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BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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March 19, 2007

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

Attention: CMS-2258-P

Dear Ms. Norwalk:

The Blue Cross and Blue Shield Association (BCBSA) appreciates the opportunity to provide comment on the proposed rule, "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership," as published in the *Federal Register* on January 18, 2006 (72Federal Register 2236).

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

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

Partnerships between states and Plans have allowed states to stretch limited resources to provide cost-effective coverage as well as expand access to quality care for disadvantaged populations. Plans have demonstrated success in improving access to preventive services, achieving improved outcomes for acute care, and coordinating care

for those with chronic conditions. We value the partnership our Plans have with states and CMS to bring valued benefits to Medicaid beneficiaries.

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

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

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

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

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

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

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

  For example, in Illinois, the Intergovernmental Transfer (IGT) and UPL arrangements played a key role in policy decisions to eliminate Managed Care Organization contracting altogether.[2] Texas attempted to expand Medicaid managed care, but faced resistance from public hospitals due to the potential loss of UPL revenues, and

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[1] Menges, Joel, and Aaron McKethan. Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Exansion. The Lewin Group. Medicaid Health Plans of America, 2006. 14-15.
[2] Id. at 8.

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

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

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

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

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

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

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

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

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

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[3] Id. at 8-15.

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

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

Sincerely,

Alissa Fox

Alissa Fox
Vice President, Legislative and Regulatory Policy

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March 9, 2007

Ms. Leslie Norwalk
Acting Administrator
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200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

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

Dear Ms. Norwalk:

The McDowell Hospital. We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule. We oppose this rule and will highlight the harm its proposed policy changes would cause to our hospital and the patients we serve.

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

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

Existing federal Medicaid regulations allow North Carolina hospitals to receive payments to offset a portion of the costs incurred when caring for Medicaid patients. Even with these payments, however, hospital Medicaid revenues for most North Carolina hospitals still fall significantly short of allowable Medicaid costs. If the proposed rule is implemented and, as a

result this important hospital funding stream is eliminated, those losses would be exacerbated. Hospitals would be forced either to raise their charges to insured patients or to reduce their costs by eliminating costly, but under-reimbursed services. The first choice would raise health insurance costs by an estimated four percent. The second would eliminate needed services, not just for Medicaid patients, but also for the entire community. Eliminating those services likely would result in the elimination of almost 3,000 hospital jobs. That reduced spending and those lost jobs would be felt in local economies and the resulting economic loss to the State of North Carolina has been estimated at over $600 million and almost 11,000 jobs.

Specifically for our hospital, the loss of this program would mean a greater than $300,000 impact to the hospital's net operating income. For FY07, The McDowell Hospital has a budgeted operating margin of $206,679 and will likely have a comparable operating margin for FY07. Therefore, the loss of the MRI program means the hospital would end its fiscal year with a net operating loss. The information delineated below indicates the criticality of the MRI program to The McDowell Hospital and McDowell County residents.

The McDowell Hospital's operating losses for FY04 and FY05 were $(4,985,875) and $(99,564), respectively. The hospital has taken great strides since FY04 to increase its outpatient care services, offer additional inpatients services and improve its managed care and commercial contracts to assist in assuring its viability. The greater $300,000 of MRI program funding is of great benefit to The McDowell Hospital and our patients, and assists us in continuing to meet the medical needs of our community.

As a small rural hospital we have struggled to accomplish our mission due to ever-increasing healthcare related costs (up-to-date equipment needs, demand for higher nursing salaries, increasing costs for medical supplies and pharmaceuticals). As the hospital continues to serve an increasing number of uninsured/self-pay and Medicaid patients, our mission will be even harder to accomplish if the collections from this payor mix continues to diminish and we lose funding from the MRI program. The hospital continues to experience annual increases in bad debt expense and expects this trend to continue in FY07, like many other hospitals in the United States are experiencing.

According to the U.S. Census Bureau and the North Carolina State Data Center, the population of McDowell County is projected to increase to almost 49,000 residents by 2010, an increase of 15.5% since the 2000 census. This increase in population will place a greater demand for healthcare services within the county and The McDowell Hospital is instrumental in the provision of healthcare to this community.

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

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

Sincerely,

Nan Tomsky
Interim CEO

cc: Senator Elizabeth Dole
Senator Richard Burr
Congressman Heath Shuler

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March 15, 2007

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

Dear Ms. Norwalk: Leslie

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

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

Background On The Proposed Rule

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

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

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

Executive Summary

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

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

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

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

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

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

The following are details regarding our concerns expressed above.

Discussion

CMS' Impact Analysis is Flawed

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The report states that:

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

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

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

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

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

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

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

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

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

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

CMS Should Address The Fundamental Issues Facing Medicaid

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

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

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

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

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

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

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

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

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

CMS Should Reconsider Cost-Based Reimbursement Limits

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

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

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

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

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

CMS Should Withdraw The Proposed Rule

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

Sincerely,

Bruce Yarwood
President and CEO

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

March 16, 2007

COMMENTS BY THE DENVER HEALTH AND HOSPITAL AUTHORITY ON PROPOSED RULE: CMS-2258-P: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership

Denver Health and Hospital Authority (DHHA) urges the Center for Medicare and Medicaid Services (CMS) to withdraw the Proposed Rule CMS-2258-P (the Proposed Rule).

DHHA has the following specific concerns about the Proposed Rule:

I. Defining a Unit of Government (Sec. 433.50)

Currently Title XIX of the Social Security Act (SSA) defines a "unit of government" for purposes of participation in the non-Federal Medicaid match as "a city, county, special purpose district, or other governmental unit in the State." The Proposed Rule adds requirements that the health care provider operating as a unit of government must have generally applicable taxing authority, be able to access funding as an integral part of a governmental unit with taxing authority that is responsible for the health care provider's expenses, liabilities and deficits, and that a contractual arrangement with the state or local government is not the primary basis for the health care provider to receive tax revenue.

We believe this clarification of the definition is not needed and should be eliminated from the Proposed Rule for the following reasons:

- Title XIX of the Social Security Act (SSA) already defines "unit of government". The restrictive definition in the Proposed Rule conflicts with this definition and exceeds CMS' statutory authority.
- State and local governments nationwide have traditionally had the right to organize their governmental structures. The Proposed Rule usurps states' rights in proposing this restrictive definition.
- The consequences of the change in the definition, for which we cannot find a valid reason, is that millions of dollars of federal funding currently received by political subdivisions such as DHHA, independent authorities and other public structures that have been created by states will be eliminated and the ability of these entities to care for Medicaid and the uninsured will also disappear.

DHHA is a political subdivision of the State of Colorado. It was created by Colorado statute and is deemed by the State of Colorado to be a unit of government in the state. As a government, DHHA is subject to Open Records

laws, Open Meeting laws, Governmental Immunity Statutes, and liability under federal constitutional laws. It is treated as a government by the State of Colorado for the purpose of entering into "intergovernmental agreements". Our Board cannot take a position on legislation under Colorado election laws. We are the Public Health Department in Denver for the treatment of communicable disease and immunizations. We are the backbone for healthcare disaster preparedness in the Denver area.

Under the Proposed Rule's definition of "unit of government", DHHA would no longer qualify as a unit of government because we do not meet the restrictive definition of "unit of government" outlined in the rule. Additionally, at least eight other major Colorado providers of care to Medicaid and the uninsured would not qualify as a "unit of government" as they do now.

DHHA and the other Colorado providers referenced above currently provide the non-federal share of Disproportionate Share (DSH) funding and Upper Payment Limit (UPL) through Certification of Public Expenditures (CPE). Given Colorado's constitutional limits on governmental revenue and spending, neither the state nor local governmental entities are in a position to replace this loss of federal funding by September 1, 2007, or even for a number of years after that date. The impact to the State of Colorado will be approximately $128 million in lost federal funding including a $75 million loss of funding to DHHA. This would essentially gut the safety net in Colorado. The nine hospitals most affected by this change provided $595 million in care to uninsured Coloradoans in State Fiscal Year (SFY) 2006. We believe many of these hospitals, including DHHA, would be unable to sustain operations with this level of reductions. The $595 million in uninsured care would thus be transferred to the privately owned hospitals which would quickly realize a sizable negative financial impact.

The ultimate impact of these funding cuts is on the patients, especially:

- The working poor (54% of DHHA's uninsured patients are working) who have no employer-sponsored health insurance;
- The disabled, who have not yet met the requirements to be on Medicaid or Medicare;
- The elderly, as the DSH and UPL payments assist Medicare patients who are above the income/resource limit for Qualified Medicare Beneficiary (QMB) Medicaid.

DHHA alone served 61,000 Medicaid patients and 69,000 uninsured patients in 2006. Many of these patients have chronic illnesses which, if not treated on a regular basis, deteriorate into acute situations which then require emergency care. DHHA is able to care for these patients in an integrated system which gets patients to the right place, at the right time for the right level of care.

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

For providers who meet the restrictive definition in Section 433.50 of the Proposed Rule, the rule further proposes to limit reimbursement for governmentally operated providers to amounts consistent with economy and efficiency by establishing a limit of reimbursement not to exceed cost. DHHA also opposes this section of the Proposed Rule for the following reasons:

- Currently, payments for Medicaid services cannot exceed what Medicare would pay for the same services. We believe this is a reasonable upper limit.
- A cost-based program gives providers no incentive to generate cost savings. By operating within the current Medicare-based upper limit, providers have incentives to save cost and receive supplemental payments that can be used to fund critical information technology, capital and reserve needs required in order to operate a sustainable business.
- Governmental providers, who disproportionately serve the uninsured, have the least ability to cost shift to private insurance companies and thus, should not be subjected to a more restrictive limit than private providers.
- Typically, cost reporting methodologies adopt a very restrictive definition of cost which does not include all cost necessary to operate a business. In essence this limitation would result in Medicaid payments below actual cost.

If Section 433.50 of the Proposed Rule were withdrawn or modified such that DHHA continues to be defined as a governmental unit, this Section 447.206 would then apply. DHHA would not be able to receive funding up to the Medicare upper payment limit, as is now permitted, which would take away any ability to use Medicaid dollars to invest in infrastructure or technology enhancements to ensure continued high-quality cost effective care to this population.

We believe this section of the Proposed Rule also would have significant financial consequences to providers resulting from payments that would actually be well below actual operating cost. We also believe this section would add additional administrative costs to providers and the state for cost reporting and reconciliation. The Medicare upper payment limit is not excessive, and we recommend that that limit stay in place.

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

The Proposed Rule, in addition to developing a very restrictive definition of a unit of government, further requires that only funding derived from taxes would be allowed to fund Medicaid expenditures. This is a departure from past practice, which has allowed use of funds such as collections for provision of patient care services through a public hospital to be used to provide the match. DHHA objects to this provision on the following basis:

- We believe CMS is exceeding its congressionally delegated authority in this provision, as Section 1902(a)(2) of the SSA allows states to rely on "local sources" for up to 60 percent of the non-federal share of program expenditures, without limiting the types of local sources that may be used.
- There is no stated reason for this restriction, but it will result in severe financial consequences for many providers and patients.
- It will result in additional administrative cost due to the recordkeeping that would now be required to ensure that specific funds used for Inter-Governmental Transfers, for example, can be traced back to a specific tax revenue source.

IV. Provider Donations

DHHA is concerned about a statement in the preamble of the Proposed Rule that states that "health care providers that forego generally applicable tax revenue that has been contractually obligated for the provision of health care services to the indigent...are making provider-related donations", implying that current payments made by localities to public providers for indigent care could not be redirected for use as the non-federal share of Medicaid payments. This provision seems to prevent states or local governments from transferring funding to the services deemed by the legislature and taxpayers to be a priority.

Under this provision, an entity such as DHHA, which may have been determined to be no longer a "unit of government" may obtain City support for Medicaid through a locally provided match from the City provided through general tax revenues. While this appears to comply with the extremely restrictive definitions of unit of government and funds that can be used for match under the Proposed Rule, another restriction is then layered on. This restriction deems that any funding DHHA is already receiving for another purpose, such as the $27 million received by DHHA from the City of Denver each year for indigent care, would be considered to be a provider donation. This in turn would require the City to increase general taxes still by $37.5 million to match another $37.5 million in federal funding to supplant DHHA's funds loss, instead of perhaps redirecting the current $27 million in tax support towards a match and attempting to raise $10.5 million in general fund tax support. Again, with the constitutional budget

restrictions in the State of Colorado obtaining this funding would be difficult or impossible particularly in the short time frame given for the rule to become effective.

V. Effective Date

The stated effective date for the new cost limit is September 1, 2007 with no transition period. The most sweeping change in Medicaid since its inception will be impossible to implement in the short time between the Final Rule and the effective date. Colorado's legislative session, for example, will have ended by September 1 and does not begin until January 1; it is costly and difficult to call a special session to attempt to address the issue. Providers will be left without critical federal funding and states will be faced with attempting to develop solutions in days for which years of thought and effort should take place.

VI. Summary

To summarize, the basis for this Proposed Rule appears to be a way to cut federal funding in the Medicaid program, but the Medicaid and uninsured patients with healthcare needs will not go away. This rule unwinds decades of progress that has been made in serving these populations and DHHA urges its withdrawal.

Thank you for the opportunity to provide these comments to this potentially devastating proposed rule. We hope that our input can prove helpful in your process of determining what action will best serve the Medicaid and uninsured patients in our nation.

VISION
ASSOCIATION OF OREGON COUNTIES
STRENGTH
"LINKING GOVERNMENTS LOCALLY"

Local Government Center ■ 1201 Court St. NE ■ P.O. Box 12729 ■ Salem, Oregon 97309
www.aocweb.org ■ Phone: 503-585-8351 ■ Fax: 503-373-7876

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March 12, 2007

By express/overnight mail:

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

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

Dear Secretary Leavitt:

The Association of Oregon Counties (AOC) respectfully submits this letter in response to the proposed rule changes for Centers for Medicare and Medicaid Services. Our association agrees with the intent of the proposed rules, which seek to provide clean sources of funds for Medicaid and State Children's Health Insurance Program (SCHIP) match, but finds the severity of the proposed rules would have an adverse impact on Oregon counties' ability to provide Medicaid services to their constituents.

The proposed rule prohibits the use of various sources of revenue from public entities that, along with funds appropriated from tax collections, have always been considered legitimate sources for the expenditures. These public funds are not recycled federal funds and as such should still be allowable as match.

Consider one example that demonstrates our concern about the new rule – in Oregon, about $4 million is provided by counties each biennium as match for vital *Babies First!* and *CaCoon* programs. The total *Babies First!* state general fund appropriation distributed to counties is $1.03 million. That means at least $3 million of the match funding must come from other local tax revenue sources – not grants, donations or other funds. An initial legal opinion provided by the State of Oregon has conservatively estimated that CMS would not allow fees to be considered a local tax source.

AOC is also concerned about the definition that will be used to determine a unit of government. In Oregon, there are a variety of ways that intergovernmental bodies may be formed. Oregon Statute allows Native American tribes, counties or other units of local government who join together to form governmental units for specific purposes. The Oregon Council of Governments is an example of one type of these intergovernmental entities. These entities are an important part of our service delivery system and AOC is concerned that they may not meet the new more restrictive definition of a governmental entity.

The proposed rule includes imposing a cost limit for public health care providers and changing the definition of "public" status. This fundamental change would diminish long-standing legitimate state funding methods that CMS has previously approved. By requiring the identification of allowable costs, it seems that we are reverting to a fee for service basis. This approach seems inconsistent with CMS direction of moving to managed care and capitated rate methodology.

Many of the other proposed changes are ambiguous and we are unable to determine exactly how counties will be affected. The Association of Oregon Counties urges you to reconsider the proposed rule changes and we look forward to your response to our questions and concerns.

Thank you for your ongoing support and your attention to this important issue.

Sincerely,

Bobby Green Sr.
AOC President
Commissioner Lane County, Oregon

Note: Original sent via Federal Express.

