PORT GAMBLE S'KLALLAM TRIBE
31912 Little Boston Road NE • Kingston, WA 98346

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

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

Dear Ms. Norwalk:

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

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

Criteria for Indian Tribes to Participate

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

(360) 297-2646 Kingston | (360) 478-4583 Bremerton | (206) 464-7281 Seattle | (360) 297-7097 Fax

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

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

Criteria for Tribal Organizations to Participate

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

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

(1) the unit that proposes to contribute the funds is eligible under the proposed amendment to 42 C.F.R. § 433.50(a)(1); and
(2) the contribution is from an allowable source of funds under the newly proposed section 447.206.[2]

---

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

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

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

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

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

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

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

---

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

made from state or local taxes. The proposed change is inconsistent with CMS policy as outlined in the October 18, 2005 and the June 9, 2006 SMD letters.

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

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

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

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

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

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

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

Sincerely,

Ronald G. Charles, Tribal Chair

Cc: National Indian Health Board

University Health Care
Hospitals & Clinics

March 16, 2007

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

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

Dear Ms. Norwalk:

On behalf of the University of Utah Hospitals and Clinics ("UUHC"), we are writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes nearly$ 40 million (Federal share) in critical Medicaid support payments for UUHC, funding that has been essential to our ability to serve as Utah's major safety net health care system.

Background:

ACADEMIC MEDICAL CENTER

UUHC is part of a complex academic health center that fills multiple unique and essential roles for the people of Utah. We offer highly specialized tertiary care services, some of which are unique to the state and region, and many of which are under-reimbursed. Our special services include a Level I trauma center, the only burn treatment facility in the region, newborn intensive care, organ transplants, an air transport service, the only National Cancer Institute-designated cancer center in the Intermountain West, Huntsman Cancer Institute and the largest eye-care and vision-research center, John A. Moran Eye Center, between the Mississippi River and the West Coast, with ten satellite clinics.

The University of Utah
Hospitals & Clinics
Hospital Administration
50 North Medical Drive
Salt Lake City, Utah 84132
Telephone (801) 581-2380
Fax (801) 585-5280

40 years

HEALTHCARE ACCESS

UUHC offers accessible(especially to Medicaid, Medicare, and the Uninsured patients) primary and preventive care services through a network of community clinics throughout the region, providing our patients with a medical home that offers access to integrated comprehensive care for all of their medical needs.

SPECIALTY CARE

UUHC specialty care clinics provide a full range of services, including orthopedics, ophthalmology, diabetes care, stroke services, dialysis, a spine center, women's health and breast care, and Alzheimers treatment. UUHC operates a Medicaid health plan called Healthy U, with enrollment of approximately 25,000 clients. In addition, the University of Utah is the state's only medical school, and UUHC has the largest teaching program in the state, training the next generation of our nation's physicians and other health professionals.

UNCOMPENSATED CARE

UUHC admits over 20,000 patients annually and provides over 900,000 outpatient visits (more than 32,000 of which are emergency visits). We serve all patients, regardless of ability to pay, and care for a disproportionate number of Medicaid patients. Twenty-three percent of our patients are Medicaid recipients, and another five percent are uninsured. We rely on government payers (Medicaid and Medicare) for 46 percent of our revenues (the highest % of government patients in the State). We also carry the highest rate (approx. 8% of net patient revenues) of uncompensated care in the State Clearly, UUHC is a vital healthcare resource to the state of Utah, but because of our reliance on funding from public healthcare programs, we are highly sensitive to even minute changes in reimbursement policies.

LOW DSH STATE

The reimbursement changes in the Proposed Rule are significant. They threaten to slash a variety of special Medicaid payments that we rely on to fulfill our safety net role. They also fail to provide some kind of leveling mechanism to offset the low level of Medicaid Disproportionate Share Hospital (DSH) monies we receive as a State.

REQUEST TO WITHDRAW PROPOSED RULE

For the reasons noted above, we strongly oppose the Proposed Rule, and respectfully request that you to withdraw it immediately.

Below we provide more detailed comments on specific aspects of the rule, along with a description of how we believe these provisions would impact UUHC, our patients and our community.

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

NEW MEDICAID COST LIMIT

Under current regulations, states are permitted to provide Medicaid reimbursement to hospitals and other providers up to the amount that would be payable using Medicare payment principles (Upper Payment Limits (UPL)). The Proposed Rule would reduce that limit to Medicaid costs for governmental providers only, resulting in significant cuts for UUHC and threatening our financial viability.

We oppose the cost limit.

EDUCATION SUPPORT NEEDED

Currently UUHC receives approximately $ 40 million (Federal share) in supplemental Medicaid funding, through a variety of different payment streams, each recognizing the important role we play in Utah's healthcare system. We receive both direct and indirect medical education payments that enable us not only to train properly the 772 interns and residents who come through our doors each year, but to absorb the additional costs that are part and parcel of our teaching role. Our physicians also receive supplemental Medicaid reimbursement in acknowledgement of the substantial financial burden they bear as teaching professionals. And we have separate payment streams that support our dental programs.

DSH "FAIR SHARE"

These supplemental payments are particularly important for UUHC as compared to many of our counterparts across the country because of Utah's status as a low Disproportionate Share Hospital (DSH) state. Our state DSH allotment, at less than $16 million, is far below the average on a percentage basis, and does not come close to covering the costs of hospital uncompensated care in the state. Using a simple population calculation to identify the ranking of the states that receive DSH, Utah is dead last. If Utah were to receive an average state DSH amount, Utah should receive an additional $70 million (Federal share) in DSH dollars as its "fair share". There are other calculations that could be made relative to the realigning or rationalizing the amount of DSH monies received by each state, but in every case, Utah would be on the receiving end.

MEDICAID PCN DISPROPORTIONATE IMPACT ON UUHC

Moreover, through Utah's Primary Care Network (PCN) demonstration program we provide hospital care to PCN enrollees for which we are not reimbursed, and we have exceeded our "fair share" commitment to providing this care by more than $1 million annually. In total we provide more than $40 million (cost basis) in uncompensated care to the uninsured and underinsured, for which we receive a DSH

payment of only $4 million (Federal share) and we receive no payments through the PCN demonstration. As the largest relative provider of uncompensated care to the uninsured, UUHC struggles daily with the fallout of the inadequate DSH allotment. Because of the lack of sufficient DSH funding, our non-DSH supplemental Medicaid payments play an even more important role in supporting our safety net activities.

CRUCIAL FUNDING SOURCE

Our other, non-DSH supplemental Medicaid payments, therefore, have become a crucial and irreplaceable funding source. Without these funds, we simply could not continue to operate many or our basic programs and provide all of the services that we now offer. We could not ensure the kind of "soup to nuts" access to services that our patients now enjoy; we could not support the broad scope of teaching programs that we currently run; and we would be a much less effective first responder in the event of a community or national emergency. We would have to scale back important investments we are making that include purchase of new medical technologies and implementation of a health information system. Utah's health and medical education system would be put at risk if the role of UUHC is diminished.

GOVERNMENT vs. PRIVATE PROVIDER IMPACT

It is particularly damaging for CMS to single out *governmental* providers – and only governmental providers – for this kind of major base funding cut. As compared to our private competitors in Utah, UUHC is the *least* able to absorb this kind of cut. Our relative reliance on governmental payers for support far outweighs that of the private systems in the state, and our ability to cost-shift to commercial payers is significantly less. **Moreover, we do not have access to the kind of non-patient care revenues (e.g. investment income) that other systems do.** In this environment, it is impossible to overstate the importance of the supplemental Medicaid payments to UUHC or the damage that the proposed funding cut would impose on our system, our patients and our community.

Fiscal Integrity

SIGNIFICANT FINANCIAL IMPACT ON UUHC

CMS asserts that the Proposed Rule is needed to ensure "fiscal integrity" in the Medicaid program and to ensure that the federal-state funding partnership is not distorted. It is not clear, however, how a funding cut focused only on governmental providers will achieve this goal. We estimate that the new rule impact on UUHC is unreasonable. The CMS proposed national Medicaid budget for next year that has been submitted to Congress is approximately $180 Billion. If the intent of

new rule proposed by CMS is to save $ 4 Billion over the next five years, or just under an average of $1 Billion savings per year, the cut is equal to about one-half of one per-cent of the total Federal Medicaid budget each year.

