMS' own contractor, RTI, noted in the Executive Summary to its report that "[u]nderstanding whether LTCH hospitals are substituting for services already paid to IPPS hospitals or whether LTCHs are providing specialized services is not well understood." 72 Fed. Reg. 4885.

As described in greater detail in the comments submitted by NALTH, physicians at ACHs use their expertise and experience to discharge certain patients to LTCHs because the specialized care they can receive at the LTCH is very different than the services provided at an ACH, and such care, and the timing of such care, clearly are in the best interests of the patient's medical care. In general, ACHs are "diagnosis focused" and provide critical care to acutely ill patients by focusing on a single clinical dimension, whereas the LTCH is designed to provide the complete array of team-based services that can focus on the recovery of the whole patient. LTCHs often help patients recover all functions (both cognitive and physical) and return to the community. ACHs simply are not designed to provide these services, and there is no current incentive for them to expend the significant resources to try to replicate those specialized services that already exist in LTCHs. The physicians at the ACH also make the medical determination of when the patient is appropriate to be transferred from the ACH to a LTCH based upon the patient's condition, medical needs, and availability of appropriate services. It makes little sense for a patient to remain at an ACH instead of being transferred to a LTCH, and thus delay (or eliminate entirely) the commencement of needed specialty services, purely for payment system reasons.

Despite CMS's generalized statements to the contrary, Lewin has demonstrated that SSO patients in a LTCH cost far more than patients with the same DRG in an ACH, and their length of stay in a LTCH more than double of those with the same DRG in an ACH. There simply is no support for CMS' belief or presumption that patients in LTCHs should be paid like patients in an ACH.

Expanded 25% rule

CMS justifies expansion of the 25% rule to all LTCHs, including grandfathered co-located LTCHs and freestanding LTCHs, based on the presumption that the ACH's discharge to the LTCH presumably is a "premature discharge" if the patient has not reached cost outlier status at the ACH. As noted above, there is no clinical or financial evidence to support CMS' conclusion that the patient is discharged prematurely. RTI, CMS' own contractor investigating these issues, has concluded that it cannot state that LTCHs are substituting for services already paid to IPPS hospitals. Without such evidence the proposal should be withdrawn. In fact, there is significant clinical and financial support presented by NALTH that ACH patients are discharged based upon the expertise of the ACH physician, who has determined that it is appropriate for the patient to receive the specialized services of the LTCH at that time in order to maximize the patient's recovery.

The proposal to expand the 25% rule fails to recognize the many localities in which LTCHs serve a small number of independent ACHs, thereby making it impossible for them to satisfy the 25% rule despite no control or ability to direct or influence the admission patterns.

Bay Special Care Hospital questions the basis of the 25% threshold itself. CMS has presented no evidence to show that there is any statistical basis for applying such an arbitrary number throughout the country to penalize LTCHs.

Expanding the 25% rule to all LTCHs not only will jeopardize patients' access to appropriate medical care, but the significant and inappropriate financial losses it will generate will all but guarantee the closure of a significant number of LTCHs, thereby preventing access to these unique services by many Medicare beneficiaries.

Bay Special Care Hospital urges CMS not to adopt the proposed rule as published. The approximately 15 LTACs with grandfathered status were all established in good faith prior to growth in the industry. The continued operation of BSCH and the patients it serves will be placed in serious jeopardy if the proposed rules are adopted. Adoption of the expanded 25% rule could indeed cause the closure of this facility as well as many others, cause a

loss of LTAC level of care in our community, and jeopardize over 100 immediate jobs within BSCH and numerous others in the community.

Extreme SSO policy

As noted above, the extreme SSO policy CMS is considering is contrary to clinical and financial realities. Under the current SSO policy a LTCH will at best receive only its cost for a SSO; there is no incentive for a LTCH to admit a patient who is likely to become a SSO. Under the extreme SSO policy being considered, a LTCH would undoubtedly lose a significant sum on treating the patient.

Besides not having any financial incentive to admit an extreme SSO, CMS also assumes that LTCHs are able to predict, prior to admission, which patients will become SSOs, much less extreme SSOs. There is no way for LTCHs to make such a prediction. Long-term care hospital patients suffer from multi-system body failures with peaks and valleys in their medical conditions. Their conditions may unpredictably improve or deteriorate at any time. SSO cases are admitted to LTCHs at the appropriate level of care based on the medical judgment of their treating physicians. It is impossible to pre-screen patients and effectively identify which patients may become SSOs. There are a myriad of reasons why a patient admitted to an LTCH may become a SSO. Some SSO cases may achieve medical stability sooner than originally expected. Other cases may become SSOs because they require discharge to an acute hospital due to a deteriorating condition or a new condition which develops subsequent to their admission to an LTCH. Other patients admitted to LTCHs from acute care hospitals may become SSO cases due to their unexpected death. Some patients and their families, after realizing the gravity of their condition, may simply give up and request that aggressive treatment be stopped after admission. Other patients may sign themselves out against medical advice.

There is no basis for a proposed rule which assumes that SSO cases should have remained in acute hospitals. CMS ignores the fact that a significant number of SSO cases are not admitted from acute hospitals but rather, at the direction of a patient's attending physician, are admitted from home or a nursing facility. It is inappropriate for CMS to presume that a patient admitted to an LTCH from a non-acute hospital setting, at the direction of the patient's attending physician, who subsequently becomes a SSO should not have been admitted to the LTCH in the first place.

CMS also disregards the fact that a percentage of SSO cases are crossover cases that exhaust Medicare Part A benefits during their LTCH stay. It would be unfair to preclude these Medicare recipients from admission to an LTCH simply based on the number of their remaining Medicare days.

The proposed SSO rule is an unprecedented intrusion on physician decision making and contrary to long standing Medicare principles that govern medical necessity determinations. It would impose a payment adjustment as a mechanism to disqualify a patient for hospital services and intrude upon a physician's ability to admit patients to LTCHs based on medical necessity, i.e., the need for specific programs of care and services provided in the LTCH.

Further, CMS ignores MedPAC's recommendation contained in its June 2004 report to Congress that CMS designate Quality Improvement Organizations (QIOs) to review the medical necessity of LTCH patient admissions. There is a comprehensive statutory and regulatory scheme which vests QIOs with authority to review the medical necessity of hospital services provided to Medicare beneficiaries. QIOs, which are composed of licensed doctors of medicine, determine, among other things, whether inpatient hospital services furnished to Medicare beneficiaries are consistent with generally accepted standards of medical care, or could be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type and the medical necessity, reasonableness and appropriateness of hospital admissions and discharges. See Sections 1154(a)(1) and (3)(C) and of the Social Security Act and 42 C.F.R. §476.71(a).

In view of the foregoing:

- Bay Special Care Hospital respectfully requests that CMS not expand the 25% rule to freestanding and grandfathered hospitals and that it reject the extreme SSO policy under consideration.

- We support a six-month extension for comments and to allow the national trade organizations an opportunity to collaborate for the good of the industry.

- We support a LTAC moratorium until 2010. The Lewin Group has provided a study of savings that the limited moratorium would provide and we encourage CMS to review that information provided by NALTH.

- We support implementation of a universal admission, continued stay and discharge criteria for LTACs whether it be NALTH criteria, InterQual or another validated LTAC tool.

- We support increased QIO review of LTACs throughout the United States.

I am grateful for this opportunity to express my opinions and hope that you will take them into consideration prior to the final ruling. Thank you.

Sincerely,

Cheryl A. Burzynski

Cheryl A. Burzynski, President