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COPY

Health Services
LOS ANGELES COUNTY

March 15, 2006

MAR 1 8 2007

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.ladhs.org

To improve health through leadership, service and education.

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

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES (LAC/DHS)

On behalf of LAC/DHS, I am writing to express our opposition to CMS' Proposed Rule CMS 2258-P, which imposes cost limits on Medicaid payments to public providers. LAC/DHS urges CMS to withdraw this proposed rule.

We are highly concerned that the proposed rule would have a severe negative impact on California's public safety net hospitals and the patients and communities they serve. If the rule is implemented, LAC/DHS anticipates that it will lose at least $200 million annually in federal Medicaid funds. Potential service reductions as a consequence of this loss are equivalent to closing all of non-hospital operated clinics and defunding our contracted clinics. This would result in eliminating 1.3 million outpatient visits per year.

We are concerned about a number of troubling provisions contained in the rule.

First, it will limit our Medi-Cal reimbursements to the costs of providing Medi-Cal services to our Medi-Cal patients. This will eliminate substantial funding for our Medi-Cal and uninsured patients, who make up 77% of our patient population and whose costs are partially covered under the Safety Net Care Pool. The pool exists under California's CMS-approved hospital financing waiver specifically for the purpose of providing financial assistance to safety net hospitals that incur significant costs in treating uninsured patients.

LAC/DHS provides a full range of services to vulnerable populations, and specialty services to both the uninsured and insured that are often not readily available elsewhere in our communities. LAC/DHS is comprised of:

- 21,700 employees, $3.3 billion budget
- 3 acute care teaching hospitals
- 2 trauma centers
- 1 acute rehabilitation hospital
- 1 multi-service ambulatory care center

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- 6 comprehensive health centers
- 10 primary care health centers
- 100 private-partner primary care sites
- Emergency Medical Services agency
- 2 medical school partners

Of LAC/DHS's nearly 700,000 patients:

- 71% are uninsured
- Median income is between $5,000 and $10,000
- 71% are Latino, 15% African American, 10% White
- 53% speak Spanish as primary language
- Chronic conditions are prevalent. Among adult patients the following conditions are present
  - 22% diabetes
  - 34% hypertension
  - 31% high cholesterol
  - 14% depression

Further,

- Hospitals in the county are often totally full – LAC/DHS has 10% of the bed capacity.
- LAC/DHS provides 35% of all trauma care in the County.
- LAC/DHS provides 55% of all inpatient burn care in the County.
- 13% of all emergency room visits county-wide occur in LAC/DHS facilities.
- LAC/DHS is responsible for 2.6 million outpatient visits each year.
- 46% (1,707) of the medical residents in the County are trained in County hospitals.
- LAC/DHS provides funding for the Medi-Cal program through certified public expenditures and intergovernmental transfers.
- The County performs Medi-Cal administrative activities on behalf of the State, such as outreach and Medi-Cal enrollment, and funds the nonfederal share of those activities.

Though we understand that staff from CMS verbally has advised the State that the regulation will not affect California's waiver, the potential harmful effects on our hospital are such that we cannot rely on these verbal assurances, particularly given the plain language of the rule. The

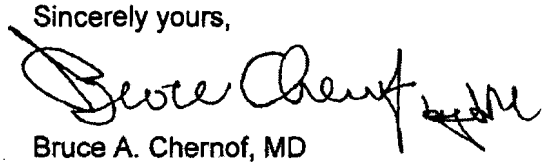
proposed rule explicitly states in the preamble that all Medicaid payments "made under the authority of the State plan and under Medicaid waiver and demonstration authorities are subject to all provisions of this regulation." 72 *Fed. Reg.* 2236, 2240. Moreover, the Special Terms and Conditions that govern the Hospital Waiver require that the State comply with any regulatory changes. Hence, we and California's other public hospitals are highly concerned that, when the rule's limit to Medicaid costs is applied to our state's hospital financing waiver, funding will be eliminated for indigent non-Medicaid patients whose costs are currently covered under the Safety Net Care Pool.

Second, the rule imposes a very restrictive definition of public providers who can participate in Medicaid funding programs. Under the proposed provision, the University of California Medical Centers and Alameda County Medical Center will likely be unable to meet CMS' stringent definition; consequently, those public hospitals stand to lose millions of federal dollars a year. These additional losses would also contribute to reduced access and services to our patients and our communities.

Finally, there are a number of legal and technical issues raised in the comment letter submitted by the California Association of Public Hospitals (CAPH), an organization of which we are a member. These include a provision that narrows which sources of funds may be used as non-federal Medicaid matching funds, and a requirement that public providers retain federal funds upon receipt. We support CAPH's comments of opposition and incorporate them by reference in this comment letter.

LAC/DHS opposes the Medicaid rule and strongly urges CMS to withdraw it. If the rule goes into effect, we will suffer extremely harmful effects that will affect our ability to care for our patients and communities. CMS should recognize the damage that this rule will have to our community's health care system and stop its efforts to move forward with the rule.

Sincerely yours,



Bruce A. Chernof, MD
Director and Chief Medical Officer

BAC:gww

c: Each Supervisor
Chief Administrative Officer
County Counsel

TGH Tampa General Hospital

Ronald A. Hytoff
President & CEO

March 19, 2007

Leslie V. Norwalk, Esq.
Department of Health and Human Services
Attention: CMS-2258-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Proposed Rule entitled: **"Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" CMS-2258-P**

On January 18, 2007 the Centers for Medicare and Medicaid Services ("CMS") released the proposed rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal State-Financial Partnership." The proposed rule will have a profound impact on Florida's safety net hospitals including **Tampa General Hospital (TGH).** The impact on Florida Hospitals alone is estimated to be in excess of $900 million and the unfavorable impact on Tampa General Hospital is calculated at $63 million in lost support of our safety-net mission.

Tampa General Hospital serves a 12-county region with a population in excess of 4 million, in West Central Florida. TGH serves as the primary teaching hospital for the University of South Florida (USF) College of Medicine. Since 1971, the College of Medicine has graduated nearly 1,700 physicians and prepared 2,000 doctors in specialty residency programs. Ranked among the nations top 100 research universities, USF and TGH are committed to developing advances in medicine through both clinical practice and research.

At TGH, we provide services found nowhere else on Florida's West Coast such as a Level One Trauma Center,), a Regional Burn Center, a solid organ transplant program, brain and spinal cord rehabilitation and ECMO, a life-saving technique for babies with severe breathing difficulties.

Tampa General's mission is to be the safety net provider for the region. The ability to provide a safety net for those who cannot pay for services has been supported by financing arrangements that the proposed rule threatens.

P.O. Box 1289 • Tampa, Florida 33601-1289 • (813) 844-7662 • rhytoff@tgh.org
Affiliated with the USF College of Medicine

The Proposed Rule is intended to: "(1) clarify that only units of government are able to participate in the financing of the non-Federal share; (2) establish minimum requirements for documenting cost when using a certified public expenditure ("CPE"); (3) limit providers operated by units of government to reimbursement that does not exceed the cost of providing covered services to eligible Medicaid recipients; [and] (4) establish a new regulatory provision explicitly requiring that providers receive and retain the total computable amount of their Medicaid payments."[1]

If the Proposed Rule is adopted, it will result in the disallowance of most of Florida's Low Income Pool ("LIP") and Disproportionate Share ("DSH") program sources of IGTs and payments as well as adversely affect hospital rates. The Proposed Rule Comments are categorized under the following subject areas: applicability to waiver states and DSH payments; definition of "unit of government"; sources and documentation of intergovernmental transfers ("IGTs"); cost limits for providers operated by "units of government"; and payment retention requirements.

A. Applicability to Waiver States and DSH Payments

Throughout the Proposed Rule, CMS confirms that the proposed changes would apply to states, like Florida, operating under Section 1115 waiver programs, and the restrictions would apply to DSH program payments.[2] The effective date of the Proposed Rule is September 1, 2007;[3] however, a transition period seems to be granted for disproportionate share payments to hospitals, but it may simply coincide with the effective date.[4] The proposed rule is a contradiction to previous work and guidance from the CMS regarding the State of Florida's Medicaid Waiver. CMS has not answered whether Florida will be treated differently under the Proposed Rule given that the waiver creating the Low Income Pool ("LIP").

The proposed rule as it stands is disastrous to the Low Income Pool and will dismantle the entire demonstration as established under the Section 1115 waiver and will eliminate the funds and services to Medicaid and uninsured persons in the State of Florida that are currently relying upon those services as their main source of health care.

B. "Unit of Government"

Title XIX defines a "unit of local government" as "a city, county, special purpose district, or other governmental unit in the State."[5] The Proposed Rule significantly narrows this definition by establishing a "unit of government" (emphasis added) as a "State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) *that has generally applicable taxing authority.*"[6] By including the catchall

[1] Proposed rule at 2240.
[2] *See, e.g., Proposed Rule* at 2240 (emphasis added, "...all Medicaid payments (***including disproportionate share hospital payments***) made under the authority of the State plan ***and under Medicaid waiver and demonstration authorities*** are subject to all provisions of this regulation."
[3] Proposed Rule at 2248.
[4] Proposed Rule 2247.
[5] 42 U.S.C. § 1396b(w)(7)(G).
[6] Proposed 42 C.F.R. § 433.50(a)(1)(i) (emphasis added).

"other governmental unit" in its definition without further restricting the designation to only those units of government with taxing authority, Congress provided the leeway to recognize the many ways in which states have created local governmental units, including governmental units without taxing authority. The Proposed Rule also uses the new "unit of government" definition to restrict the providers operated by such to only those providers with a) taxing authority or b) "unit of government" funding for its expenses, liabilities, and deficits.[7]

In the Proposed Rule, CMS recognizes only a restrictive subset of governmental entities and providers as "units of government." Traditionally, consistent with federalism principles, the federal government has deferred to states in determining which units of government could be considered "public" for purposes of contributing to the non-federal share of the states' Medicaid expenditures.[8]

The importance of this new definition is that only the State and "units of government" with taxing authority are eligible to provide IGTs, and the benefit of the IGTs may likewise be restricted to only "units of governments" or health care providers operated by "units of government". Further, a contractual arrangement with a "unit of government" would be insufficient to claim "operated by unit of government status."[9]

In addition to the Proposed Rule, CMS developed a form entitled "Governmental Status of Health Care Provider" ("Status Form"),[10] which is designed to assist providers in determining whether they qualify as a "unit of government".[11]

It appears that there is no statutory authority for the proposed regulatory definition of "unit of government" or for the proposed definition of "health care provided operated by a unit of government." Tampa General relies on local appropriations to qualify as federal match under the current system. The rule as proposed threatens our ability to provide the services contemplated by the new Waiver including services to uninsured and the underinsured in the region due to the restricted definition of "unit of government."

C. Sources and Documentation of Intergovernmental Transfers ("IGTs")

Under the Proposed Rule, inter-governmental transfers (IGT's) may only be made by "units of government" as defined above, and IGTs can only derived from tax revenues. The Proposed Rule expressly states "...that tax revenue cannot be committed or earmarked for non-Medicaid activities [and that t]ax revenue that is contractually obligated between a unit of State or local government and health care providers to

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[7] Proposed Rule at 2246.
[8] 42 U.S.C. § 1396b(w)(6)(A).
[9] Proposed Rule at 2240.
[10] Proposed Rule at 2242. A copy of this form is available at: http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=2&sortOrder=descending&itemID=CMS1192476&intNumPerPage=10.
[11] Proposed 42 C.F.R. § 433.50(a)(1)(ii)(definition of health care provider operated by a unit government), Proposed Rule at 2246.

provide indigent care is not considered a permissible source of non-Federal share funding for purposes of Medicaid payments."[12]

Under Florida law, counties are required to provide a portion of the required state match for hospitals and nursing homes. It is unclear in the proposed rule whether these state laws comport with the Proposed Rule. Furthermore, several "units of government" in Florida impose local option taxes expressly for health care providers and services, in order for these tax revenues to be used as IGT, must the statutory authority expressly state that such revenues can be used as Medicaid match?

The Proposed Rule includes new documentation requirements whenever CPE's are used to fund the non-federal share of Medicaid expenditures. Governmental entities must submit a certification statement to the Medicaid agency which must in turn submit it to CMS within two years from the date of expenditures attesting that the expenditures are in fact eligible for FFP,[13] it is not clear whether this requirement also applicable to IGTs.

D. Cost Limit for Providers Operated by "Units of Government"

Under current law, State Medicaid programs have the flexibility to pay providers in excess of Medicaid costs. It has been long been the accepted policy and practice to include the costs of providing services to Medicaid as well as uninsured persons in recognition that safety net providers provide essential services to low income and other vulnerable populations. States have used the payment flexibility available under Medicaid to target supplemental payments to particular providers, including payments to safety net Hospitals.

The Proposed Rule would limit reimbursement for governmentally operated providers to the documented cost of providing Medicaid covered services. For hospitals and nursing homes, the costs would be documented using the Medicare Cost Report.[14] The Proposed Rule does retain the upper payment limit principals and also limits payments to hospital outpatient and clinic services to "a reasonable estimate of the amount that would be paid...under Medicare payment principals."[15]

The Proposed Rule seems to suggest that only providers operated by a "unit of government" would be eligible to receive supplemental payments.

E. Retention Requirement:

Tampa General does not believe that the requirement in the Proposed Rule that providers receive and retain all Medicaid payments to them is enforceable. Nor do we believe that this provision will have a major impact on the funding of safety net providers. Although CMS asserts that governmental providers will benefit from the Proposed Rule in part because of the retention provision, this new requirement does not come close to undoing

[12] Proposed Rule at 2239.
[13] Proposed Rule at 2241
[14] For example, Medicare 2552-96, hospital cost report.
[15] Proposed Rule at 2247.

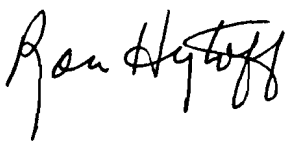
the significant damage caused by the cuts to payments and changes in financing required by other provisions of the Proposed Rule.

The retention provision is drafted broadly, requiring, without qualification, providers to "retain" all payments to them, and providing CMS with authority to "examine any associated transactions" to ensure compliance. Taken to extremes, the requirement to retain payments would prohibit providers from making expenditures with Medicaid reimbursement funds. Certainly, any routine payments from providers to state or local governmental entities for items or services unrelated to Medicaid payments would come under suspicion.

Tampa General Hospital urges the Centers for Medicare and Medicaid Services (CMS) to withdraw Proposed Rule CMS-2258-P (the Proposed Rule). The Proposed Rule exceeds the agency's legal authority, defies the bipartisan opposition of a majority of the Members of Congress and would, in short order; dismantle the intricate system of Medicaid-based support for America's health care safety net, seriously compromising access for Medicaid and uninsured patients. Without any plan for replacement funding, CMS would eliminate millions of dollars of support payments that have traditionally been used to ensure that Florida's poor and uninsured have access to a full range of primary, specialty, acute and long term care. The cuts would eliminate funding that has ensured that Tampa General can provide emergency response capabilities, highly specialized but under-reimbursed tertiary services (such as trauma, neonatal intensive and burn care), and trained medical professionals. The result of this regulation would be a severely compromised safety net health system in Florida, unable to meet current demand for services and incapable of keeping pace with the fast-paced changes in technology, research and best practices that result in the highest quality care.

Best regards,

Sincerely yours,



THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER
WASHINGTON DC

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SCHOOL OF PUBLIC HEALTH
& HEALTH SERVICES

DEPARTMENT OF HEALTH POLICY

March 14, 2007

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

Re: CMS-2258-P (72 CFR 1126, January 18, 2007)

Gentlepersons;

Faculty and staff of the Department of Health Policy, The George Washington University School of Public Health and Health Services hereby submit these comments on the above-captioned rule related to Cost Limits for Providers Operated by Units of Government. These comments are given by the faculty and staff whose names appear at the end of this letter. These comments do not represent the view of the University, the Medical Center, the School of Public Health and Health Services, or the Department of Health Policy.