If we were to cut our (UUHC) Medicaid budget by a full 1% per year over the next five years, the cumulative impact would be less than $6 million. The magnitude of the rule change on UUHC over the next 5 years is estimated to be almost $200 million (Federal share) which will far exceed our ability to absorb. Our fiscal integrity is at stake with this new rule and the estimated savings to Medicaid appears to be significantly understated.

CMS GAVE UTAH A FAVORABLE RATING ON THE USE OF IGT's

UUHC, as a governmental entity (and we believe we will remain governmental even under the narrow new definition of a "unit of government" under the rule), has long contributed to the non-federal share of Medicaid expenditures in our state. Our intergovernmental transfers are legitimate and appropriate. We have not engaged in the types of recycling and other practices to which CMS objects. Indeed, a recently released chart compiled by CMS itself, entitled "Summary of State Use of IGTs and Recycling," lists Utah as among the "States that Use IGTs Appropriately," referring to IGTs for inpatient hospitals, nursing facilities and physician payments. Yet the Proposed Rule would subject us to the governmental provider cost limit, which in our case is no more than a straightforward funding cut, as there are no CMS identified "fiscal integrity" issues to be addressed in Utah.

UTAH MEDICAID SUPPORTS ALL ASPECTS OF HEALTHCARE DELIVERY

CMS claims that governmental providers use Medicaid payments in excess of costs to "subsidize health care operations that are unrelated to Medicaid." (72 Fed. Reg 2241) Nothing could be further from the truth in the case of UUHC. The types of activities we use our supplemental payments for --- teaching programs, community-based access, specialty care clinics, tertiary services, emergency preparedness, investments in technology, quality initiatives, etc. --- are very much related to Medicaid. Medicaid recipients, like all of our other patients, have a right to expect excellence in each of these areas. Utah Medicaid (State of Utah Department of Health Division) has recognized the essential role that our medical education activities play for the Medicaid program. Utah, like other states, understands the importance of a strong safety net to the viability of their Medicaid programs and has chosen to support it through supplemental payments in excess of the direct costs of serving Medicaid patients.

CMS SHOULD WITHDRAW ITS PROPOSAL

The current regulatory upper payment limits provide an appropriate balance of flexibility for states to target Medicaid payments to areas of need with a reasonable limit on reimbursement (Medicare payment principles). The proposed governmental provider cost limit, adopted in the name of fiscal integrity, does nothing to further that goal. Rather it is simply a funding cut, deep and severe, imposed on those providers already facing the greatest financial challenges. CMS should withdraw its proposal to limit payments to cost and retain the current limits.

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

IMPACT ON PHYSICIANS?

CMS has approved a state plan amendment that allows our physicians to receive enhanced Medicaid reimbursement. Given the disproportionate burden that our physicians willingly undertake in serving low income Medicaid and uninsured patients, this enhanced funding has been critical to their financial viability as well. The cost limit contained in the Proposed Rule does not specify whether it applies only to institutional providers or also to professional providers and we have estimated zero impact to our physicians payments. If it applies to professional providers, it is unclear how to determine whether such providers are an "integral part" of a unit of government or are "operated by" a unit of government. A cost limit would be particularly inappropriate for professional services. We request that CMS clarify that the provisions of the Proposed Rule do not apply to professionals.

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

IMPLEMENTATION TIMELINE IS UNREASONABLE

CMS proposes to implement the Proposed Rule as of September 1, 2007 – an astonishingly ambitious schedule given the sweeping nature of the changes proposed. Assuming that a final regulation is not issued until this summer, states will have very little time to adopt the changes necessary to come into compliance. In our state, for example, the 2007 legislative session ended on February 28 and the legislature is not scheduled to meet again in a general session until next year. It would not be able to properly consider the changes in our program that may be required under the regulation in time to meet the deadline. Nor would our State Department of Health have time to develop and obtain approval for any state plan amendments that may be required or to adopt changes to state rules and provider manuals. Establishing appropriate cost-reporting mechanisms as envisioned in the Proposed Rule will, in and of itself, require months of work.

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

* * *

Conclusion---Plea

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

If you have any questions about this letter, please feel free to contact Gordon Crabtree, Chief Financial Officer at (801) 587-3572 or Barbara Viskochil, Director of Government Programs at (801) 297-4965.

Sincerely,

A. Lorris Betz, M.D., Ph.D.
Senior Vice President for Health Sciences
Executive Dean, School of Medicine
CEO University Health Care

David Entwistle
Chief Executive Officer
University of Utah Hospitals and Clinics

cc Michael O. Leavitt, Secretary DHHS

Enclosure

Summary Of State Use Of IGTs And Recycling

State	(1) States that Do Not Use IGTs	(2) States that Use IGTs Appropriately	(3) States that have Revised Existing IGTs by Removing Recycling	(4) CMS Identifies Potential Recycling-States May Disagree	(5) Unknown-SPAs Pending Review	(6) No SPAs Submitted
Alabama			X(IH/DSH/NF/HHA) **		X(PHYS)	
Alaska	X (OP)			X (IH/DSH/NF)		
Arizona*		X(OP)				
Arkansas		X (OP/PHYS)	X (IH/NF)			
California	X (NF)	X(OP)	X (IH/DSH)			
Colorado	X (IH/NF/PHYS)					
Connecticut	X (IH/NF)					
Delaware						X
DC						X
Florida		X (IH/OP/NF/PHYS)				
Georgia			X (IH/DSH/OP/NF)			
Hawaii	X (IH/NF)					
Idaho	X (NF)	X(IH)***				
Illinois				X (DSH)^ X(NF)		
Indiana		X (IH/PHYS/OP/TRANS)				
Iowa			X (IH/DSH/NF)			
Kansas			X (DSH/NF)			
Kentucky	X (OP)	X(OLP)	X (IH/NF) (PHYS)**			
Louisiana	X (DSH)		X (IH/OP/NF)			
Maine	X (NF/OP)	X (IH)				
Maryland	X (IH/NF/PHYS)					
Massachusetts			X (IH/OH/NF)			
Michigan		X(PHYS)	X (IH/NF)			
Minnesota			X (IH - GME)	X (IH/DSH/NF)		
Mississippi		X(NF)	X (DSH)			
Missouri	X (IH)	X (PHYS)	X (NF)		X (OP)	
Montana		X (IH/TRANS)	X (NF)			
Nebraska	X (IH)		X(NF)			
Nevada	X(NF)	X (IH/CLINIC)			X (PROF)	
New Hampshire	X (IH)		X (NF)			
New Jersey			X(NF)			
New Mexico						X
New York		X (CLINIC)	X (IH/DSH/OP/NF)			
N. Carolina	X (PHYS)		X (DSH)			
N. Dakota	X(IH)		X(NF)			
Ohio	X (NF)		X(IH)			
Oklahoma	X (NF)	X (PHYS)	X (IH/OP)			
Oregon		X (IH/SBS)	X (NF)			
Pennsylvania	X (IH)		X(NF)			
Rhode Island	X (IH/NF)					
S. Carolina		X (OP)	X (DSH/NF)		X (OLP)	
S. Dakota	X (IH)		X(NF)			
Tennessee			X (NF)			
Texas	X (NF)	X (IH/OP)			X (OP/PHYS)	
Utah		X (IH/NF/PHYS)				
Vermont	X (IH/NF)					
Virginia			X (IH/NF/OP)			
Washington			X(IH/DSH/NF)			
West Virginia		X (NF/IH/OP)				
Wisconsin		X (IH)	X(NF)			
Wyoming		X (IH/OP)				
Total States	**23**	**22**	**30**	**3**	**6**	**3**
	*Has not submitted any IH/NF SPAs	*** Final documentation of procedures pending	** Final SPAs to be submitted/approved	^Cook County DSH		

Key
NF - Nursing Facility Services
IH - Inpatient Hospital Services
DSH- Disproportionate Share Hospital
OP - Outpatient Hospital Services
SBS - School Based Services
GME - Graduate Medical Education
Trans - Transportation
Clinic - Clinic Services
Prof - Professional Services
Phys - Physician Services
OLP- Other Licensed Practitioners
HHA- Home Health Agency

48

Congress of the United States
Washington, DC 20515

March 19, 2007

The Honorable Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Leavitt:

We are writing to request that you withdraw proposed rule CMS-2258-P, which was published on January 18, 2007. We also request that this letter be included in the record of public comments on this proposed rule. The proposal would, among other things, threaten the capacity of safety net hospitals to deliver critical but unprofitable services that benefit entire communities, such as trauma centers, burn units, and emergency departments. In our opinion, by proposing this rule, the Centers for Medicare & Medicaid Services (CMS) exceeded its statutory authority and ignored the direct opposition of a majority of Congress.