The faculty and staff who join in these comments are members of the Department of Health Policy, the only one of its kind among U.S. Schools of Public Health, offers one of the nation's largest academic programs in health policy. While the Department is known for a wide array of topical areas, our faculty and staff are particularly well-known for our work on issues affecting access to health care for low income, medically underserved and vulnerable populations. Included among its faculty and staff are individuals who conduct national evaluations on this issue for both government and private funders, testify regularly before Congress and other policy makers, and write extensively on health care policy changes affecting vulnerable populations and their implications for access, quality, and population health.

We consider this proposed rule one of the most significant ever issued by any Administration. This proposed rule has the potential to undo major public health care systems nationwide, from public hospitals to public health services capable of responding to public health threats, public clinics, school based health systems, and other public health services that carry out vital population health missions. Furthermore, the rule cuts deeply into fundamental state powers of self-governance, potentially imposing an unconstitutional condition on federal funding.

We recommend in the strongest terms that this proposal be rescinded. In our view, in its specifics and in its totality, the proposal constitutes an *ultra vires* exercise of power by the Secretary. We further recommend that, to the extent that the Administration desires to make

changes in federal policy regarding Medicaid financing of the non-federal share total program spending, such a proposal be treated as a legislative initiative. Our detailed comments follow.

Background

Over the years, several legislative proposals to dramatically structure the federal/state Medicaid financing relationship have been considered and rejected by Congress.[1] This regulatory proposal appears to attempt to achieve the type of fundamental alteration in the federal/state Medicaid financial relationship that has been rejected by Congress numerous times over the years.

Moreover, the proposal, if adopted in its current form, could have far-reaching consequences for government healthcare initiatives, ranging from hospital care to publicly supported managed care systems, public primary care clinic networks in medically underserved urban and rural communities, school health services in low income schools, and other governmental initiatives aimed at promoting healthcare access and protecting public health. CMS states that this proposal has been undertaken to improve program "economy and efficiency."[2] Yet this proposal would impose unprecedented documentation burdens on state and local governments.

The impact of the proposed rule appears to be significantly understated. CMS estimates federal savings at $3.87 billion in federal savings over five years. Even cursory discussions with senior healthcare officials around the country suggest a far greater loss of funding. Thus, while the quoted figure is not substantial in the context of Medicaid's size, its reliability may become an increasingly open question, as scores of individual states and localities begin to seriously focus on the proposal in order to calculate its impact. Because the proposal has the potential to undermine entire publicly supported metropolitan and rural healthcare systems, the difference between the published estimates and total impact may be exponential.

The proposed rule also appears to extend well beyond the outer bounds of existing statutory law. Federal law sets forth extensive requirements related to eligibility, enrollment, benefits and services, coverage and patient protections, provider participation and payment, and state administration.[3] Federal law also establishes the federal payment formula, which ranges from 50% to 83% of total expenditures.[4] Federal payments are available only in relation to state expenditures, but states are given considerable latitude with respect to how they generate the non-federal share of total program spending.

This broad state authority was amended by 1991 amendments to restrict the use of provider taxes and donations. At the same time, Congress codified the practice, allowing it to take place either by "intergovernmental transfer" or by "certified public expenditure." This codification, which acted as a validation of longstanding state custom, was part of legislation whose purpose was to curb states' use of provider donations and contributions as a means of generating the non-federal

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[1] Legislation to block grant Medicaid was considered and rejected during the 104th Congress. A 2003 proposal from the Bush Administration to partially block grant Medicaid was not considered"

[2] 72 Fed. Reg. 2241

[3] The most detailed overview of Medicaid can be found in the CCH Medicare/Medicaid Guide.

[4] 42 U.S.C. §1301(a)(8)(B), as explained in CCH Medicare/Medicaid Guide ¶ 14,905.

share. Thus, in shutting down one revenue source for securing non-federal revenues, Congress simultaneously and expressly sanctioned the use of funds from various governmental units to create the non-federal share.[5] In enacting the governmental expenditure provisions of the provider tax and donation law, Congress also specified that

> Notwithstanding the provisions of [the tax and donation law] the Secretary may not restrict States' use of funds where such funds are derived for 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 Title, *regardless of whether the unit of government is also a health care provider.*[6] [emphasis added]

The provider tax and donation legislation thus formalizes the role of units of government in Medicaid financing, which would be accomplished through certified expenditures or intergovernmental transfers. The legislation also acknowledges that a unit of government could be either a healthcare provider or a government instrumentality that purchased healthcare services. In either case, public financing would qualify as the non-federal share when certification or transfer procedures were used.

The underlying reason for this alternative drafting approach would appear obvious: at the time of enactment, as is the case now, many governmental healthcare undertakings were carried out either as direct governmental operations or as contractual arrangements with affiliated healthcare enterprises. In many instances, healthcare entities might once have functioned as directly governmentally operated facilities; over time however, their legal structure had been altered in order to allow greater operational efficiencies or broader access to private capital markets. Even in their new structure however, these healthcare entities existed solely or in major part to carry out the public governmental purposes.

Beyond the question of how states derive the non-federal share of Medicaid expenditures, the statute gives states broad latitude to set payment rates for participating healthcare providers, whether public or private. In setting Medicaid rates, states must comply with certain payment principles including an aggregate upper payment limit on public providers by class. States also must comply with certain "upper payment limit" rules in the case of publicly operated facilities; these rules have been developed over the past number of years in order to ensure that compensation levels to public providers are appropriate and reasonable.

By and large however, state programs enjoy considerable payment latitude under the statute. They can structure payment arrangements to recognize the full array of costs associated with the provision of healthcare (including capital for building and facility upgrades such as health information technology). They also can set rates that exceed those paid by Medicare. Finally, states can build into their compensation arrangements financing components that recognize the core costs associated with developing and furnishing healthcare, such repayment of capital loans, additional payments to support teaching, and compensation approaches such as "pay for

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[5] P.L. 102-234, The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, amended by §4722(a)(1)-(2) of the Balanced Budget Act of 1997 P.L. 105-33 and subsequent laws

[6] 42 U.S.C. §1396b(w)(6)(A)

performance" in order to incentivize quality improvement, technology innovation (including information technology), or other types of desirable performance.

The Proposed Rule: Elements and Issues

The NPRM Preamble begins by acknowledging that the routine state plan submission and amendment process functions as the means by which state compliance with these requirements can be readily measured and achieved:

> [s]ince the summer of 2003, we have received and processed over 1000 state plan amendments related to state payments to providers. Of these, approximately 10 percent have been disapproved. . . or withdrawn.[7]

Despite this admission that routine oversight appears to work fine, CMS nonetheless asserts a need for dramatic revision of current standards. The rule proposes three fundamental changes: (a) a fundamental redefinition of the types of expenditures that will be considered intergovernmental in nature; (b) a related, proposed revision in the meaning of a "unit of government" in order to achieve this fundamental alteration in the range of permissible spending, and (c) sweeping changes in how public providers can be paid, despite Congress' rejection of a nearly identical proposal during the 109th Congress. In all three instances, the proposed rule's connection to the statute appears tenuous at best.

After noting that the statute does not define an intergovernmental transfer (IGT), the Preamble goes on to assert (without citing any basis) that the "plain meaning" of an IGT "in a Medicaid context" involves *an actual transfer of tax revenues* from local governmental units to the state agency, rather than a transaction in which a state agency is refunded by a governmental healthcare provider for that portion of the non-federal share owed by the provider/unit of government. No explanation is given for this assertion that in order to qualify under the statute, an intergovernmental transfer must involve the actual transfer of tax revenues to a state agency as opposed to refunds.[8]

A refund system both ensures that a local unit of government actually makes up its portion of the non-federal share but also is consistent with healthcare institutional cash flow needs. Under a refund arrangement, a public provider pays its share only when it receives an actual payment for services. Were the entity to be required to make a prospective revenue transfer in advance of actual payment for care, such a requirement would not only be inefficient but also would totally disrupt the revenues vital to maintaining essential healthcare services.

Beyond delineating the procedures that must be used to achieve an intergovernmental transfer, the proposed rule would redefine the meaning of a governmental transfer to prohibit healthcare providers from being considered "units of government" unless the provider:

> . . . 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;

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[7] 72 Fed. Reg. 2237
[8] Proposed 42 C.F.R, §433.51 (b)

> 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 providers 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.[9]

In essence, this proposed rule seeks to set aside contractual arrangements between healthcare systems and units of government, ostensibly because such arrangements demonstrate insufficient nexus to government to count as a governmental expenditure. Furthermore, it seems the proposal would present significant enforcement issues, since doing so would require federal lawyers and auditors to examine state and local governmental arrangements to verify their legal and structural underpinnings.

Beyond its likely inefficiencies and intrusiveness, CMS' proposal seems to sweep away, without explanation, longstanding principles of law that recognize that public functions can be carried out by government in myriad ways, through direct operation as well as by contractual arrangement. Very few governmental functions are considered non-delegable under law;[10] indeed, in the modern world contracts underlie the provision of governmental health services, from hospital care to immunization clinics, Medicaid managed care operations, school based health clinics, clinics that identify and treat communicable diseases, and healthcare entities that have "first responder" duties in the face of public health threats.

Given that no one can say with certainty how many governmental undertakings are built on contractual arrangements rather than direct governmental undertakings, the potential impact of this proposal would be nearly incalculable at this point. Indeed, the answer would become evident only were federal officials to scrutinize every single governmental healthcare arrangement serving Medicaid beneficiaries, in order to determine the propriety of the state's claim for federal funding.

This level of involvement into the inner workings of state units of government appears to have no basis in the statute and, given the modern approach to the provision of governmental services generally, seems very problematic. Indeed, this attempt to restructure the inner workings of state and local governments may achieve the near-legally-impossible and actually step over the line that separates Congress' considerable Spending Clause powers from states' Tenth Amendment authority. Based on this assessment, it is not difficult to understand why the nation's governors on February 23 sent a letter to Congressional leaders objecting to the proposal.[11]

The proposed rule also would impose new limitations on state powers to devise payment standards for public healthcare providers. With the exception of the Indian Health Service and tribal facilities operated under the Indian Self-Determination and Education Act, the proposed rule would limit payment to an "individual provider's cost of providing Medicaid services to

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[9] Proposed 42 C.F.R. §433.50(a)(1)
[10] American Manufacturers Mut. Ins. Co. v Sullivan, 526 U.S. 40 (1999).
[11] Letter from NGA to the Hon. Nancy Pelosi, Speaker, U.S. House of Representatives, Harry Reid, Senate Majority Leader, Mitch McConnell, Senate Minority Leader, and John Boehner, House Minority Leader (Feb. 23rd, 2007)

eligible Medicaid recipients."[12] This shift to a mandatory, facility-specific cost structure appears to have no basis in the statute, and it would have several consequences.

First, such a shift would eliminate the ability of state Medicaid programs to employ the same types of payment innovations in the case of public hospitals (and presumably publicly operated managed care systems, nursing facilities, and clinics) that increasingly are in use today.

Second, the regulation appears to prohibit payment of costs other than the marginal costs associated with treating Medicaid patients, leaving public providers uncompensated for the range of costs that underlie healthcare. As a result, public healthcare entities would likely face a serious financial impact, since for most, Medicaid is not only a marginal payer but in fact is the largest payer. The NPRM requires that costs be supported "using information based on the Medicare cost report."[13] At the same time however, the NPRM also carefully avoids recognizing that all Medicare-allowable costs will be recognized in calculating payments, including capital-related costs and the costs of graduate medical education (GME) and health professions training. Indeed, the Preamble notes specifically that "the Secretary will determine a reasonable method for identifying allowable Medicaid costs that incorporates . . . OMB Circular A-87 [and] Medicare cost principles *as appropriate*."[14] [emphasis added] Since the President's budget proposes to eliminate state authority to recognize GME as a permissible Medicaid cost,[15] it is clear just how many Medicare costs would become impermissible in a Medicaid context, a deadly blow to the public healthcare system, especially large teaching hospitals that both furnish care and train physicians and other health professionals.

Third, by requiring facility-specific costs rather than permitting aggregation by class of provider, the proposed rule would override existing, carefully developed, Medicaid upper payment limit regulations (UPLs)[16] governing payments to governmental healthcare services. The rule would effectively ratchet down permissible payment levels for public entities to levels well below existing permissible standards.

The proposed rule also requires that the full amount of all computable payments received by public healthcare providers be retained in order to be permissible.[17] This sounds sensible in principle, but in practice is likely an inaccurate and inefficient way of thinking about healthcare. Public healthcare providers, like any business, operate with an annual budget. In a year when revenues exceed budgets, a public entity, just like its private counterparts, may be expected to repay funds to its sponsor. It is unclear why public entities should be any different in this regard. Furthermore, the inefficiencies in enforcing such a requirement are substantial. One need only read the enforcement provision of the NPRM to appreciate the problem:

> The Secretary will determine compliance with this provision by examining any associated transactions that are related to the provider's total computable payment to ensure that the State's claimed expenditure, which serves as the basis for

[12] Proposed 42 C.F.R. §447.206(c)
[13] Id.
[14] 72 Fed. Reg. 2241
[15] Budget of the United States (February 5, 2007)
[16] 72 Fed. Reg. 2242; proposed §447.321
[17] Proposed 42 C.F.R. §447.207

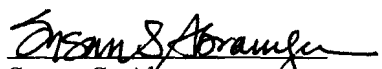
> Federal Financial Participation, is equal to the State's net expenditure and that the full amount of the non-Federal share of the payment has been satisfied. [18]

Finally, the proposed rule would prohibit state Medicaid programs from paying providers more for inpatient hospital services than the "provider's customary charges to the general public for the services."[19] But a hospital's customary charge to the general public may in fact be discounted to adjust for income, insurance status, and other factors that are not relevant when setting a Medicaid rate.

* * * *

In conclusion we recommend that the proposed rule be withdrawn and that any changes in federal standards related to what constitutes the non-federal share of Medicaid spending be addressed through the legislative process.

Sara Rosenbaum, J.D.
Hirsh Professor and Chair



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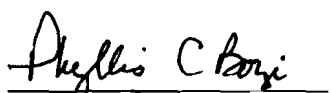

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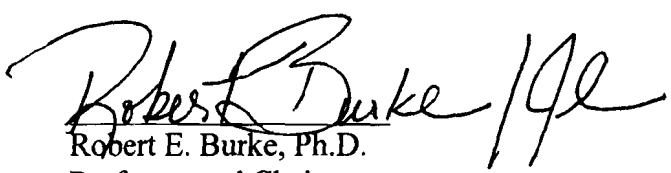

Robert E. Burke, Ph.D.
Professor and Chair

[18] Proposed 42 C.F.R. §447.207
[19] Proposed 42 C.F.R. §447.271

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March 9, 2007

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

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

Dear Ms. Norwalk:

On behalf of WellPoint, Inc., thank you for the opportunity to comment on proposed rule CMS-2258-P (Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership) published in the *Federal Register* on January 18, 2007.

As the nation's largest health insurer, WellPoint supports your efforts to clarify and solidify the federal-state partnership on which the Medicaid program is built. The proposed rule represents an important step toward defining the parameters of this partnership. We are concerned, however, that several provisions of the rule are inconsistent with the goals of the Medicaid program, and, in particular, with the principles of economy and efficiency required by the Medicaid statute.[1] If implemented as proposed, these changes could have a devastating impact on vulnerable safety-net providers that treat a disproportionate share of Medicaid and uninsured patients – and thus, a negative impact on the program as a whole.

In addition, the changes included in the proposed rule fail to address a critical flaw in the regulatory interpretation of Medicaid upper payment limits (UPLs), one that is forcing states to make a choice between implementing the coordinated care delivery systems delivered by managed care organizations or preserving millions of dollars in Medicaid matching payments for safety-net providers. In fact, the current managed care delivery system is one that has been long-promoted by many governors as well as the Administration.

[1] 42 USCa(a)(30)(A)

Our comments address a range of concerns with the proposed rule, but focus on the following principles that we believe are critical to maintaining access for Medicaid beneficiaries:

- Managed care days and fee-for-service days should be treated equally for purposes of calculating upper payment limits (UPLs). "UPL parity" will allow states to maintain funding for safety-net providers while providing beneficiaries with high-quality, coordinated care and enhanced access to services.
- The definition of "unit of government" should exclude health plans; and
- Any savings realized from the implementation of this rule should be reinvested in the Medicaid program to expand coverage and enhance access to services.

Each of these principles is discussed in detail below.

Treatment of Managed Care Days in UPL Calculations

Studies have indicated that expanded Medicaid managed care enrollment can slow the growth of Medicaid costs, lead to more efficient service delivery, and promote high quality integrated systems of care. In addition, capitated managed care offers states and the federal government greater predictability in annual Medicaid expenditures.
Nationally, however, only 16 percent of Medicaid expenditures were capitated as of Fiscal Year 2003, indicating significant room for expanded use of Medicaid managed care.

One of the primary reasons for the limited penetration of Medicaid managed care is a little known and unintended effect of current federal regulations governing the calculation of Medicaid upper payment limits. States are often limited in their ability to implement managed care delivery systems due to federal regulations governing the calculation of upper payment limits. Under current regulations, states may only count the services utilized by Medicaid beneficiaries that are paid on a fee-for-service basis. Services provided to Medicaid beneficiaries enrolled in managed care organizations (MCOs) on a capitated contracting basis are not counted towards the calculation of upper payment limits. This creates an inverse relationship between enrollment in managed care and the funding available for safety-net providers via supplemental UPL payments; as managed care enrollment increases, the upper payment limit decreases. The inverse relationship is particularly steep when Medicaid managed care programs include aged, blind and disabled populations, who have the highest spending in institutional settings.

The unintended result of current federal regulation is that the benefits of managed care for Medicaid enrollees are over-shadowed by the need to protect funding for safety net providers. As a result, hospitals, nursing facilities, and other institutions frequently oppose managed care expansions out of fear of losing supplemental UPL payments. Local governments also may oppose the expansion of managed care on the grounds that it reduces payments to public safety net hospitals. As Medicaid funding to these providers declines, local governments may be forced to increase local funding to supplement the gaps left by Medicaid. Failing to address this important issue will negatively impact our nation's already fragile health care system and result in greater costs relating to acute and emergency care services.

A recent Lewin Group report highlights several recent examples of the impact of the current regulations and the difficulties some states have had in attempting to expand their use of managed care:

- In Texas, the attempt to expand the STAR+Plus Program (a pilot program that uses managed care to integrate acute and long term care services) was derailed by hospital concerns that the expansion would reduce the hospital UPL by $150 million. As a result, the state legislature directed the Medicaid agency to "carve out" inpatient hospital services from the capitation payments made to health plans and deliver hospital services on a fee for service basis.[2]

- In Illinois, intergovernmental transfers and upper payment limit arrangements have played a key role in policy decisions to avoid expanding the use of capitation contracting in Medicaid and also to eliminate managed care organization contracting altogether.[3]

- In Ohio, the potential loss of UPL funds has served as a barrier to expansion of managed care.[4]

- Georgia, facing a 50 percent reduction in the UPL due to the expansion of managed care, instituted a managed care organization quality assessment fee to fund targeted safety-net providers. It is not yet known whether this will fully hold hospitals harmless from the financial losses they will suffer as a result of reduced UPL. Moreover, the assessment sunsets in 2009, a factor that further limits this approach. Georgia may seek to establish a "Low-Income Pool" to protect UPL funds or may seek additional DSH funding.[5]

The experience of these states clearly demonstrates that current UPL policy is discouraging the expansion of managed care, which, in turn, affects the quality of health care available to Medicaid enrollees. For example, by carving out hospital services from the STAR+PLUS program in Texas, services are, in effect, becoming less integrated in order to protect UPL funding. This is clearly counter to one of the goals of the Medicaid program and the key principles of managed care – integrated, coordinated care for beneficiaries.

Some states have been able to address the consequences of the current UPL policy through the Medicaid waiver process. For example, in negotiating a waiver that included a managed care expansion, Florida reached an agreement with CMS to replace the UPL program with Low Income Pool (LIP) payments to safety net providers. The LIP eliminates the differing impact of managed care versus fee-for-service payments.[6] California has negotiated a similar

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[2] Menges, Joel, and Aaron McKethan. Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion. The Lewin Group. Medicaid Health Plans of America, 2006. 14-15.
[3] Menges, supra. at 8.
[4] Id. at 8.
[5] Id. at 10-11
[6] Id. at 8-10

provision in its recent Medicaid waiver.

It is important to note, however, that the outcomes achieved by Florida and California were accomplished only through lengthy waiver negotiations and only on a case-by-case basis. This is not the solution to a problem that affects all states. In addition, the applicability of this rule to waiver states remains unclear. Modifications to federal policy are necessary to ensure that managed care exists on a level playing field with fee-for-service Medicaid on a nationwide basis. Allowing managed care days to be included in the calculation of UPLs will accomplish this while simultaneously preventing large decreases in payments to safety net providers – decreases these providers are unlikely to be able to sustain. To reiterate, allowing managed care days to be included in the UPL results in significant savings to the federal and state governments.

This approach is consistent with current payment methodologies under the Medicaid Disproportionate Share Hospital (DSH) program, which provides supplemental payments to hospitals serving a disproportionate share of Medicaid and uninsured patients. The formula used to calculate the maximum allowable DSH payment to hospitals does not distinguish between fee-for-service and managed care days. The DSH formula places fee-for-service and managed care on equal footing, while recognizing the need to protect safety-net providers. Federal UPL policy should adhere to these same principles.

In summary, WellPoint strongly believes in the value of managed care and its ability to contain costs and improve quality for Medicaid beneficiaries. WellPoint supports providing states with additional incentives to expand capitated managed care programs, including the equal treatment of fee-for-service and managed care days for purposes of calculating UPL.

Definition of "Unit of Government"

The proposed rule adds new language to 42 CFR 433.50 to further define a "unit of government." As definitions are finalized on what constitutes a "unit of government," CMS must mitigate any unintended consequences created by those definitions. Because many state and local governments were instrumental in the development, launch and operation of local MCOs, the local administrators of these plans are often considered public entities through state statute. Under the refined definitions proposed by CMS they also may fall under the federal definition of a "unit of government," thereby potentially creating an unequal playing field for commercial and public MCOs.

CMS' attempt to establish concrete definitions, coupled with the need to place acceptable parameters around how states may perform inter-governmental transfers (IGTs) and certified public expenditures (CPEs), may create incentives to qualify quasi-governmental MCOs as "units of government" in order to allow eligible IGTs or CPEs to flow from these entities. Commercial MCOs, meanwhile, could be left to compete under fundamentally inequitable rules of competition. While states have historically chosen MCOs based on quality, performance, and patient service, the proposed rule may now place commercial MCOs at a competitive disadvantage because of their inability to generate additional federal matching funds for the state. To ensure a vibrant and competitive Medicaid managed care marketplace,

CMS should strictly enforce these definitions as they apply to managed care organizations and should further clarify that states may not consider an MCOs public status in procurement decisions and auto-assignment algorithms.

Reinvestment of Funds

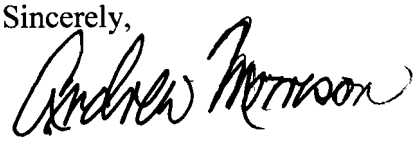
While CMS works to preserve the integrity of the Medicaid program, it is important that its efforts are not at the expense of safety net providers and vulnerable Medicaid beneficiaries. At a time when innovation at the federal, state, and local levels has helped propel the issue of reducing the number of uninsured to the forefront, continued access to scarce health care dollars is critical. A significant reduction in the flow of these funds will reverse the current momentum of tangible and attainable health care reform.

CMS estimates that the proposed rule, if implemented in its current form, will result in savings to the federal government of $120 million in the first year and $3.87 billion over five years. Some groups have estimated that the savings from implementation of the rule could be much greater. Unless vital funds removed by the proposed rule are put back into the health care system, many health care programs and advancements in accessibility could be severely diminished. As state General Fund dollars become increasingly constricted, local implementations and expansions of indigent health care programs will be threatened, increasing uncompensated care costs for those serving the nation's uninsured. This will result in a more fragile health care safety net, one that state and local governments and patients can ill afford. Therefore, we urge CMS and the Administration to reinvest all savings realized by the proposed rule's implementation back into the creative ideas and innovations that are addressing the nation's uninsured problem and improving care for tens of millions of Medicaid beneficiaries.

Again, thank you for the opportunity to comment on this important rule. Unless otherwise specified in the enclosed comments, WellPoint agrees with the comments submitted by our national trade associations: America's Health Insurance Plans and the Blue Cross Blue Shield Association. I respectfully refer you to their comment letters for additional perspectives regarding the proposed rule.

We look forward to continuing to work with you and your staff on the finalization and implementation of this rule. If you have any questions, please do not hesitate to contact Jerry Steffl, Director of Federal Affairs, at 202-628-7840.

Sincerely,



Andrew Morrison
Senior Vice President, Public Affairs

City and County of San Francisco **Department of Public Health**

Gavin Newsom
Mayor

Mitchell H. Katz, MD
Director of Health

March 14, 2007

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

Re: Opposition to Proposed Rule CMS 2258-P

On behalf of San Francisco General Hospital (SFGH), I am writing to express our opposition to Proposed Rule CMS 2258-P, which imposes cost limits on Medicaid payments to public providers and to urge CMS to withdraw it.

Each year, SFGH sees more than 100,000 unique patients, one-third of whom are uninsured, another third of whom are on Medi-Cal. I am proud of the high-quality health care services that each patient receives at SFGH, regardless of his or her source of payment. However, as a result of this new rule, SFGH stands to lose an estimated $24 million each year, funds which support critical patient services including trauma care, care to the uninsured, specialty care services, and training of new physicians.

This new rule would put a restrictive cap on public hospitals and does not take into account the important safety net role SFGH and other public hospitals play in cities and counties nationwide. It could severely limit funds for care to the uninsured that SFGH receives from the Safety Net Care Pool created in the state's recently negotiated hospital financing waiver. The pool exists under California's CMS-approved hospital financing waiver specifically for the purpose of providing financial assistance to safety net hospitals that incur significant costs in treating uninsured patients. The rule could also significantly narrow the funding sources the hospital is allowed to use for Certified Public Expenditures (CPEs) and Intergovernmental Transfers (IGTs), which could result in even greater losses to SFGH.

Despite California's new hospital financing waiver with CMS, we believe that the State is not protected against the provisions of this new rule. Though we understand that staff from CMS has verbally advised the State that the rule will not affect California's waiver, the potential harmful effects on our hospital are such that we cannot rely on these verbal assurances, particularly given the plain language of the rule. The proposed rule explicitly states in the preamble that all Medicaid payments "made under the authority of the State plan and under Medicaid waiver and demonstration authorities are subject to all provisions of this regulation." 72 *Fed. Reg.* 2236, 2240. Moreover, the Special Terms and Conditions that govern the Hospital Waiver require that the State comply with any regulatory changes. Hence, we and California's other public hospitals are highly concerned that, when the rule's limit to Medicaid costs is applied to our state's hospital financing waiver, funding will be eliminated for indigent non-Medicaid patients whose costs are currently covered under the Safety Net Care Pool.

(415) 554-2600 **101 Grove Street** **San Francisco, CA 94102-4593**

Finally, there are a number of legal and technical issues raised in the comment letter submitted by the California Association of Public Hospitals (CAPH), an organization of which we are a member. These include a provision that narrows the sources of funds that may be used as non-federal Medicaid matching funds, and a requirement that public providers retain federal funds upon receipt. We support these comments of opposition and incorporate them by reference in this comment letter.

SFGH strongly opposes this new Medicaid rule and respectfully urges CMS to withdraw it. If the rule is enacted, it will severely and detrimentally affect our ability to care for our patients and our community. CMS needs to recognize the damage that this rule will have to our community's health care system and should stop its efforts to move forward with the rule.

Sincerely,

Mitchell H. Katz, MD
Director of Health

Cc: House Speaker Nancy Pelosi
Mayor Gavin Newsom

JEFFREY PAUL EDELSTEIN,MD.,LTD
OPHTHALMOLOGY
OCULOPLASTIC SURGERY

March 8, 2007

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

I am an Oculoplastic surgeon who practices at Warner Park Surgery Center in Chandler, Arizona. Warner is a multi-specialty surgery center that annually performs over 7000 procedures and employs approximately 50 employees. We are joint-ventured with Catholic Healthcare West. Thank you for the careful consideration and tremendous work that the Centers for Medicare and Medicaid (CMS) has undertaken in developing proposals for the new ASC payment system for implementation in 2008.

Today, I am writing to express my deep concern about this draft fee schedule. It is obvious in the preamble of the rule your prejudice for the community hospital's out patient department where I also practice. One small example is where you indicate the reason for community hospitals receiving higher differentials in the relative weights is because the HOPD is open 24/7. That is not true and has not been for many years.

I would like to set the record straight by reminding you that for 30 years physicians have tried to move appropriate surgeries out of the hospital operating rooms to relieve the scheduling nightmares, improve patient and physician satisfaction and provide more cost effective procedures.

A major part of our success is due to the fact that individual physicians are partners in many of these facilities. As any business owner, I take pride in my facility and have worked hard to make sure the quality of surgical care remains high. And frankly, I am much more aware of the costs and how to better deliver care more cost effectively than a hospital administrator.

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The initial findings from CMS and MEDPAC provides data that support our own findings that outcomes are significantly better than in the acute care hospital setting, costs are lower, patients prefer these facilities and physician owner referral patterns are no different than non owners. Therefore, maintaining the status quo by giving acute care hospitals protection from market forces will only lead to higher health care costs for us all.

It is my recommendation that CMS consider the following changes to the 2008 ASC fee schedule rule:

- Recognizing that budget neutrality is a requirement of the MMA of 2003, the ASC industry believes and I agree that the migration ratios used in your calculations are incorrect. Though we have no way of knowing the exact migration numbers, I can tell you that once I invest in the equipment and staff for a procedure in my office I will not be taking it out and putting it in an ASC so the migration percentage is way off – perhaps there are a few physicians who would do so but not for more than 1% of the total procedures across the country.

- CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list as with the HOPD.

- The ASC fee schedule should be updated based upon the hospital market basket because this more appropriately reflects inflation in providing surgical services than does the consumer price index. Also, the same relative weights should be used in ASCs and hospital outpatient departments.

CMS must see that the benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law encouraging the more expensive HOPD procedure out of the hospital when appropriate and into the ASC. Additionally, aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data, which we are committed to providing you to evaluate outpatient surgical services for Medicare beneficiaries.

Please consider carefully the decision you will make with regards to this fee schedule. Medicare patients deserve access to the best medical care in the world. I urge you not to prohibit access by differentiating between the hospital outpatient department and the convenient efficient ambulatory surgery center. Your doing so will not only affect the right of a patient to have the most convenient cost effective care, it will affect the delivery of health care for generations to come.

Sincere regards,

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Alan D. Aviles
President

March 18, 2007

Ms. Leslie V. Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Room 314G
200 Independence Ave., SW
Washington, DC 20201

Dear Ms. Norwalk:

On behalf of the New York City Health and Hospitals Corporation (NYCHHC), the public hospital system of New York City, I urge the Centers for Medicare and Medicaid Services (CMS) to withdraw Proposed Rule CMS-2258-P (the Proposed Rule). The Proposed Rule would seriously undermine the existing system of Medicaid-based support for New York City's health care safety net, thereby compromising access for Medicaid and uninsured patients.