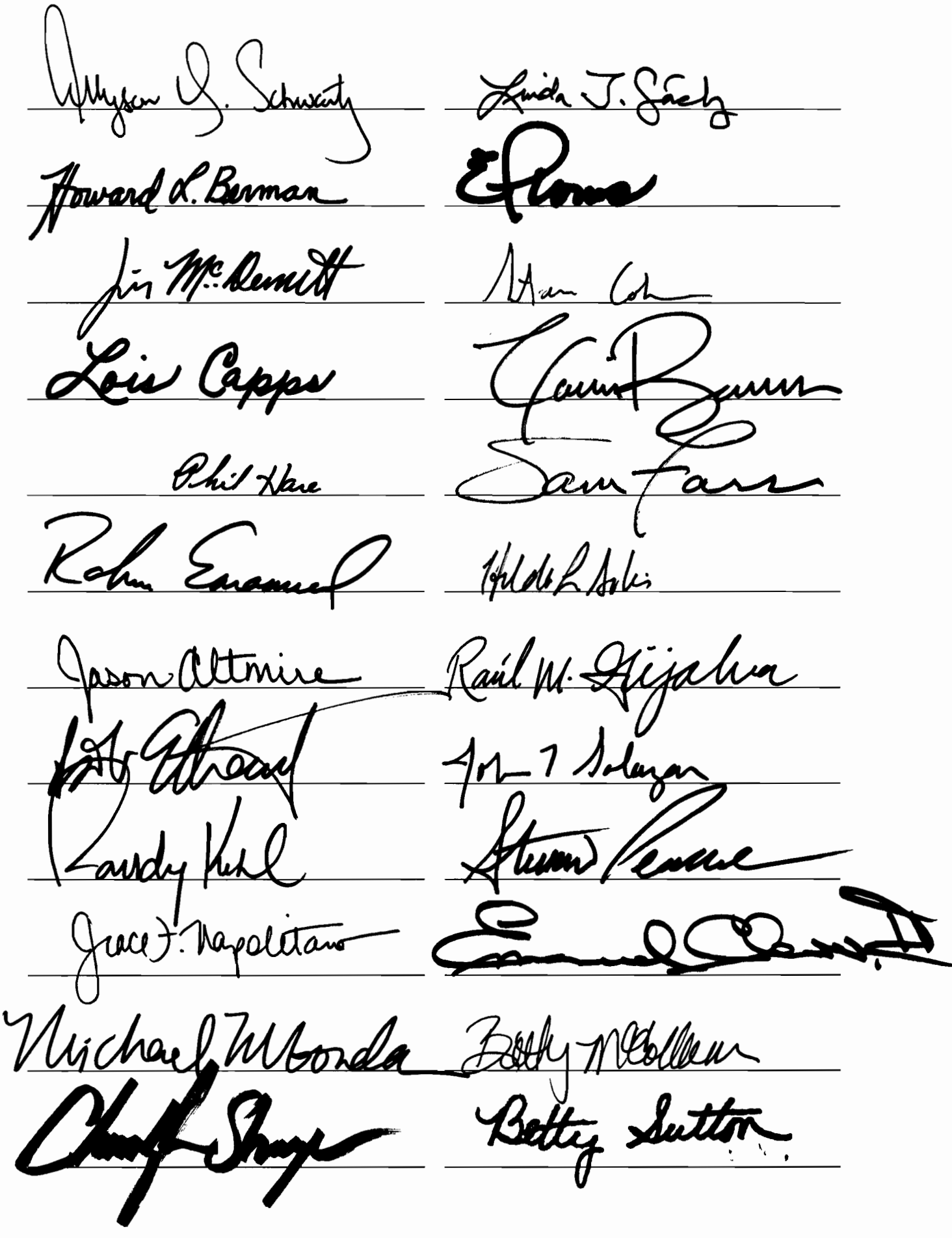
Your proposal would fundamentally change current financing and payment arrangements in many state Medicaid programs. By your own estimates, this would result in the loss of at least $3.8 billion in the federal share of Medicaid payments to safety net providers over the next five years. As you know, Congress has in the past rejected, on a bipartisan basis, repeated efforts by the Administration to amend the Medicaid statute to make these changes, including proposals in the President's FY 2005 and FY 2006 budget requests. You now propose to make these fundamental changes by administrative action. You have neither the statutory authority nor the Congressional support to do so.

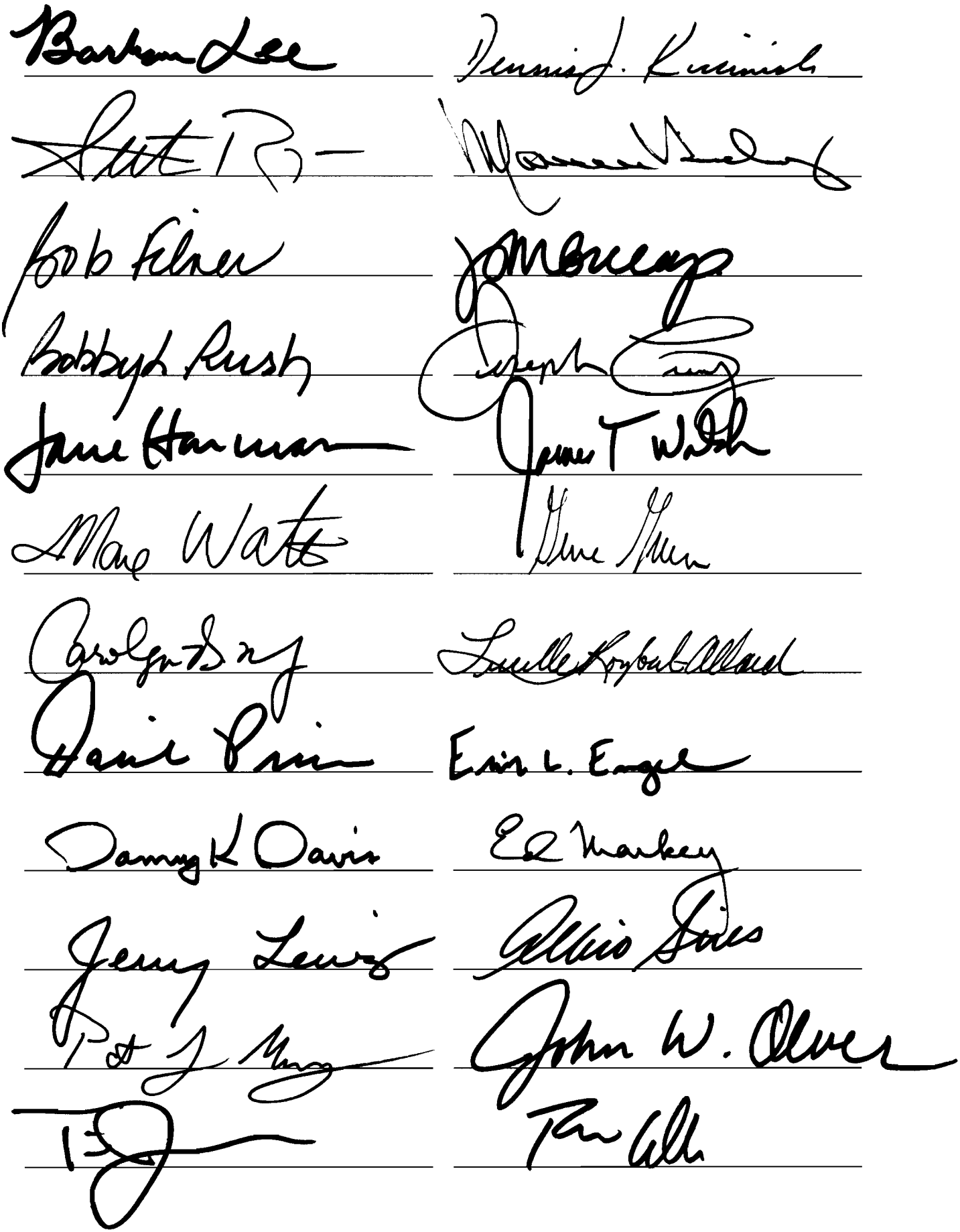
In addition, we are highly concerned about the timing of this proposed rule. U.S. hospitals are already diverting more than 1/2 million ambulances per year due to facility crowding. Our Nation remains at risk of terrorist attacks, and we are currently expending considerable federal, state and local resources preparing for a possible onslaught of avian flu.