In New York, the proposed cost limitations contained in the Proposed Rule would significantly reduce annual Medicaid funding to New York State, resulting in an estimated $350 million reduction to NYCHHC. Loss of these supplemental Medicaid funds would put a severe financial strain on the NYCHHC system which encompasses eleven public hospitals, six trauma centers, four long term care facilities and an extensive primary care network. We provide health care to 1.3 million New Yorkers, of whom 400,000 are uninsured. Additionally, supplemental Medicaid funds have played a major role in ensuring that communities throughout the United States are protected with adequate emergency response capabilities, highly specialized tertiary services (such as trauma care, neonatal intensive care, burn units and psychiatric emergency care), and trained medical professionals.

The Proposed Rule would eliminate the long-standing regulatory exception that allows payments to public providers in excess of cost (42 CFR § 447.271(b)). The basis for this exception is rooted in the Medicaid statute, which specifically directs regulations permitting an exception "if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public." 42 U.S.C. § 1396b(i)(3). Therefore, we question whether CMS has the legal authority to eliminate this exception. In addition, we believe that the elimination of the nominal charge exception is inappropriate, since the exception properly recognizes the special situation of public providers that have substantially reduced charges. Public providers with substantially reduced charges should not be penalized because of these reduced charges.

The current upper payment limits, based on what Medicare would pay for the same services and calculated in the aggregate for each category of hospital, are reasonable and allow states appropriate flexibility to target support to communities and providers where it is most needed.

Over the last three years, CMS has significantly increased its oversight of payment methodologies and financing arrangements in states, including New York, to restructure their programs to eliminate inappropriate federal matching arrangements. We share CMS' goal of ensuring that Medicaid dollars be spent properly and applaud past efforts to rein in the misuse of such funds. Officials from the Department of Health and Human Services (HHS) have repeatedly claimed success from this initiative, stating that they have largely eliminated "recycling" from those programs under scrutiny. However, as there is no evidence that the legislative, regulatory and administrative steps already taken have been insufficient to eliminate the financing practices about which CMS is concerned, one wonders how the restrictive policies in the Proposed Rule will further its stated goals. Rather, the Proposed Rule imposes payment and financing policies that have nothing to do with institutionalizing the oversight procedures that CMS has used successfully. Instead, the proposed rule seems designed to cut deeply into the heart of Medicaid as a safety net support program with no measurable increase in fiscal integrity.

Additionally, it is ill-considered that providers, such as NYCHHC, that disproportionately serve uninsured patients, should be subject to a more restrictive limit on Medicaid Reimbursements than private providers. Furthermore, imposing a restrictive cost limit only on Government Providers would undermine their capacity to actualize important public policy goals related to quality, patient safety, emergency preparedness, enhancing access to primary and preventive care, reducing costly and inappropriate use of hospital emergency departments, and reducing disparities.

We are also unclear if the Proposed Rule's limitations on reimbursement not in excess of the individual providers' cost of providing "covered Medicaid services to eligible residents" impact payments made to public hospitals through the Disproportionate Share Hospital (DSH) program or through Section 1115 Waivers. A clarification clearly exempting DSH payments and 1115 demonstration program funds is needed.

It is also unclear which "costs" would be allowed for the purpose of the cost limit. Would graduate medical education, capital costs necessary to maintain an adequate physical infrastructure, investments in health information technologies, investments in community-based clinics, and Medicaid's fair share, beyond DSH, of the costs of treating the growing number of uninsured Americans be included? It is imperative that any definition of Medicaid "costs" include these vital items.

Finally, we believe that the cost limit would violate Section 1902(a)(30)(A) of the Social Security Act (SSA) by preventing states from adopting payment methodologies that are economic and efficient and that promote quality and access; and it would violate Section 705(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 by adopting upper payment limits that are not based on the proposed rule announced on October 5, 2000. CMS should not modify the current upper payment limits.

In response to President Bush's FFY 2007 budget, which first announced the intent to restrict Medicaid Payments via regulation (foreshadowing the Proposed Rule), 300 Members of the House of Representatives and 55 Senators in the 109th Congress urged the Administration not to move forward with this change administratively. Nevertheless, the Proposed Rule was issued on January 18, 2007; subsequently, in the 110th Congress' 226 members of the House and 43 Senators have similarly objected to both to the proposed Rule's severe impact on the nation's public hospitals and the disregard for the views of the legislative branch. Given the overwhelming bipartisan opposition, CMS should withdraw this proposal immediately and seek authorization from Congress for any major Medicaid changes it wishes to implement.

NYCHHC urges CMS to withdraw this ill-conceived proposed rule. At a time when the administration is professing a commitment to addressing the crises of uninsured, it seems contradictory to propose a rule that would severely cripple the nation's public hospitals. These hospitals are the backbone of the safety net that provides comprehensive health care for tens of millions of uninsured Americans.

Sincerely,

Alan D. Aviles

cc: Michael O. Leavitt

OREGON CASCADES WEST
Council of Governments

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March 15, 2007

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

SUBJECT: Response to Proposed Regulations of the Centers for Medicare and Medicaid Services – Proposed Rule CMS-2258-P

Dear Mr. Leavitt:

I am writing to express opposition to the new Medicaid regulations published in the Federal Register on January 18, 2007. These regulations seek to limit the use of Intergovernmental Transfers in the Medicaid funding contracts between state and local governments.

In Oregon, our agency manages a portion of the Long Term Care Medicaid Program serving seniors and people with disabilities for Linn, Benton and Lincoln Counties. As a Council of Governments, serving a vulnerable population through the Medicaid Program, these proposed regulations appear to create limitations on the matching of local funds which are a significant source of revenue assisting us in the ability to enhance the operation of our services for Medicaid clients. We believe that the regulations unfairly and inappropriately limit the sources of matching funds to a narrow definition of State or local tax revenue. If the intent is to prevent the use of recycled Federal funding as a source of local match, the proposed regulations far exceed what would be called a reasonable approach to this issue.

We are also concerned with the proposed regulations' definition of a unit of government. Councils of Governments in Oregon are authorized by law and are organized as a means for local

governments to jointly carry out programs on behalf of the member governments. The complex and rich history of local governments in Oregon working together to manage services through Councils of Governments is an example of the partnerships that have been created to serve the citizens of Oregon. We are concerned that the proposed regulations create new and restrictive definitions concerning units of governments and create restrictions that interfere with State and local decision making, potentially damaging the system of care created in Oregon to serve our vulnerable populations.

Lastly, we are concerned with the draft regulations' potential to create undue administrative burdens. Our organization currently meets and exceeds all generally accepted accounting principles and practices in performing our services. We are concerned that additional cost reporting and administrative documentation, as drafted, will undermine our service delivery and duplicate the efforts that already exceed current contractual expectations.

We urge you to cancel these rule changes and recognize that they go far beyond the steps that would be necessary to protect the fiscal integrity of the Medicaid Program. Instead, these rule changes undermine the fragile safety net of services to our most vulnerable seniors and people with disabilities.

Respectfully,

Jay Dixon, Benton County Commissioner
Chair, Oregon Cascades West Council of Governments

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LCOG

LANE COUNCIL OF GOVERNMENTS

March 15, 2007

Mr. Michael Leavitt
Secretary of Health and Human Services
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
Mailstop C4-26-05
Baltimore, MD 21244-1850

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

Dear Mr. Leavitt:

The Lane Council of Governments (LCOG) respectfully submits this comment in response to the above-proposed rule changes. While LCOG agrees with the need to provide clean sources of funds for Medicaid match, we strongly disagree with the proposed strategies. The breadth of the proposals would certainly have an adverse impact on the provision of Medicaid services to the vulnerable citizens of our state. Our comments fall into two major categories, as outlined below.

Restriction of Medicaid Match to State and Local Tax Revenue

This proposal seeks to limit the monies used for local Medicaid match to funds directly derived from state and local tax revenue. We do not support this concept, and believe it unduly disadvantages entities such as Councils of Governments as we seek to deliver important services to Medicaid clients. The proposal represents significant changes that will result in cuts of clean sources of match ***that are not recycled Federal funds***, such as fees and local grants. These funds have been allowed up until now and should continue to be permitted. Regarding increased documentation in the accounting of the funds, our agency already follows general accepted accounting principles and is very careful to track these expenditures. To add additional reporting requirements will be an undue burden and increase administrative costs while diminishing our ability to provide services to the people in need.

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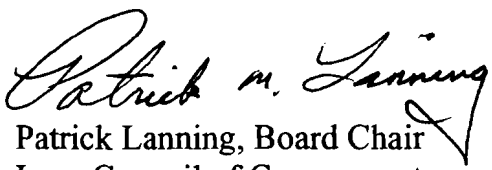
Definition of a Unit of Government

The proposed rule changes appear to disqualify all regional councils of governments from consideration as a governmental unit, and thus make them ineligible to provide matching funds. Oregon statute allows tribes, counties or other units of local government to join together to form governmental units. Our own Lane Council of Governments is an example of such an intergovernmental unit. These entities are an important part of the service delivery system and have been so for many years. The changes proposed in CMS-2258-P are unnecessary and unduly restrictive. We urge that the proposed Rule not be approved as submitted in the NPRR, but that it be reassessed in light of the points made here.

Sincerely,



Patrick Lanning, Board Chair
Lane Council of Governments

cc: Congressman Peter Defazio
House of Representatives
2134 Rayburn H.O.B.
Washington, DC 20515

Senator Ron Wyden
U.S. Senate
230 Dirken Senate Office Building
Washington, DC 20510-3703

Senator Gordon Smith
U.S. Senate
404 Russell Building
Washington, DC 20510

Forms Response:
Attn. Kathryn P. Astrich
Office of Information and Regulatory Affairs
Office of Management and Budget
Room 1023 New Executive Office Building
Washington, DC 20503

Attn: Melissa Musotto
Centers for Medicare and Medicaid Services
Office of Strategic Regulations and Regulatory Affairs
Division of Regulatory Development
CMS-2258-P
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

DENVER HEALTH
Level One Care for ALL

March 16, 2007

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

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

Dear Administrator Norwalk:

Denver Health and Hospital Authority (DHHA) is pleased to submit the attached comments regarding the above-referenced Proposed Rule. We believe that the changes proposed in this rule are the most significant and potentially devastating changes in the 41-year history of the Medicaid program. We join the National Association of Public Hospitals, American Hospital Association, the National Governors' Association, and numerous other groups and hospitals across the state of Colorado and the nation in urging the Centers for Medicare and Medicaid Services (CMS) to withdraw the Proposed Rule.

Our most significant concerns relate to the Proposed Rule's definition of a unit of government, but we also are gravely concerned about the limit on payments to governmental providers to the cost of Medicaid services and the timing of the proposed rule.

DHHA is the largest provider of care to Medicaid and the uninsured in the State of Colorado, serving 61,000 Medicaid patients and 69,000 uninsured patients annually. Our organization operated as an agency of the City and County of Denver until 1997, when the Colorado General Assembly created DHHA as a political subdivision of the state. Our mission, which is to serve all citizens of the City and County of Denver regardless of ability to pay, is codified in the Colorado statute that created our organization.

Since the creation of the authority structure, DHHA has evolved into a model for the nation: a financially stable, integrated system of primary, specialty and acute and trauma care operating in a cost-effective manner while demonstrating cutting-edge use of technology in promoting advances in patient quality and safety. One of the intended goals of the DHHA's creation was to enhance our ability to generate revenue from

private insurance and minimize the need to generate additional governmental tax support. We have achieved this as we generate 27% of our funding from private sources.

A core underpinning of our ability to provide cost-effective high quality care to Medicaid and uninsured patients is the Disproportionate Share (DSH) and Upper Payment Limit (UPL) funding we receive. In the most recent Colorado State Fiscal Year (SFY), DHHA received $75 million in DSH and UPL funding. We provide the non-federal share of these payments through Certification of Public Expenditures (CPE). Under the Proposed Rule, DHHA would not qualify as a unit of government eligible to provide the non-federal share of Medicaid payments as we do not have generally applicable taxing authority nor are we an integral part of a governmental unit with taxing authority legally obligated to fund our expenses, liabilities and deficits.

Colorado's constitutional limits on governmental revenue and spending make it impossible for state or local governments to replace the $75 million match that would be required to replace this funding by the September 1, 2007 implementation date for the Proposed Rule, and improbable even for the future. We assume therefore, that effective September 1, 2007; DHHA would receive a $75 million funding cut for Medicaid and the uninsured.

It would be difficult for DHHA to sustain this reduction and still operate at all, but it is a certainty that the entity that would remain would not be an integrated, technologically advanced model for the nation, but perhaps a small public hospital with a limited-capacity emergency department and limited inpatient medical-surgical services. A $75 million reduction in funding would require a reduction of approximately 16% of our budget, equating to approximately 1,200 of our 4,300 employees.

For the State of Colorado, the funding reduction would be $128 million. But the impact would go beyond the reduction of funding to the direct recipients of these funds. Because Colorado has a dominant safety net provider model, with two large safety net hospitals serving the majority of the state, other hospitals throughout the state do not provide and are not equipped to provide the level of uninsured care that Denver Health provides. The $280 million of care to the uninsured that Denver Health currently provides would be largely dispersed to a number of private for-profit and non-profit entities that do not have financial structures capable of absorbing this level of uninsured care. We believe these hospitals would quickly be destabilized. In short, the impacts of this Proposed Rule would devastate not only the financial structure of DHHA but of a number of non-public hospitals as well.

We believe that the statutory definition contained in Section 1903(w)(7)(G) of the Social Security Act (SSA) which defines a "unit of local government" as "a city, county, special purpose district, or other governmental unit in the State" does not need to be changed or clarified as currently written and that to do so goes against Congressional intent.

The limit on payments to governmental providers to the cost of Medicaid services is also concerning, particularly given that governmental providers have the least ability to cost-shift. The restriction on sources of non-federal share funding found in the rule are also of great concern. We outline our concerns related to these items in more detail in the attached comments.

To summarize, it is DHHA's position that the proposed rule would eliminate the ability of the safety net in Colorado and nationwide to care for Medicaid and uninsured patients in a high-quality, cost-effective manner, and would exacerbate greatly the problem of the uninsured that we grapple with today even with the current safety net structure. Further, if this rule is implemented it will have a significant downstream impact on private hospitals and the entire healthcare system will be jeopardized in the state of Colorado and nationwide. We believe this rule is not a constructive response to the challenges of Medicaid and the uninsured. We would like to work with the Administration and Congress to develop alternative solutions to the funding issues related to these populations.

Thank you for the opportunity to submit these comments. If you have any questions, please contact me at 303-436-6611 or Peg Burnette, Chief Financial Officer at 303-436-6076.

Sincerely,

Patricia A. Gabow, M.D.
Chief Executive Officer and Medical Director

PAG:pb

cc: The Honorable Wayne Allard, United States Senate
The Honorable Diana Degette, U.S. House of Representatives
The Honorable John Hickenlooper, Mayor, City of Denver
The Honorable Doug Lambourn, U.S. House of Representatives
The Honorable Marilyn Musgrave, U.S. House of Representatives
The Honorable Ed Perlmutter, U.S. House of Representatives
The Honorable Bill Ritter, Governor of Colorado
The Honorable John Salazar, U.S. House of Representatives
The Honorable Ken Salazar, United States Senate
The Honorable Tom Tancredo, U.S. House of Representatives
The Honorable Mark Udall, U.S. House of Representatives

Enclosure

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March 16, 2007

VIA FEDERAL EXPRESS

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

Re: File Code: CMS-2258-P

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

Issue Identifiers: Defining a Unit of Government (§433.50)
Intergovernmental Transfer (IGT)
State and Local Tax Revenue
Cost Limit For Providers Operated by Units of Government (§447.206)

Dear Sir or Madam:

We hereby submit comments on the proposed rule, published in the Federal Register on January 18, 2007 at 72 Fed Reg 2236, which in part defines a unit of government for purposes of determining what local governmental entities may participate in the financing of the non-Federal share of Medicaid and places cost limits for providers operated by units of government.

We make these comments on behalf of our clients, Forrest County General Hospital in Hattiesburg, Mississippi; Memorial Hospital at Gulfport in Gulfport, Mississippi; Singing River Hospital System in Pascagoula and Ocean Springs, Mississippi and Southwest Mississippi Regional Medical Center in McComb, Mississippi (collectively, the "Public Hospitals"). All of the Public Hospitals are publicly owned community hospitals which are governmental providers and component units of local governmental entities as defined by Mississippi law. Under the proposal by CMS to redefine a "unit of government" to require such entities to have taxing authority, these Public Hospitals would no longer meet the definition and would be barred from making intergovernmental transfers to the State of Mississippi for funding of Medicaid costs.

Additionally, as governmental providers the Public Hospitals serve as safety-net hospitals for the uninsured. The application of a cost limit on Medicaid payments to these Public Hospitals will seriously compromise their ability to continue to serve Medicaid patients and the uninsured and threaten their financial ability to provide the health care services to the communities they serve. All of these Public Hospitals are located in communities in the Mississippi Gulf Coast region which were devastated by Hurricane Katrina.

If implemented in its current form, the proposed rule would have a dramatic and draconian affect on reimbursement for Mississippi's public community hospitals. Mississippi's population, by any measure, is disproportionately poor and rural. The State depends on a favorable state/federal match rate to draw down the money necessary to finance even basic health care services. Under this model, the state's public and community hospitals have long served as a safety net for a very significant percentage of Mississippi's population - patients that would otherwise be denied access to care. The proposed change to this methodology would jeopardize the mission of Mississippi's public community hospitals and threaten access to critically necessary healthcare services for the patients they are committed to serve.

The timing of this proposed rule change is of particular concern for health care providers located in the areas of Mississippi recently devastated by Hurricane Katrina, the largest and most expensive natural disaster ever to strike our nation. The impact on health care and human services was staggering. Hospitals alone suffered nearly half a billion dollars in operational losses and tens of million of dollars in physical damage to health care facilities. This area of the nation is only now beginning to recover. Public community hospitals still face a myriad of issues, including, but not limited to, workforce recruitment and retention and other problems related to treating a population with many uninsured or, at best, underinsured patients. The Public Hospitals fulfilled their mission heroically in the weeks and months following Hurricane Katrina. It seems ill-advised, if not cynical, to add the specter of dramatically reduced reimbursement to the burden these safety net providers are carrying in areas of Mississippi so recently devastated by Hurricane Katrina.

On behalf of the Public Hospitals, we urge the Centers of Medicare and Medicaid Services (CMS) to withdraw Proposed Rule CMS-2258-P (the "Proposed Rule"). We specifically recommend that CMS:

Definition Of Unit Of Government (§433.50)

- Defer to state law determinations as to the public status of public hospitals and other units of government and
- Eliminate in the Proposed Rule the requirement that units of government must have taxing authority;
- Or
- Modify the Proposed Rule to recognize the public status of public community hospitals organized and operated in the State of Mississippi under Miss. Code Ann §§41-13-10, et. seq. (1972 and supplements) and include these hospitals under the unit of government definition;
- Or
- Modify the Proposed Rule to recognize an entity as a unit of government even though the entity may not itself have taxing authority so long as the entity's owner has taxing authority and can transfer funds or lend its bonding authority to the entity.

Cost Limit For Providers Operated By Units Of Government (§447.206)

- Reject the Proposed Rule and retain as set forth in the current rule the aggregate upper payment limits based on Medicare payment principles for all categories of providers;
- Or
- Modify the cost limit on Medicaid payments to government providers in the Proposed Rule to recognize as allowable costs all costs necessary to operate the governmental provider.

I. BACKGROUND INFORMATION

In the Proposed Rule, CMS has chosen to define a unit of government as a State, a city, a county, a special purpose district or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority. In addition, a health care provider may be considered a unit of government when it is operated by a unit of government and (i) the health care provider has generally applicable taxing authority or (ii) 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... [1]

Under the Proposed Rule, the Public Hospitals and all other public community hospitals in the State of Mississippi will be unable to meet CMS's definition of a unit of government because they do

[1] 72 Fed. Reg. 2240 and 2246

not have taxing authority. Additionally, although the owners of the Public Hospitals have taxing authority, their authorized taxing authority for the support of the operations of the Public Hospitals is limited. Regardless of the fact that the Public Hospitals do not have taxing authority, they are clearly a component unit of government under Mississippi state law. The limitations placed by the Proposed Rule on when a health care provider may be considered a unit of government should not apply to the Public Hospitals and all other similar Mississippi public community hospitals because they themselves are considered by Mississippi law as a governmental unit in the State.

A public community hospital in Mississippi is defined by statute. The statutes on community hospitals are codified as Miss. Code Ann §§41-13-10, et seq. (1972 and supplements). The statutes allow the ownership of a community hospital to be in various combinations between counties, municipalities and subdivisions thereof. Specifically, a community hospital may be owned by a county and/or any political or judicial subdivision of a county (such as a supervisors district, judicial district or election district of the county) and/or any municipality of the State of Mississippi.[2] (The unit of government which owns a public community hospital in Mississippi is referred to herein as the "owner" or "owners"). The owner has taxing authority and is authorized by statute to assess up to five (5) mills in ad valorem taxes per year to support the operations of the public community hospital.

In the case where there is joint ownership of a community hospital, the owners may, by contract with each other, determine the pro rata ownership of the hospital, the proportionate cost of maintenance and operation of the hospital and the proportionate financing that each owner will contribute to the hospital.[3] Owners may also contract with each other or with the board of trustees of a community hospital for necessary purposes related to the establishment, operation or maintenance of community hospitals and related programs.[4] This authority to contract extends to the right to sell or contribute to the other entities, monies, personal property or existing health facilities. The owner must ratify the purchase by the board of trustees of the community hospital of real property as authorized in Sections 41-13-10 et. seq. of the Mississippi Code of 1972 (as supplemented)[5]

Sections 41-13-19 through 41-13-23 of the Mississippi Code authorize the owner of a community hospital to issue bonds, notes or other evidences of indebtedness for the purpose of providing funds with which to acquire real estate for and to "establish, erect, build, construct, remodel, add to, acquire, equipment and furnish community hospitals ... and related facilities..."[6] An owner may pledge its full faith, credit and resources to secure such bonds, notes or indebtedness.[7] In addition, the owner of a community hospital is authorized to levy ad valorem taxes on all the taxable property in such

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[2] Miss Code Ann §41-13-15 (1)

[3] Miss Code Ann §41-13-15 (2)

[4] Miss Code Ann §41-13-15 (3)

[5] Miss Code Ann §41-13-15 (4); 41-13-35 (5)(j)

[6] Miss Code Ann §41-13-19

[7] Miss Code Ann §41-13-19

owner for the purpose of raising funds for the operation of the community hospital and related facilities.[8] The owner may pledge such ad valorem taxes, whether or not such taxes have been actually levied for the retirement of debt incurred by or on behalf of such facilities.[9] The amount levied may not exceed five (5) mills in any one (1) year.[10]

The public operation of a community hospital is a governmental function.[11] The Mississippi Supreme Court has determined that a public community hospital in Mississippi is a subdivision of the state or municipal corporation thereof.[12] The owners of public community hospitals are authorized to appoint trustees for the purpose of operating and governing the community hospital.[13] The board of trustees is defined to mean the board appointed by the owner pursuant to Section 41-13-29, Mississippi Code of 1972, to operate the public community hospital.[14]

The office of trustee of a community hospital is a public office.[15] The public community hospital in Mississippi is considered a component unit or authority of the governmental entity that owns it as defined in Section 25-4-103 (a) of the Mississippi Ethics in Government Act.[16] As such, the members of the board of trustees and the employees of public community hospitals are public servants whose actions, activities and business relationships are governed by the Mississippi ethics laws.[17] In addition, Mississippi's Public Purchase Law defines a "governing authority" to include the boards of trustees of any public hospitals.[18] Accordingly, all purchases of commodities and contracts for public construction by a public community hospital must meet the bid requirements and exceptions for public purchases.[19]

The general powers and duties of the board of trustees in its governance and operation of the community hospital are contained in Section 41-13-35 of the Mississippi Code. This authority includes

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[8] Miss Code Ann §41-13-25

[9] Miss Code Ann §41-13-25

[10] Miss Code Ann §41-13-25

[11] City of Leland v. Leach, 227 Miss. 558, 560-61, 86 So. 2d 363, 364-65 (1956)

[12] Enroth v. Memorial Hospital at Gulfport, 566 So. 2d 202 (July 25, 1990); Parish v. Frazier, 195 F. 3d 761 (October 13, 1999, decided, as revised December 16, 1999)

[13] Miss Code Ann §41-13-29 (1)

[14] Miss Code Ann §41-13-10 (b)

[15] State Ex Rel. Pair v. Burroughs, 487 So. 2d 220 (Miss. 1986)

[16] Op. of Miss. Ethics Comm. Op. No. 97-144-E

[17] Miss Code Ann §25-4-105.

[18] Miss Code Ann §31-7-1 (b)

[19] Miss Code Ann §31-7-13

the power to (i) deposit and invest funds of the hospital[20]; (ii) establish equitable wage and salary programs and other employment benefits[21]; (iii) authorize employees to attend and to pay actual expenses incurred while on hospital business or in attending education or professional meetings[22]; (iv) enter into certain loan or scholarship agreements[23]; (v) devise and implement employee incentive programs[24]; (v) recruit and financially assist physicians and other health care practitioners[25]; (vi) file suit and to defend and/or settle claims[26]; (vii) sell or otherwise dispose of chattel property[27](viii) borrow money and pledge a percentage of hospital revenues as security for financings[28]; (ix) expend funds for public relations or advertising[29]; (x) to provide an ambulance service[30] and (xi) establish a hospital auxiliary[31]. In addition, the board of trustees is authorized to contract for the provision of property, equipment or services by or to the hospital or regarding any facet of the construction, management, funding or operation of the hospital or any division or department or any related activity.[32]

Although the board of trustees has full and broad authority and responsibility for the administration, government, maintenance and operation of the community hospital under its control,[33] once the board of trustees is constituted, the authority of the owner of the community hospital, with respect to the operations of the hospital, continues with respect to appointment and/or removal of the trustees,[34] ratification of the purchase of real property by the board of trustees,[35] establishment of the maximum borrowing authority and the maximum percent of revenue which may be pledged by the

[20] Miss Code Ann §41-13-35 (5) (a)

[21] Miss Code Ann §41-13-35 (5) (b)

[22] Miss Code Ann §41-13-35 (5) (c)

[23] Miss Code Ann §41-13-35 (5) (d)

[24] Miss Code Ann §41-13-35 (5) (e)

[25] Miss Code Ann §41-13-35 (5) (f)

[26] Miss Code Ann §41-13-35 (5) (h)

[27]Miss Code Ann §41-13-35 (5)(i)

[28] Miss Code Ann §41-13-35 (5) (k)

[29] Miss Code Ann §41-13-35 (5) (l)

[30] Miss Code Ann §41-13-35 (5) (p)

[31] Miss Code Ann §41-13-35 (5) (r)

[32] Miss Code Ann §41-13-35 (5)(g)

[33] Miss Code Ann §41-13-35 (3)

[34] Miss Code Ann §41-13-29

[35] Miss Code Ann §41-13-35 (5)(j) and (o); 41-13-15 (4)

board of trustees during any fiscal year[36] and approval of the budget of the community hospital proposed by the board of trustees.[37]

The board of trustees of a community hospital is required annually to file financial statements with their owners.[38] The Governmental Accounting Standards Board ("GASB") dictates standards for financial reporting by governmental entities, such as the owners of public community hospitals in Mississippi. GASB Standard 34 gives direction as to how an owner is to determine whether a component unit of the owner is material and therefore should be reported on the owner's consolidated annual financial report as a component unit.[39] In fact, based on discussions we have had with the Mississippi Public Auditor's Office, it is our understanding that most owners of public community hospitals in Mississippi report these hospitals as a component unit on their audited financial statements.

II. COMMENTS

A. DEFINITION OF UNIT OF GOVERNMENT (§433.50)

The provisions of the Social Security Act relating to Medicaid do not define a unit of local government by requiring that it have taxing authority. Section 1903 (w)(1)of the Social Security Act (the "Act")[40] provides that **a State or other unit of local government in the State** may finance the non-Federal share of Medicaid payments subject to certain reductions for revenues received by the State (or by the unit of local government in the State) from certain provider-related donations or from certain health care related taxes. Section 1903 (w)(7)(G) of the Act defines the term "unit of local government" to mean a State, a city, county, special purpose district, or other governmental unit in the State.[41]

The Proposed Rule goes beyond the federal agency's charge to implement the terms of the Social Security Act and instead would result in a modification or amendment of the federal statute.

The Proposed Rule redefines and limits the term "unit of government" to include only:

> a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority.[42]

CMS has exceeded its statutory authority by requiring a public entity to have "generally applicable taxing authority" in order to meet the definition of a "unit of government". Section 1903

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[36] Miss Code Ann §41-13-35(5)(k)

[37] Miss Code Ann §41-13-47

[38] Miss Code Ann §41-13-47

[39] Governmental Accounting Standards Board, Standard 34

[40] 42 U.S.C. §1396b(w)(6)

[41] 42 U.S.C. §1396b(w)(7)(G)

[42] Proposed 42 C.F.R. §433.50(a)(1)(i).

(w)(7)(G) of the Act clearly evidences the intent of Congress to allow states to determine which entities are political subdivisions for the purpose of participating in Medicaid funding. In addition, there is no requirement elsewhere in the Medicaid statute that units of government must have taxing authority in order to contribute to the non-federal share of Medicaid expenditures. For example, Section 1903(d)(1) which requires states to submit quarterly reports for purposes of drawing down the federal share provides that the states must identify 'the amount appropriated or made available to the State and its political subdivisions.[43]

By adopting this definition in the Proposed Rule, CMS is invading the province of the states to organize their governmental structures and to define their public bodies. The State of Mississippi has organized its public community hospitals, such as the Public Hospitals, as political subdivisions which are units or authorities of the governmental entities which own the public hospitals. However, the owner, and not the public community hospital, is granted taxing authority related to the hospital operations.

Mississippi has chosen to structure its public hospitals with a governing board separate from its owner. The governing boards of Mississippi's public hospitals are responsible for the day to day operations of their hospitals based on the revenues earned by the hospital and subject to a fixed budget approved by its owners.

Congress's definition of a "unit of government" affords deference to the states' determinations of which of their instrumentalities are governmental. Such deference is required by Constitutional principles of federalism. Our Constitution provides a carefully crafted division of authority between the states and the federal government. This unique and essential part of our system of government, known as federalism, is extremely important to the functioning of government and the rendition of services to the people. We as a people have long recognized that many services can best be provided by the government closest to the people. For a federal agency to disregard Congressional intent and a Federal Act and to interfere and tell state governments they can not define what is and what is not a governmental unit violates this basic and fundamental principle of our government that has worked so well.

CMS has exceed its statutory authority in proposing to adopt a definition of a "unit of government" to require that such governmental unit must have generally applicable taxing authority. This definition is more restrictive than that required by the Social Security Act and intended by Congress. This definition would result in an unprecedented intrusion into the core of the states' rights to organize and define its governmental bodies.

CMS's proposed definition would in Mississippi disregard all of its public community hospitals as units of government merely because Mississippi has chosen not to give them taxing authority. It is clear from our discussion in the Section on Background Information above, that Mississippi's statutory scheme provides that its public community hospitals are wholly owned by a unit of government which has taxing authority and that the public community hospital is a subdivision of its owner. The operation of a public community hospital in Mississippi is clearly a governmental function. As such, CMS should recognize the public status of public community hospitals organized and operated in the State of

[43] 42 U.S.C. §1396b(d)(1)

Mississippi under Miss. Code Ann 41-13-10, et. seq. (1972 and supplements) and include these hospitals under the unit of government definition.