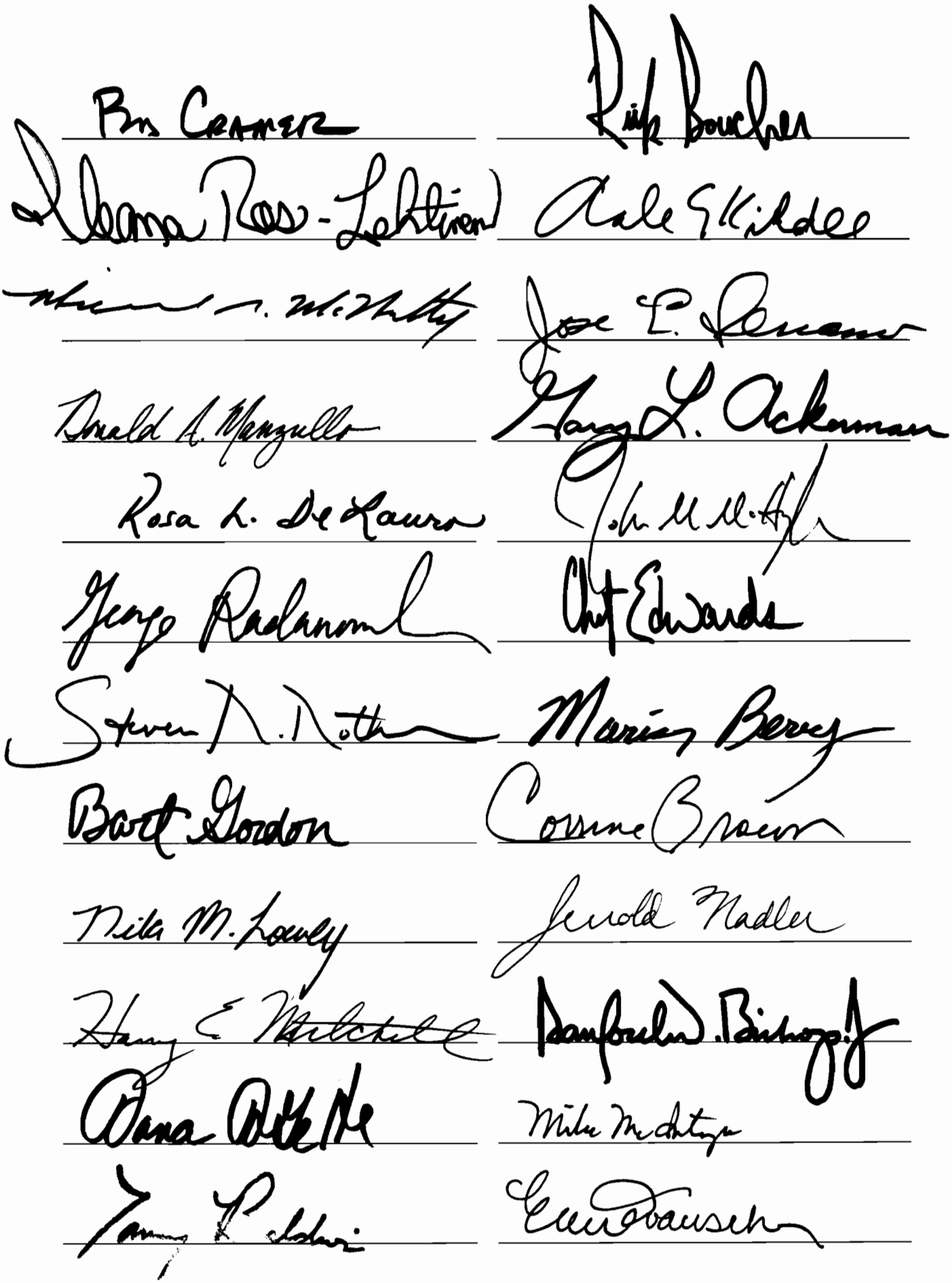
Under these circumstances, we question the wisdom of a policy change that will withdraw large amounts of federal and state Medicaid funds from institutions that play an essential part of the health care systems of our nation's largest and most strategic cities. Doing so will inevitably compromise vital emergency and trauma care capacity.

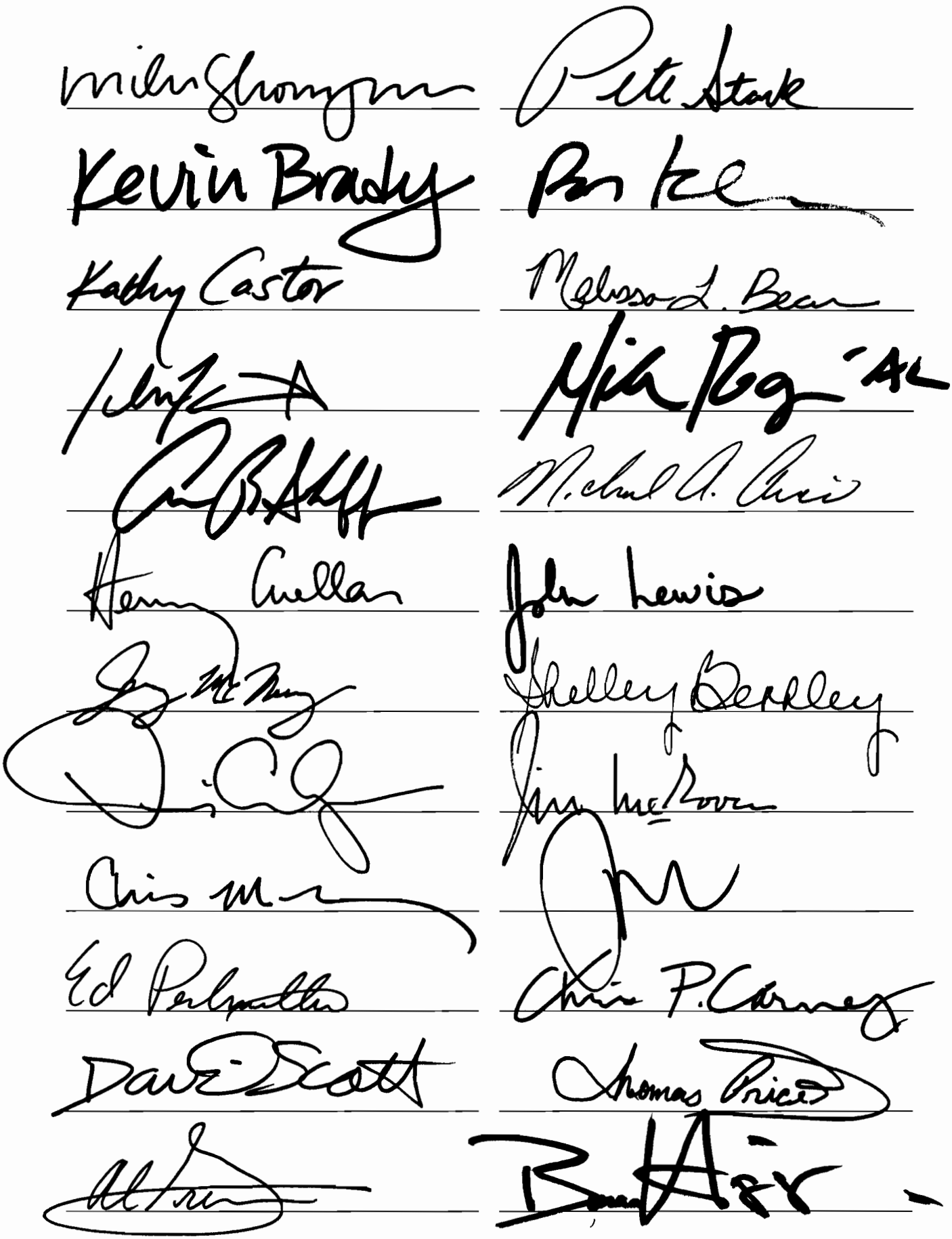
We urge you to withdraw the proposed rule.