We urge CMS to defer to the intent of Congress, the plain language of the Act and state law determinations of public status in defining a unit of government. Accordingly we recommend that CMS revise the Propose Rule to:

- **Defer to state law determinations as to the public status of public hospitals and other units of government, and**
- **Eliminate the requirement that units of government must have taxing authority.**

Alternatively, we request that CMS modify the Proposed Rule to specifically recognize the public status of public community hospitals organized and operated in the State of Mississippi under Miss. Code Ann §§41-13-10, et. seq. (1972 and supplements) and include these hospitals under the unit of government definition.

Alternatively, we request that CMS modify the Proposed Rule to recognize an entity as a unit of government even though the entity may not itself have taxing authority so long as the entity's owner has taxing authority and can transfer funds or lend its bonding authority to the entity.

B. SOURCES OF NON-FEDERAL SHARE FUNDING (§433.51(b))

The Proposed Rule requires that intergovernmental transfers ("IGTs") be derived solely from tax revenues. This requirement is clearly inconsistent with the provisions of the Social Security Act, in which Congress has authorized all sources of public funding to be used as the non-federal share of Medicaid expenditures. Consequently, the implementation of this proposed regulation would exceed the proper authority of CMS under the Act. Moreover, this strict limitation on source of funding ignores the reality of governmental operations, in which public funds are derived from sources other than taxes. As a matter of both statutory authority and public policy, the proposal to restrict the source of IGTs to tax revenues is not a proper exercise of rule-making by CMS.

We urge CMS to eliminate the proposed requirement that IGTs be derived solely from tax revenues.

C. COST LIMIT FOR PROVIDERS OPERATED BY UNITS OF GOVERNMENT (§447.206)

CMS's proposal to impose a cost limit on governmental health care providers is unreasonable and will result in the limitation of services by these providers or their ultimate closure. The Proposed Rule provides that:

> All 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.[44]

By making this change in the Proposed Rule, CMS is treating public hospitals differently from private hospitals and would provide less Medicaid reimbursement to public hospitals than to private hospitals for the same services rendered.

The Congressional Budget Office has confirmed that governmental hospitals provide more Medicaid and uncompensated care and other community benefits than private hospitals.[45] The payor mix of governmental hospitals reflect a higher number of Medicaid patients than that of private hospitals and therefore a greater reliance on Medicaid revenues to fund operations. This finding reflects the status of our governmental hospitals as safety-net hospitals for Medicaid beneficiaries and individuals in our communities who are under insured or uninsured or indigent. Limiting the ability of governmental hospitals from obtaining any margin on Medicaid patients would be economically devastating.

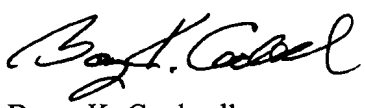
We urge CMS to reject the Proposed Rule and retain as set forth in the current rule the aggregate upper payment limits based on Medicare payment principles for all categories of providers.

Alternatively, we ask CMS to modify the cost limit on Medicaid payments to government providers in the Proposed Rule to recognize as allowable costs all costs necessary to operate the governmental provider.

On behalf of the Public Hospitals, we greatly appreciate the opportunity to submit these comments for your review and consideration.

Respectfully submitted,

BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, PC



Barry K. Cockrell

BKC:meb

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[44] Proposed Rule 42 CFR §447.206(c)

[45] Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits*, December 2006.

Memorial Health System

We Hear. We Heal. We Care.

Sent Via Email and Federal Express

March 16, 2007

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

The purpose of this letter is to comment on the proposed rule, 42 CFR Part 433, 447 and 457 entitled, *Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal–State Financial Partnership.* 72 FR 2236-01, (2007) (to be codified at 42 CFR Parts 433, 447, and 457, proposed Jan. 18, 2007). This comment is submitted on behalf of Memorial Health System (MHS), a wholly-owned enterprise by the City of Colorado Springs (City). Colorado Springs City Code 13.1.103 (2006). MHS submits this comment requesting that CMS further clarify its definition of a "unit of government" under the proposed rule.

According to the proposed rule, a health care provider meets the definition of a "unit of government" if it can demonstrate that: (1) it is "city-operated"; (2) it is included "as a component unit on the government's consolidated annual financial report"; and (3) the city "appropriates funding derived from taxes it collected to finance the health care provider's generally operating budget". 72 FR 2240, (2007)(to be codified at 42 CFR §433.50, proposed Jan. 18, 2007)

MHS does meet the definition of unit of government as specified in numbers one and two above as evidenced by the following facts. MHS was purchased by the City in 1943. In 1949, the citizens of the City approved ordinances that read in pertinent part, "The [hospital] Board shall advise the City Manager and Council of the amount deemed necessary to be raised by tax levy for the hospital for the ensuing year". Colorado Springs City Code 13.1.101, (2006). "The City of Colorado Springs shall continue the operation and maintenance of Memorial Hospital, now owned by said City, and the City Council shall, commencing with the annual tax and appropriation ordinance for the year 1950, annually levy a tax and appropriate the proceeds there from solely for the use of said Hospital. Said tax shall be sufficient to pay the estimated deficit in all expenses incurred in conducting, maintaining and improving the hospital in the next

ensuing fiscal year, including the payment of bonds and interest thereon, repairs, upkeep, betterments, equipment, supplies, depreciation, insurance, employee's salaries and all other expenses incident to the operation and maintenance." City of Colorado Springs Code 13.1.108, (2006). Furthermore, MHS is reflected on the City's consolidated annual financial report.

The aforementioned facts lead MHS to conclude that it essentially meets the definition of a "unit of government" as set forth in the proposed rule. There is one fact however that brings this conclusion into question. MHS has been financially self-sufficient since 1974 and therefore has not had to rely on City tax revenues for its operations, even though the City is required by ordinance to levy a tax and appropriate the revenues to MHS. It is therefore questionable as to whether MHS meets criterion number three mentioned above.

This criterion is also set forth in question number three in CMS' Form 10176 entitled, *Governmental Status of a Health Care Provider*. This question number reads, "Does the unit of government that operates the health care provider appropriate generally applicable tax revenue to the health care provider", to which MHS would have to answer "no".

It appears that for the most part, MHS does meet the definition of a unit of government because it is owned and operated by the City, is a component unit in the City's annual financial report and the City is required by ordinance to levy a tax to fund its operations. The mere fact that MHS has not required the City to do so brings into question whether MHS meets the definition of a unit of government.

MHS is hereby requesting that CMS clarify the definition of a unit of government with respect to whether a health care provider that is owned and operated by a local government that is required by ordinance to levy a tax to support its operations, must actually access these revenues on an annual basis in order to meet the definition of a unit of government.

Respectfully Submitted,

Richard K. Eitel, Chief Executive Officer

Health Services
LOS ANGELES COUNTY

March 15, 2006

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To improve health through leadership, service and education.

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

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES (LAC/DHS)

On behalf of LAC/DHS, I am writing to express our opposition to CMS' Proposed Rule CMS 2258-P, which imposes cost limits on Medicaid payments to public providers. LAC/DHS urges CMS to withdraw this proposed rule.

We are highly concerned that the proposed rule would have a severe negative impact on California's public safety net hospitals and the patients and communities they serve. If the rule is implemented, LAC/DHS anticipates that it will lose at least $200 million annually in federal Medicaid funds. Potential service reductions as a consequence of this loss are equivalent to closing all of non-hospital operated clinics and defunding our contracted clinics. This would result in eliminating 1.3 million outpatient visits per year.

We are concerned about a number of troubling provisions contained in the rule.

First, it will limit our Medi-Cal reimbursements to the costs of providing Medi-Cal services to our Medi-Cal patients. This will eliminate substantial funding for our Medi-Cal and uninsured patients, who make up 77% of our patient population and whose costs are partially covered under the Safety Net Care Pool. The pool exists under California's CMS-approved hospital financing waiver specifically for the purpose of providing financial assistance to safety net hospitals that incur significant costs in treating uninsured patients.

LAC/DHS provides a full range of services to vulnerable populations, and specialty services to both the uninsured and insured that are often not readily available elsewhere in our communities. LAC/DHS is comprised of:

- 21,700 employees, $3.3 billion budget
- 3 acute care teaching hospitals
- 2 trauma centers
- 1 acute rehabilitation hospital
- 1 multi-service ambulatory care center

- 6 comprehensive health centers
- 10 primary care health centers
- 100 private-partner primary care sites
- Emergency Medical Services agency
- 2 medical school partners

Of LAC/DHS's nearly 700,000 patients:

- 71% are uninsured
- Median income is between $5,000 and $10,000
- 71% are Latino, 15% African American, 10% White
- 53% speak Spanish as primary language
- Chronic conditions are prevalent. Among adult patients the following conditions are present
  - 22% diabetes
  - 34% hypertension
  - 31% high cholesterol
  - 14% depression

Further,

- Hospitals in the county are often totally full – LAC/DHS has 10% of the bed capacity.
- LAC/DHS provides 35% of all trauma care in the County.
- LAC/DHS provides 55% of all inpatient burn care in the County.
- 13% of all emergency room visits county-wide occur in LAC/DHS facilities.
- LAC/DHS is responsible for 2.6 million outpatient visits each year.
- 46% (1,707) of the medical residents in the County are trained in County hospitals.
- LAC/DHS provides funding for the Medi-Cal program through certified public expenditures and intergovernmental transfers.
- The County performs Medi-Cal administrative activities on behalf of the State, such as outreach and Medi-Cal enrollment, and funds the nonfederal share of those activities.

Though we understand that staff from CMS verbally has advised the State that the regulation will not affect California's waiver, the potential harmful effects on our hospital are such that we cannot rely on these verbal assurances, particularly given the plain language of the rule. The

proposed rule explicitly states in the preamble that all Medicaid payments "made under the authority of the State plan and under Medicaid waiver and demonstration authorities are subject to all provisions of this regulation." 72 *Fed. Reg.* 2236, 2240. Moreover, the Special Terms and Conditions that govern the Hospital Waiver require that the State comply with any regulatory changes. Hence, we and California's other public hospitals are highly concerned that, when the rule's limit to Medicaid costs is applied to our state's hospital financing waiver, funding will be eliminated for indigent non-Medicaid patients whose costs are currently covered under the Safety Net Care Pool.

Second, the rule imposes a very restrictive definition of public providers who can participate in Medicaid funding programs. Under the proposed provision, the University of California Medical Centers and Alameda County Medical Center will likely be unable to meet CMS' stringent definition; consequently, those public hospitals stand to lose millions of federal dollars a year. These additional losses would also contribute to reduced access and services to our patients and our communities.

Finally, there are a number of legal and technical issues raised in the comment letter submitted by the California Association of Public Hospitals (CAPH), an organization of which we are a member. These include a provision that narrows which sources of funds may be used as non-federal Medicaid matching funds, and a requirement that public providers retain federal funds upon receipt. We support CAPH's comments of opposition and incorporate them by reference in this comment letter.

LAC/DHS opposes the Medicaid rule and strongly urges CMS to withdraw it. If the rule goes into effect, we will suffer extremely harmful effects that will affect our ability to care for our patients and communities. CMS should recognize the damage that this rule will have to our community's health care system and stop its efforts to move forward with the rule.

Sincerely yours,

Bruce A. Chernof, MD
Director and Chief Medical Officer

BAC:gww

c: Each Supervisor
Chief Administrative Officer
County Counsel

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Joseph E. Robertson, Jr., M.D., M.B.A.
President

March 7, 2007

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

Re: Comments for CMS-2258-P, *Proposed Rule: Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership*, 72 Fed. Reg. 2236 (Jan. 18, 2007)

Dear Ms. Norwalk:

On behalf of Oregon Health and Science University (OHSU), I am submitting comments on the above captioned proposed rule issued by the Centers for Medicare and Medicaid Services (CMS), published in the January 18, 2007 Federal Register, relating to the Medicaid Program (CMS-2258-P) (Proposed Rule).

OHSU is the only academic health center in the State of Oregon, consisting of hospitals and clinics, schools of medicine, dentistry, nursing, science and engineering, as well as operations with major grant awards for health related research. OHSU serves as the tertiary care center for the State of Oregon and Southwest Washington State, is a Level 1 trauma center and a major transplant center, and trains over 350 medical residents annually. OHSU is a public corporation operating under specific authority granted by the Oregon legislature.[1] OHSU receives substantial funding, in the form of appropriations, from the state legislature annually.

OHSU serves a significant safety net role in Portland and in Oregon, both in terms of serving large numbers of underserved populations with Medicaid and with no third party coverage and in terms of providing specialized services not available from other hospitals in the State. OHSU relies heavily on Medicaid program funding. The cuts in Medicaid reimbursement that could result from the proposed regulation would be financially devastating. According to our calculations, the Proposed Rule could cut between $4.4 and $36.3 million in annual funding to OHSU and would compromise our ability to continue our public mission.

1. **The Proposed Rule would erode supplemental payments that support OHSU's mission.**

CMS proposes to abandon, for government owned hospitals, the current aggregate upper payment limit (UPL) based on Medicare payment principles that

[1] Oregon Statutes Chapter 353.

currently acts as a ceiling for Medicaid funding, and to replace it with an as-yet undefined "cost limit." The Oregon Medicaid agency, since 2001, paid Pro-Share payments to OHSU up to the current UPL in recognition of OHSU's public mission and, in particular, role as a public academic teaching hospital. CMS reviewed and approved state plan amendments authorizing these payments. Since Medicare pays OHSU more than governmental calculations of cost, CMS' Proposed Rule will significantly lower reimbursement to OHSU. Our conservative estimates are that OHSU would likely lose at least $4.4 million annually in Pro-Share related revenues should the Proposed Rule be finalized.

Given that the federal government monitors and sets Medicare rates based on a complicated and sophisticated formula, it seems hard for us to believe that Medicare rates in the Medicaid context are not reasonable.

In the final rule, CMS should reinstate Medicare payment rates as the UPL for government hospitals, instead of the as yet undefined cost limit.

2. **The Proposed Rule's conditions on the definition of a unit of government exceed CMS's statutory authority and intrude on State prerogatives.**

OHSU is clearly recognized by state law as a public entity. According to OHSU's authorizing statute, OHSU is a "governmental entity performing governmental functions and exercising governmental powers." OHSU is proud of the governmental history and status of its hospitals, which have their origins in both the governmental hospitals created by the state's medical school built in 1956 and in the Multnomah County hospital created in 1923, as well as other institutions. OHSU's mission is a longstanding public mission to provide excellence in health care to all residents or Oregon and beyond, including a "commitment to provide health care to the underserved patient population of Oregon." Although we believe that OHSU's status as a unit of government (or at least an integral part of a unit of government) is not in question under the Proposed Rule due to the significant appropriations OHSU receives from the State of Oregon in the annual legislative appropriations process, we believe that CMS's definition of unit of government is an inappropriate intrusion into State prerogatives and beyond its statutory authority.

Under the federal system of government in the United States, it is a fundamental concept embodied in the Tenth Amendment to the Constitution that "The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people." One of the powers reserved to the states is the power to create and dictate its own constituent units of government. The Medicaid statute recognizes this broad flexibility by including a definition of unit of local government that includes "or other government unit" as part of its definition. 42 U.S.C. 1396b(w)(7)(G). CMS, in the Proposed Rule, would introduce new conditions that are not permitted either by the Constitution or the Medicaid statute.

In the final rule, CMS should not restrict the definition of unit of government beyond what is contained in the Medicaid statute.

3. **Restrictions on Medicaid financing would further jeopardize OHSU and go beyond CMS's statutory authority.**

CMS proposes to limit the participation of local government entities in financing the Medicaid program. OHSU has traditionally participated in the financing of Medicaid payments to OHSU. If OHSU were not able to assist the State in financing the Medicaid program, $36.3 million per year in OHSU revenues could be at risk. A loss of those funds would severely compromise our ability to serve Medicaid and non-sponsored patients.