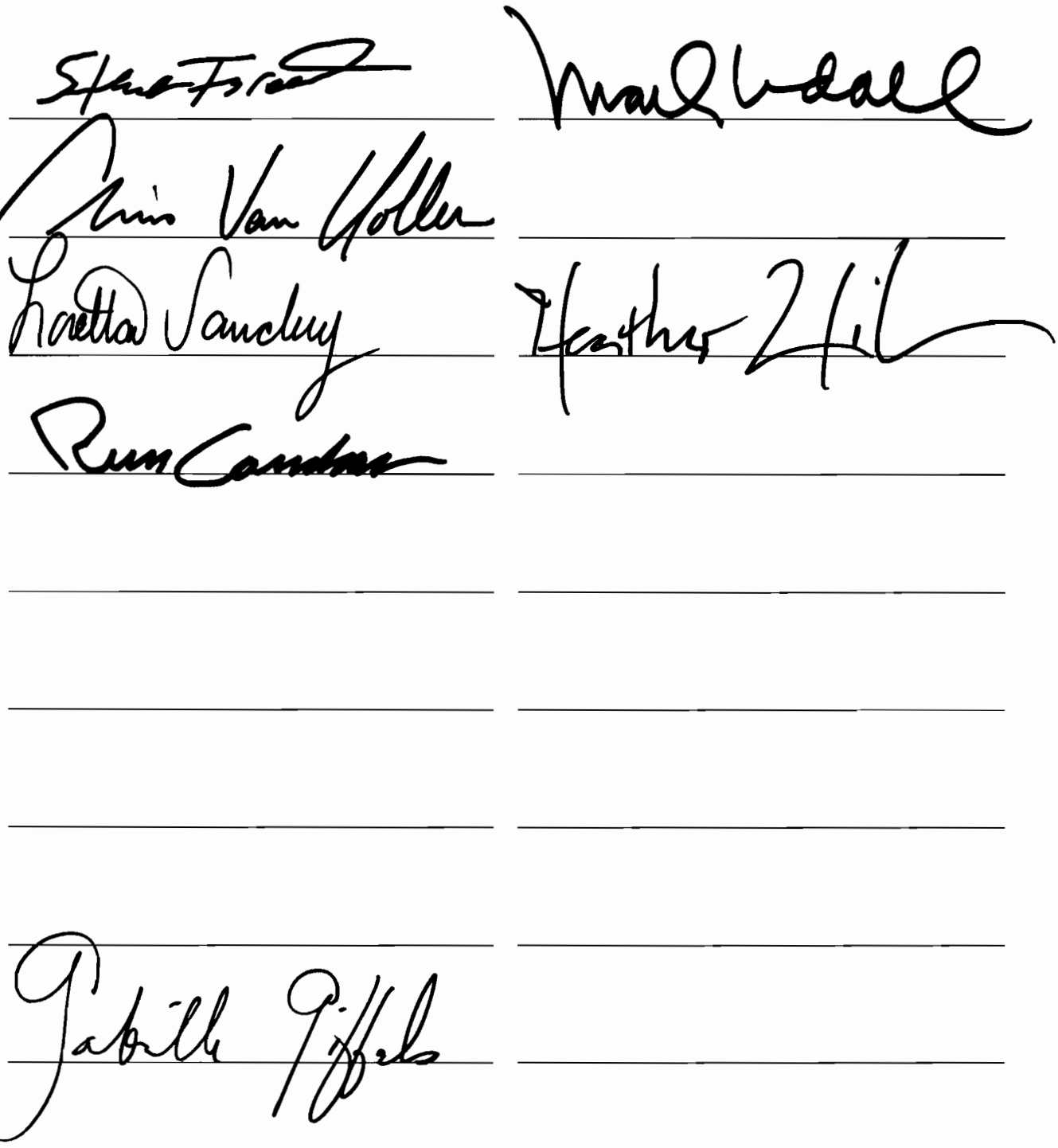
Sincerely,











Stephen G. Breyer

Thomas Ruled

Yvette D. Clarke

Vito Fuller

JACKSON
HOSPITAL

MAR 20 2007

March 19, 2007

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

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

Dear Ms. Norwalk:

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

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

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

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

Yours truly,

Victoria W. Jones

Victoria W. Jones
Vice President – Operations

/vwj

50

The SHOSHONE-BANNOCK TRIBES

FORT HALL INDIAN RESERVATION
PHONE (208) 478-3700
FAX # (208) 237-0797

FORT HALL BUSINESS COUNCIL
P.O. BOX 306
FORT HALL, IDAHO 83203

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

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

Dear Ms. Norwalk:

My name is Alonzo Coby, Chairman of the Fort Hall Business Council, Shoshone-BannockTribes. We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule published on January 18, 2007 at 72 Federal Register 2236. As currently written, we oppose the proposed rule and would like to offer suggested regulatory language that we believe will address tribal concerns consistent with existing CMS policy.

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

Criteria for Indian Tribes to Participate

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

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

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

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

Criteria for Tribal Organizations to Participate

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

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

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

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

section 447.206.[2]

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

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

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

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

---

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

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

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

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

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

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

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

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

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

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

Sincerely,

Alonzo Coby, Chairman
Fort Hall Business Council

Cc: National Indian Health Board

51

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

March 16, 2007

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

To Whom It May Concern:

Enclosed are New York State's comments on the Centers for Medicare & Medicaid Services' proposed rule published in the January 18, 2007, Federal Register, which adds 42 CFR sections 447.206 and 447.207 and modifies 42 CFR sections 433.50, 433.51, 447.271, 447.272, 447.321, 457.220, and 457.628. Questions regarding these comments may be addressed to Mark H. Van Guysling, of my staff, at (518) 474-6350.

Sincerely,

Deborah Bachrach

Deborah Bachrach
Deputy Commissioner
Office of Health Insurance Programs

Enclosure

Comments Regarding Proposed New Section 42 CFR 447.206 and Proposed Modification to 42 CFR 447.271, 447.272, 447.321

These provisions would:

1. limit Medicaid reimbursement to each individual public provider's cost of providing covered Medicaid services to eligible Medicaid recipients;

2. for public hospitals and nursing facilities, require the State to demonstrate compliance with the new Medicaid reimbursement limit through use of Medicare cost reports or other standardized, nationally recognized cost reports;

3. for non-hospital and non-nursing facility public providers, require the State to provide auditable documentation in a form approved by the Secretary to demonstrate compliance with the new Medicaid reimbursement limit;

4. require providers using certified public expenditures (CPEs) to submit annual reports to the State's Medicaid Agency that reflect the cost of serving Medicaid recipients during the year. The State would then be required to reconcile interim Medicaid payments to these filed cost reports for the spending year; and,

5. require the State to repay the federal share of any overpayments made to public providers based on the new Medicaid reimbursement limits.

For the following reasons, the State objects to these proposed provisions:

1. The proposed rule conflicts with prior Congressional intent. The Administration has previously offered legislation with language similar to CMS's proposed rule and Congress rejected these proposals. Indeed, in the history of Medicaid, Congress has steadily moved away from requiring cost reconciliation and given states greater flexibility to create innovative prospective payment methods. As recently as 1997, Congress amended Medicaid law to remove the Boren amendment's "reasonable and adequate" standard and replace it with a standard requiring a public notice and process to establish rate methodologies. This is the law as it currently stands. Given the legislative history, it is clear Congress does not intend for states to be held to facility specific cost based reimbursement methodologies.

2. CMS's proposal to severely curtail reimbursement to all public providers nationwide is an unnecessary and unfair overreach by CMS to address isolated Medicaid funding practices that it deems inappropriate. Solutions to such issues should be targeted and should not come at the expense of all public health care providers and recipients of their services. We believe CMS has sufficient administrative authority to assure the Medicaid program's financial integrity without resorting to these intrusive regulations that will undermine the effectiveness of the Medicaid program.

3. The proposed rule unjustifiably creates explicit dual standards between Medicaid and Medicare by capping Medicaid payments to costs while allowing Medicare to pay above costs. Both Medicare and Medicaid have for many years crafted payment methodologies to provide financial incentives to achieve economy, efficiency and other public policy goals. Prime examples are the pricing methodologies employed by Medicare and New York State's Medicaid program to reimburse inpatient hospital services on amounts per discharge. These reimbursement methodologies were intentionally crafted to allow hospitals to make a "profit" by providing efficient and economical services that result in reduced lengths of stay, which in the long run contains overall health care cost growth by reducing excess bed capacity. It is inappropriate for CMS to propose abandoning such principles for public hospital services provided under Medicaid, especially since Medicare continues to embrace them for the very same providers.

4. CMS's proposals are crafted in a manner that will result in public providers having surplus payments recouped for one service category (such as inpatient hospital services) at the same time they are incurring deficits for other services (such as outpatient hospital services). This is unfair and will result in many public providers losing money serving Medicaid recipients. This is not sound public policy. No business sector, including public health care, can compete in the marketplace without accruing some financial surplus for the services it provides. Such surpluses are essential to the viability of health care providers, especially in their ability to access capital and reconfigure services to respond to changes in the health care marketplace and emerging health problems. Further, if public providers are starved of Medicaid resources, cost shifts to other payors will likely occur, making private health insurance more expensive and unaffordable. This could exacerbate the problem of the uninsured.

5. Public providers are the backbone of New York's health care safety net, often serving the poorest and most severely disabled citizens of the State. These persons commonly have extremely complex and multi-faceted issues due to medical conditions, mental illness, and developmental disabilities. The proposed rule has the potential to negatively impact access to quality care provided by the full spectrum of public providers, including:

   - the New York City Health and Hospitals Corporation (HHC), a public health care delivery system that includes thirteen hospitals and five nursing homes;

   - public hospitals in the counties of Erie, Nassau, Westchester, Lewis, Rockland and Wyoming;

   - county operated nursing homes in every region of the State;

   - the State's service delivery system for persons with developmental disabilities, which cares for more than 90,000 individuals who depend on federal Medicaid funding for day-to-day direct support to maintain health and safety. These

individuals need substantial care for their entire lives. The continued success of NYS' system of care for individuals with developmental disabilities, relies on stable Medicaid funding streams provided through currently approved prospective reimbursement methodologies, including those established for programs under the State's Home and Community Based Services (HCBS) waiver. CMS's proposed regulations will interfere with these stable funding streams, which will undermine essential programs and affect NYS' ability to comply with requirements to provide services in the least restrictive settings (The Olmstead Decision);

- psychiatric hospitals and mental health programs operated by state and county providers. Medicaid reimbursement to these providers sometimes results in a modest surplus that is reinvested in programs that provide crucial support for persons with mental illness and are essential to keeping these individuals out of more expensive emergency services, homeless shelters, jails, and inpatient beds. If mental health providers are not allowed to retain these surpluses, they will be forced to curtail many of these services, which will jeopardize the safety and well being of mentally ill persons and their communities; and,

- school districts and counties that provide services to pre-school and school-age children. These services are essential to early identification and treatment of children's health problems and developmental delays. Without such services, many children will be negatively impacted for the duration of their lives.

6. The proposed requirements for extensive facility specific cost reporting and associated state review, auditing, and rate reconciliation are extremely burdensome for providers and State and local governments. We are deeply concerned these requirements may drive some providers from the Medicaid program, particularly school based health providers. Further, hospitals and nursing homes are currently required to submit State developed cost reports. CMS's rule would require that public hospitals and nursing homes also submit Medicare cost reports to the State for purposes of demonstrating compliance with Medicaid cost limits. This would be duplicative and costly.

Comments Regarding Proposed New Section 42 CFR 447.207 and Proposed Modifications to 42 CFR 433.50, 433.51, 457.220 and 457.628

These provisions would:

1. redefine which health care providers are considered "units of government" by requiring they have taxing authority or be an integral part of a unit of government with taxing authority that is legally obligated to fund the health care provider's expenses, liabilities and deficits;

2. prohibit health care providers that do not meet the new definition of 'units of government" from certifying public expenditures (CPEs) or transferring funds to state and local governments in support of the non-federal share of Medicaid and S-CHIP expenditures (under penalty of reduced Medicaid federal financial participation to the applicable state);

3. authorize health care providers that meet the definition of "units of government" to use CPEs or transfer funds to state and local governments. Transferred funds may only be used to support the non-federal share of Medicaid and S-CHIP expenditures and must be derived from state or local taxes (which must be demonstrated on the provider's financial records). Further, CMS states in the preamble that such transfers must occur prior to, rather than after, a Medicaid payment is made;

4. require states to implement significant cost reporting and auditing of CPEs;

5. require all providers to receive and retain the full amount of Gross Medicaid and S-CHIP payments provided to them for services furnished under the approved State plan (or the approved provisions of a waiver or demonstration, if applicable); and,

6. require the Secretary of Health and Human Services to determine compliance with the retention of funds requirement by examining any associated transactions that are related to a provider's total computable payment to ensure that the State's claimed expenditure, which serves as the basis for Federal Financial Participation, is equal to the State's net expenditure, and that the full amount of the non-Federal share of the payment has been satisfied.

For the following reasons, the State objects to these proposed provisions:

1. CMS's proposed definition of "unit of government" is not in keeping with the Social Security Act (SSA), thus it is outside CMS's regulatory authority. SSA 1903 (w) (7) (G) states that: *" the term 'unit of local government' means, with respect to a State, a city, county, special purpose district or other governmental unit of the State."* Nowhere in this definition is it mentioned that a health care provider may not be considered a "unit of government" unless it has direct taxing authority or legally mandated access to financial support for its operations, deficits and liabilities from a governmental entity with taxing authority.

2. CMS's definition of governmental health care provider is far too narrow. A number of health care institutions in New York are established under state statute as public benefit corporations (PBCs), whose boards of directors are mandated to be appointed by State and/or local governments. We believe this statutory framework is more than adequate to establish these providers as "units of government" under the SSA definition. We are concerned, however, that some of these PBCs may not meet CMS's proposed redefinition of "unit of government", because assistance they receive from their sponsoring governments is not necessarily mandated in statute. Consequently, CMS' proposed regulation could jeopardize currently existing

financial relationships between providers that have for many years been appropriately treated as public entities and their sponsoring governments.

3. CMS States in its preamble: *"Generally, an IGT that takes place before the Medicaid payment, which originates from an account funded by taxes that is separate from the account in which the health care provider receives Medicaid payments, is usually supportable."* CMS appears to be taking the position that the non-federal share of all Medicaid expenditures must be supported solely from governmental taxes. Such an arbitrary policy would prohibit states, localities and governmental providers from funding the non-federal share of Medicaid expenses from such sources as tobacco settlement guarantee funds, the sale of stocks, user fees, endowments and private payor revenue. The State seeks clarification from CMS as to whether its intent is to impose such a policy in all instances or solely when a health care provider is providing the non-federal matching funds. Either way, we believe the prohibition is not supported by the SSA and is outside CMS's authority to regulate. Further, the associated requirements for documentation and account segregation are highly burdensome and would make the Medicaid program exponentially more complicated to administer.

4. CMS's proposed requirement that states extensively document and audit CPEs creates an onerous administrative and financial burden on states, local governments and providers. In place of these requirements, the State recommends that CMS require certifications and assurances from providers and state and local governments regarding the appropriateness of their CPEs. Further, the State believes the Federal Government should fund one hundred percent of all costs associated with any new mandate.

5. We believe it is inappropriate for CMS to attempt to regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are in all probability extremely varied and complex. As an example, local governments might provide direct and/or indirect monetary subsidies to their public hospitals to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net hospitals. If the hospitals eventually receive alternative revenue sources, it is entirely appropriate for them to partially or fully repay their sponsoring local governments for the first instance subsidies through a transfer of general patient care receipts. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State, as would be the case under CMS's proposed rule.

6. The requirement that states and public providers complete and submit answers to questionnaires to determine whether they meet CMS's definition of "unit of government" is an administrative and financial burden. In place of these requirements, the State recommends that CMS require certifications and assurances from providers and state and local governments regarding their

governmental status. Further, the State believes the Federal Government should fund one hundred percent of all costs associated with any new mandate.

52

COVINGTON & BURLING LLP

1201 PENNSYLVANIA AVENUE NW
WASHINGTON, DC 20004-2401
TEL 202.662.6000
FAX 202.662.6291
WWW.COV.COM

WASHINGTON
NEW YORK
SAN FRANCISCO
LONDON
BRUSSELS

CHARLES A. MILLER
TEL 202.662.5410
FAX 202.778.5410
CMILLER@COV.COM

March 19, 2007

MAR [illegible] 2007

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

Re: CMS-2258-P

Dear Sir or Madam:

Enclosed please find an original and two copies of Joint Comments of Seventeen States on the above-captioned proposed rule. We have also endeavored to submit these Joint Comments electronically, but are causing the attached to be hand delivered to be assured that the Comments will be received within the time specified in the Notice of Proposed Rulemaking.

Sincerely,

Charles A. Miller
On Behalf of the
Seventeen Commenting States

Enclosures

BEFORE THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

In the Matter of	)
	)
Proposed Medicaid Program Rules on	)
	)
COST LIMIT FOR PROVIDERS OPERATED BY UNITS OF GOVERNMENT AND PROVISIONS TO ENSURE THE INTEGRITY OF FEDERAL-STATE FINANCIAL PARTNERSHIP	)
	)
CMS-2258-P	)
	)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The only justification ever offered by CMS is the assertion that the Medicaid program has always been predicated on state tax-funded contributions equal to the non-federal share of its costs. That is simply not the case. From its inception, Title XIX has contemplated that public entities not funded by state appropriations would contribute to the non-federal share of Medicaid expenditures. Section 1902(a)(2) permits a State plan to provide for local participation in as much as 60 percent of the non-federal share of total Medicaid expenditures, as

long as the lack of adequate "funds" from "local sources" does not result in lowering the amount, duration, scope or quality of care and services under the plan. There is no requirement in this section of the law that such "funds" come from tax revenues or that the "sources" be federally determined to be "units of government."

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

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

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

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

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

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

CMS now asserts that it must substitute "units of government" for "public agencies" as the only entities qualified to put up the non-federal share through transfer or certification in order "to be consistent with" and "to conform the language to" Section 1903(w)(6)(A), which was added to Title XIX as part of the Provider Tax Amendments of 1991. 72 Fed. Reg. at 2240. The Provider Tax Amendments do not dictate or even suggest the result that CMS now seeks to achieve. Section 1903(w)(6)(A) is not a limitation on the nature of public entities contributing to the non-federal share of financial participation but instead a limitation on CMS's authority to regulate in this area. It states that notwithstanding any other provision:

> the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this subchapter, regardless of whether the unit of government is also a health care provider. . . . .

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

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

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

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

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

Pub. L. 102-234 § 5.

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

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

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

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

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

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

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

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

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

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

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

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

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

CMS proposes two definitions of the "units of government" whose funds can be considered as making up the non-Federal share of Medicaid expenditures. The first is a "State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority." Proposed § 433.50(a)(1)(i). A health care provider will be considered to be a "unit of government" only if the provider itself has taxing authority or is "an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities and deficits, so that a contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues." Proposed 42 C.F.R. § 433.50(a)(1)(ii)(A), (B). In the preamble, CMS asserts that a provider is likely not operated by a unit of government if an "independent entity [has] liability for the operation of the health care provider and will not have access to the unit of government's tax revenue without the express permission of the unit of government." 72 Fed. Reg. at 2240. Both aspects of the definition of "unit of government" are faulty and should not be adopted.

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

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

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

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

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

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

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

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

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

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

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

---

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

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

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

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

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

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

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

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

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

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

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

* * * * *

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

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

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

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

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

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

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

The proposed rule would eliminate existing § 447.271(b), which permits payments to "a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider's charges were equal to or greater than its costs." *Id.* Section 447.272, which applies to ratesetting for inpatient services provided by hospitals, nursing facilities, and ICFs/MR, would be changed to provide that the UPL for all government operated facilities is "the individual provider's cost," and to provide that Medicaid payments to these facilities "must not exceed the individual provider's cost." *Id.* The same changes would be made to § 447.321's UPL rules for ratesetting for outpatient hospital and clinic services. *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The Nominal Charge Hospital Provision Should Be Retained

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

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

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

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

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

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

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

IV. Retention of Payments (Proposed § 447.207)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

---

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

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

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

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

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

Conclusion

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

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

Respectfully submitted,

Charles A. Miller
Caroline M. Brown
Covington & Burling LLP
1201 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2401
202-662-5410

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

March 19, 2007

United States Senate

WASHINGTON, DC 20510

March 16, 2007

2007 MAR 20 AM 9:59

The Honorable Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Leavitt:

We are writing to express our strong opposition to the Medicaid changes contained in the Proposed Rule CMS-2258-P, which was issued on January 18, 2007. As you know, bipartisan objections to the changes called for in this proposed rule have been raised by Congress and our nation's Governors since 2005. We urge you to withdraw this rule immediately.

The Medicaid program is the foundation of our health care safety net. As our nation's largest insurer, it provides access to meaningful and affordable health care for more than 50 million people. It also keeps hospitals, doctors, nursing homes, and clinics operating in our communities. Without this critical source of funding, many providers would not be able to afford to offer high-quality health care, especially in rural areas.

Since its enactment in 1965, Medicaid has been a federal-state partnership. The federal government has worked together with the states to ensure health care coverage and access for the most vulnerable Americans – children, pregnant women, the elderly and the disabled. This shared responsibility has been paramount, with states implementing the program within broad federal guidelines.

The new proposed rule would usurp state flexibility and fundamentally alter the nature of state funding for the Medicaid program. We are particularly concerned with three aspects of the proposed rule: 1) the new definition of a "unit of government;" 2) the restrictions placed on states' ability to fund their share of Medicaid expenditures; and 3) the "cost" limit imposed on Medicaid provider payments. We are also alarmed by CMS' refusal to provide any state-specific data on the impact of this proposed rule, which we believe could be much greater than a $5 billion reduction in federal Medicaid spending.

The new definition of a "unit of government" contained in the proposed rule is at odds with the definition adopted by Congress in Title XIX (Section 1903(w)(7)(G)), as described in House Report 102-310. The proposed rule adopts a federal definition in which only those governmental entities with taxing authority would be deemed governmental enough to contribute to the non-federal share of Medicaid expenditures. This is not what Congress intended. The statutory definition of a "unit of government" respects the fundamental right of states to establish subdivisions to suit their needs and best carry out governmental functions. In the case of Medicaid, federal law grants states the authority and flexibility to provide health care through the most efficient and effective methods possible. In most states, this means that state university hospitals, public nursing homes, school-based health centers, and other providers become an essential part of the governmental health care infrastructure. We believe the narrow definition of "unit of government" proposed by this new rule would lead to substantial cuts for public

providers and limit access to the vital health care services that millions of Americans depend upon.

Similarly, CMS is also singling out public providers by restricting the type of public funds that can be used to finance the state share of Medicaid expenditures. Under the proposed rule, only funding derived from state and local taxes would be allowed to fund the state share. By your agency's own admission, inappropriate federal matching arrangements have been largely eliminated over the last three years through CMS' oversight activities. Given these activities, it is unclear why the new restriction on public funds is necessary or how it will further the overall efforts of CMS to reduce Medicaid fraud and abuse.

Furthermore, this aspect of the proposed rule also seems to contradict federal law. Section 1902(a)(2) of the Social Security Act allows states to rely on "local sources" for up to 60 percent of the non-federal share of program expenditures. Current law does not limit the types of local sources that may be used to only those sources derived from tax revenue. Such a policy shift would hamper states abilities to fund their Medicaid programs, and we question CMS' authority to pursue such a far-reaching policy change.

Finally, we are concerned about the cost limit imposed on public providers by this proposed rule. Under current regulations, states are permitted to provide Medicaid reimbursement to hospitals and other providers up to the amount that would be payable using Medicare payment policies. The proposed rule would reduce that limit to Medicaid costs for governmental providers only, with no concurrent change for private providers. Public providers, who disproportionately serve the uninsured, should not be subject to a more restrictive cost limit than private providers. Such a reimbursement policy would have an adverse impact on system-wide health care needs, such as trauma care, school-based health care and medical education.

We understand and respect the efforts of CMS to ensure that the Medicaid program is operating on a fiscally sound and responsible basis; however, we believe the proposed rule has gone far beyond what is necessary to secure fiscal integrity. Instead, the proposed rule would undermine both the federal-state partnership and the shared goal of ensuring health care coverage and access, which are the hallmarks of the Medicaid program.

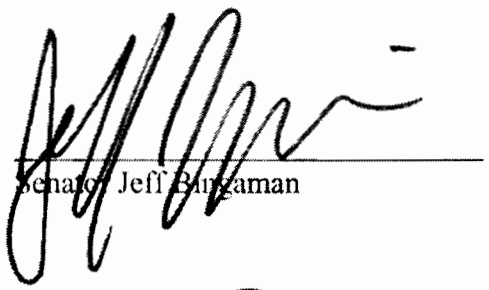
While we are willing to work with you and CMS to strengthen Medicaid, fundamental changes in Medicaid's financing and payment mechanisms as envisioned in this rule can only be adopted by Congress. For this reason, we request that you withdraw the regulation.

We thank you for your prompt consideration of and attention to this request. We also ask that our comments be placed in the public record of the rulemaking.

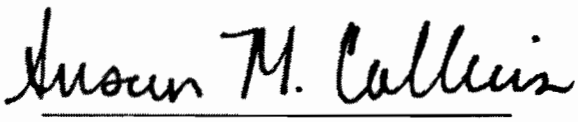
Sincerely,

Senator John D. Rockefeller IV

Senator Gordon H. Smith

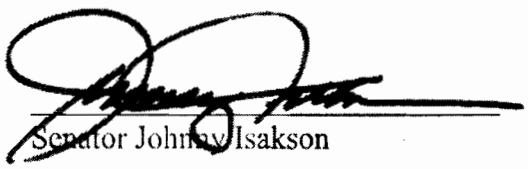


Senator Jeff Bingaman

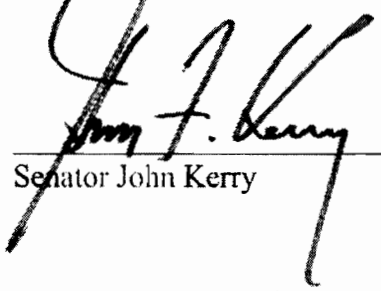


Senator Susan Collins

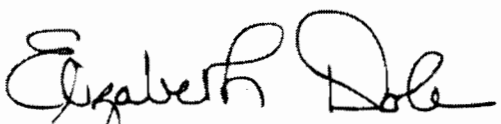
Senator Richard Durbin



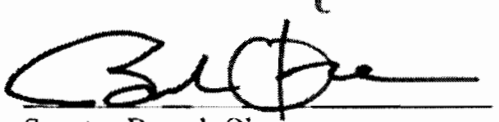
Senator Johnny Isakson



Senator John Kerry

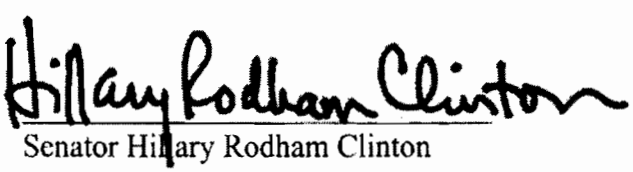


Senator Elizabeth Dole



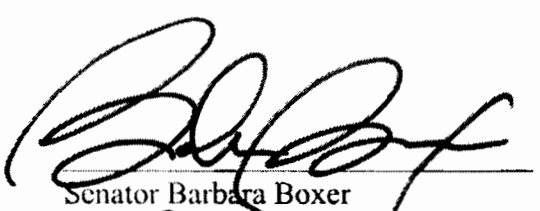
Senator Barack Obama

Senator Kay Bailey Hutchison

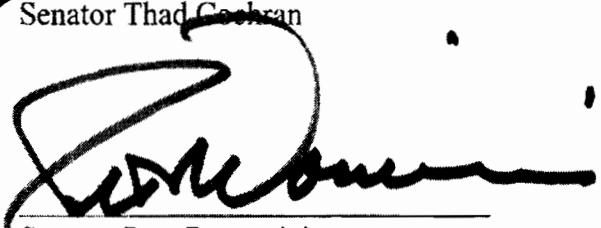


Senator Hillary Rodham Clinton

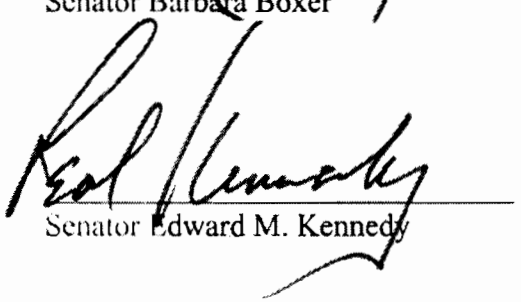
Senator Thad Cochran



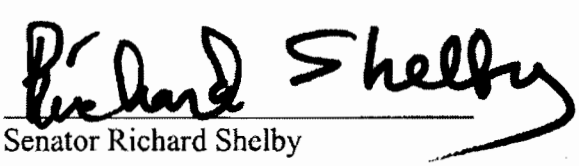
Senator Barbara Boxer



Senator Pete Domenici



Senator Edward M. Kennedy



Senator Richard Shelby

Senator Ken Salazar

Senator Olympia Snowe

Senator Dianne Feinstein

Senator Saxby Chambliss

Senator Bill Nelson

Senator Richard Burr

Senator Jim Webb

Senator Wayne Allard

Senator Debbie Stabenow

Senator Christopher Bond

Senator Robert Menendez

Senator Pat Roberts

Senator Evan Bayh

Senator John Warner

Senator Ron Wyden

Senator Bernard Sanders

Senator Carl Levin

Senator Blanche Lincoln

Senator Joseph Lieberman

Senator Mark Pryor

Senator Sherrod Brown

Senator Frank Lautenberg

Senator Charles Schumer

Senator Russell Feingold

Senator Harry Reid

Senator Maria Cantwell

Senator Joseph Biden

Senator Tom Harkin

Senator Daniel Akaka

Senator Amy Klobuchar

Senator Barbara Mikulski

Senator Benjamin Cardin

Senator Christopher Dodd

Senator Claire McCaskill

Senator Patrick Leahy

Senator Jon Tester

Senator Patty Murray

Senator Herb Kohl