OHSU's participation in the financing of the Medicaid program, as well as the participation of other entities of local government is protected by the Medicaid statute. According to the Medicaid statute, the Secretary of HHS "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 [Medicaid] expenditures." 42 U.S.C. 1396b(w)(6)(A). Given OHSU's status as a State university teaching hospital, it is difficult to see how the Proposed Rule could even purport to restrict OHSU's participation in the Medicaid program.

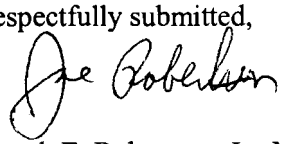
In the final rule, CMS should clarify that it is not restricting States' use of funds appropriated to State university teaching hospitals such as OHSU, consistent with the Medicaid statute.

4. **CMS' rationale that the Proposed Rule is necessary to curb improper Medicaid financing mechanisms is flawed.**

CMS' rationale for issuing the Proposed Rule was based in large part on the agency's belief that current Medicaid payments to public providers in excess of cost are being used by providers to return some or all of the federally-matched payments to the state. We wish to stress that, under current rules, OHSU has retains 100% of the Medicaid funds paid to us and have used it for patient care services. As a result, the Proposed Rule is unnecessarily punitive to OHSU and other similarly situated safety net providers.

In summary, I appeal to CMS to reconsider the proposed regulations. Current reimbursement rules already force hospitals to shift costs to private third party payors. A further forced "cost shift" cannot be sustained by those payors. The ultimate result will be a total breakdown of the health care safety net for Medicaid and non-sponsored individuals here in the State of Oregon, and I fear, across the nation.

Respectfully submitted,



Joseph E. Robertson, Jr., M.D., M.B.A.
OHSU President

MORROW COUNTY

BEHAVIORAL HEALTH SERVICES

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Kimberly Lindsay
Executive Director

March 7, 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

My name is Kimberly Lindsay and I represent Morrow County Behavioral Health, a county run mental health organization in the State of Oregon. I am writing to comment on the impact that proposed regulation CMS 2258-P will have on the Medicaid system in Oregon, with specific emphasis on the Medicaid Mental Health System.

Oregon County governments provide a substantial amount of Medicaid Mental Health Services under the State's 1115 demonstration waiver. Substantially all of the Medicaid Mental Health Services are provided by county government in 15 of the 36 Oregon Counties and 7 additional counties use a hybrid model of government and non-governmental providers. In all 22 cases, the counties are the critical safety net provider, treating the most seriously disabled Medicaid enrollees in their communities.

In most of the 22 counties served by government providers, the Medicaid Prepaid Inpatient Health Plans (PIHP) use risk-bearing payment mechanisms where counties are sub-capitated for all or a portion of the Medicaid enrollees. Under these financial arrangements the counties are responsible for meeting the mental health needs of enrollees regardless of whether sufficient sub-capitation revenue is available in a given year.

As with any risk-bearing arrangement for the provision of healthcare, revenues do not necessarily match costs in a given month, quarter, or year, and risk reserves are necessary to ensure financial viability of the risk-bearing entity – in this case the county health department.

As currently written, it appears that the drafters of CMS 2258-P did not envision these types of payment arrangements between the MCO and the provider organization. By limiting allowable Medicaid payments to cost, using a cost reporting mechanism that doesn't take into account a risk reserve, it appears that CMS has assumed that all risk is being held by the MCOs/PIHPs. This is not the case in Oregon or a significant number of other states that have 1115 or 1915(b) waivers for their Medicaid Mental Health Systems.

The Cost Limits for Units of Government provision, as currently written, would render all of the sub-capitation arrangements with counties financially unsustainable due to the fact that there would be no mechanism for building a risk reserve and managing the mismatch of revenue and expense across fiscal years – something that is a core requirement for health plans and all risk-bearing entities.

This level of federal intervention in the reimbursement and clinical designs of state and local governments appears to be unintended. In essence, the regulation is creating a de facto rule that provider organizations that are units of government cannot enter into Medicaid risk-based contracts.

I am writing to request that this be corrected through a modification of the proposed regulation. ***Specifically I am requesting the Cost Limit section of the regulation be revised to include, as allowable cost, an actuarially sound provision for risk reserves when a Unit of Government has entered into a risk-based contract with an MCO or PIHP.***

Sincerely,

Kimberly Lindsay

Kimberly Lindsay
Director
Morrow County Behavioral Health

Medi-Cal Administrative Activities Targeted Case Management

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March 15, 2007

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

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

Dear Ms. Norwalk:

On behalf of the Local Governmental Agency (LGA) Medi-Cal Administrative Activities and Targeted Case Management Consortium ("Consortium"), we are writing to express strong opposition to the proposed Medicaid rule, which would severely limit California's ability to fund its Medi-Cal program. (CMS-2258-P) The Consortium is a group of local governmental agencies (LGAs) whose purpose is to identify system-wide issues of California health policy and administration related to the Medi-Cal Administrative Activities (MAA) and Targeted Case Management (TCM) programs and to advise and recommend policy positions, management strategies, and other actions which address the identified issues. The Consortium leads policy development efforts and works collaboratively with the California Department of Health Services and other organizations that share common concerns.

Under California law, LGAs perform critical administrative activities on behalf of the State's Medicaid program, known as Medi-Cal. (Welf. & Inst. Code Sections 14132.44-47). That law and the Medi-Cal state plan authorize LGAs to provide targeted case management services to Medi-Cal beneficiaries. LGAs perform these functions directly or through community based organizations. In addition, the LGAs use local, and sometimes state, public dollars to fund the nonfederal share of MAA and TCM services through certified public expenditures ("CPE"). If implemented, the rule would hinder our members' ability to continue providing these critical services. Therefore, the Consortium urges you to withdraw this proposed rule.

The key concerns of the Consortium relate to the restrictions imposed in Section 433.50 and 433.51 of the rule and the related discussion in the regulatory preamble. The proposed rule would inappropriately limit states' ability to fund the nonfederal share of Medicaid expenditures by narrowing the types of public entities that can participate in that funding, and by restricting the

states' ability to use local public funding for the Medicaid program. These restrictions are not authorized by the Medicaid statute and are inconsistent with congressional intent.

The proposed rule would inappropriately limit those entities qualified to provide the nonfederal share of Medicaid expenditures to units of government with "generally applicable taxing authority." The legal analysis presented in support of the proposed rule is flawed.

The proposed regulatory definition is inconsistent with the plain language of the statutory definition of unit of government on which CMS relies, Section 1903(w)(7)(G) of the Social Security Act.[1] The proposed rule, simply adds the requirement of "generally applicable taxing authority" to the statutory definition. If Congress had intended to impose this additional requirement, it would have done so. Instead, Congress adopted a broad definition with the intent of maintaining then existing policy allowing public agencies to fund Medicaid. The Conference Committee stated:

> 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.[2]

Moreover, Section 1903(w)(7) of the Act expressly limits the scope of the terms defined there to be used only "for purposes of this subsection." CMS goes far beyond this limitation by applying the definition to its interpretation of Section 1902(a)(2) of the Act.[3] This Section of the law has not been changed since 1967 and is the provision on which CPE programs such as those in California are based.

Neither the proposed rule nor the discussion in the regulatory preamble explains what is meant by "generally applicable taxing authority." Because the Consortium members are counties and cities, we assume they have the requisite taxing authority. However, the proposed limitation would seem to eliminate the ability of special purpose districts to participate in funding Medicaid, even though the statutory definition of a unit of government expressly includes that type of governmental unit. (See Section 1903(w)(7)(G).)

The Consortium is also concerned that this rule may preclude federal matching based on the expenditures of public funds by other state or local public agencies for purposes directly aligned with the purposes of the MAA and TCM programs. For example, certain local commissions in California, known as "First Five" commissions, are allocated state Proposition 10 tobacco tax dollars to implement programs designed to benefit California's children.[4] Expenditure of these public funds by the First Five commissions under the MAA and TCM programs for activities such as Medi-Cal outreach and enrollment is perfectly consistent with both State and federal law, but it

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[1] 42 U.S.C. § 1396b(w)(7)(G).

[2] H.R. Conf. Rep. No. 102-409, at 1444(1991).

[3] 42 U.S.C.§ 1396a(a)(2).

[4] California Children and Families First Act of 1998, Health & Safety Code § 130105

appears that no federal matching funds would be available for those expenditures because the commissions themselves do not have taxing authority. There is no legitimate policy reason for CMS to preclude the State from funding its Medi-Cal program with these State dollars.

The Consortium's second concern relates to the sources of dollars to be used for MAA and TCM expenditures. In the preamble, CMS states that tax revenue is the only valid source of intergovernmental transfers.[5] While neither current law nor the proposed regulations expressly imposes such a requirement, the preamble statements suggest that CMS intends to adopt an interpretation that would limit local Medicaid funding to those funds derived directly from taxes. Any such limitation on the use of public funds would be directly inconsistent with the long-standing implementation of the Medicaid statute and with the protections intended by Congress in Section 1903(w)(6) of the Act.[6]

The preamble also indicates that tax dollars will not be recognized as an appropriate source of Medicaid funding if they are "committed or earmarked for non-Medicaid activities."[7] It is unclear how this reference to tax dollars being "earmarked" will be interpreted. While the proposed rule intends to assure that Medicaid funding does not pay for non-Medicaid purposes, we fear that the ambiguity in this proposal could lead to overly restrictive requirements. The rule apparently fails to recognize that funds can be "earmarked" for a purpose, other than Medicaid, that is consistent with the use of the funds for Medicaid purposes. One example is the use of Proposition 10 tax revenues as discussed above.

Any final regulation should explain the definition of "earmarked" and how this limitation would be applied. LGAs often rely on public expenditures under non-specific contracts that allow for a wide range of services to be provided under a single contract. The specific types of services/activities provided under the contract are determined by the provider and are reimbursed as MAA or TCM services if they are also consistent with the requirements of those programs. How does this new rule apply or address these types of contracts?

There is no legitimate federal interest in imposing the proposed restrictions on California's ability to fund its Medi-Cal program. While the proposed rule would result in federal savings, those savings would be accomplished in violation of the State's right under the Medicaid statute to use local funds as the nonfederal share of Medicaid expenditures under Sections 1902(a)(2) of the Act. The Consortium urges CMS to withdraw the proposed changes to Sections 433.50 and 433.51. If CMS goes forward with a final rule, the definition of unit of government must be amended to exclude the reference to generally applicable taxing authority and the rule should clarify that states are not limited to using only tax dollars as the nonfederal share of Medicaid expenditures.

Finally, as currently drafted, proposed Section 447.207 is too broad. The regulation would require all providers to "receive and retain" the full amount of the Medicaid payment. Although the preamble suggests that this requirement would only apply to IGT funded Medicaid payments, the language of the regulation is much broader, applying to all Medicaid payments to all types of

[5] 72 Fed. Reg. 2236, 2238, Jan. 18, 2007.

[6] 42 U.S.C.§ 1396b(w)(6).

[7] 72 Fed. Reg. 2236, 2239, Jan. 18, 2007.

providers. The Consortium is concerned about the impact this provision may have on administrative fees for operation of the MAA/TCM programs. The State charges such a fee from LGAs and the LGAs may similarly charge their community based organizations a fee to cover the cost of the program. Often the fee is offset against amounts due for services. We are requesting a clarification of whether these fees would be prohibited and, if not, whether an offset against Medi-Cal payments due would continue to be authorized.

The preamble suggests that this rule is necessary to protect against abuses. While this is a legitimate goal, the rule is neither a necessary nor effective means of addressing state funding abuses. The Consortium urges CMS to withdraw the rule in its entirety. If a final rule is adopted, however, we request that CMS amend the final rule to address the concerns raised in this letter.

Sincerely,

Janice DiCroce, Ph.D.
Co-Chair
LGA Consortium

Lynda Lindsay
Co-Chair
LGA Consortium

BHR

Behavioral Health Resources

March 12, 2007

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

Dear Sir/Madam:

My name is John Masterson and I represent Behavioral Health Resources, a private not for profit (501c3) organization in the State of Washington. I am writing to comment on two specific ways the proposed regulation CMS 2258-P will impact the Medicaid Behavioral Health System in a number of states.

Cost Limit Provisions in States with At-Risk Provider Contracts

A large number of county governments provide substantial amounts of Medicaid Behavioral Health Services under 1915(b), 1915(c) or 1115 waivers across the country. In many cases the counties are the critical safety net provider, treating the most seriously disabled Medicaid enrollees in their communities.
In many of these systems, the Medicaid health plans use risk-bearing payment mechanisms where counties are sub-capitated or case rated for all or a portion of the Medicaid enrollees. Under these financial arrangements the counties are responsible for meeting the behavioral health needs of enrollees regardless of whether sufficient sub-capitation revenue is available in a given year.

As with any risk-bearing arrangement for the provision of healthcare, revenues do not necessarily match costs in a given month, quarter, or year, and risk reserves are necessary to ensure financial viability of the risk-bearing entity – in this case the county health department.

As currently written, it appears that the drafters of CMS 2258-P did not envision these types of payment arrangements between the MCO and the provider organization. By limiting allowable Medicaid payments to cost, using a cost reporting mechanism that doesn't take into account a risk reserve, it appears that CMS has assumed that all risk is being held by the MCOs/PIHPs. This is not the case in a significant number of waiver states.

The Cost Limits for Units of Government provision, as currently written, would render all of the sub-capitation arrangements with counties financially unsustainable due to the

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fact that there would be no mechanism for building a risk reserve and managing the mismatch of revenue and expense across fiscal years – something that is a core requirement for health plans and all risk-bearing entities.

This level of federal intervention in the reimbursement and clinical designs of state and local governments appears to be unintended. In essence, the regulation is creating a de facto rule that provider organizations that are units of government cannot enter into Medicaid risk-based contracts.

I am writing to request that this be corrected through a modification of the proposed regulation. **Specifically I am requesting the Cost Limit section of the regulation be revised to include, as allowable cost, an actuarially sound provision for risk reserves when a Unit of Government has entered into a risk-based contract with an MCO or PIHP.**

Intergovernmental Transfers in States with Government-Organized Health Plans

A second issue concerns a number of states where Medicaid Behavioral Health Plans have been set up as government entities by one county or a group of counties to manage the risk-based contract. Under this arrangement, local dollars are paid to the health plan for Medicaid match and these funds are then submitted to the state to cover the match.

In reviewing the proposed regulation, specifically pages 22 – 23, it appears that the intergovernmental agreements that set up the Medicaid Health Plans do not meet the definition of a "unit of government" because the plans were not given taxing authority and the counties have not been given legal obligation for the plan's debts. Thus, it appears that the regulation would render the flow of local dollars, the purpose of which is to supply Medicaid match, unallowed match, simply because of the chain of custody of those dollars.

This regulatory language, which is intended to prevent provider-related donations, appears to have the impact in a number of states of preventing bona fide local dollars from being use as match. I am writing to request that this be corrected through a modification of the proposed regulation. **Specifically I am requesting the regulation explicitly state that local dollars will be considered valid Intergovernmental Transfers <u>if they originated at a Unit of Government regardless of the entity that submits the payment to the state.</u>**

Sincerely,

John P. Masterson
Chief Executive Officer

JM:E:\Documents\Correspondence\CMS 03-12-07.doc
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ROGUE VALLEY COUNCIL OF GOVERNMENTS

Administration Office

Rogue Valley Council of Governments

(541) 664-6674 ▪ FAX (541) 664-7927 ▪ www.rvcog.org

March 13, 2007

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

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

Dear Mr. Leavitt:

This letter is in response to the above-proposed rule changes. While no responsible party would argue with the need to ensure that Medicaid match is appropriately derived and applied, the fifteen member jurisdictions of the Rogue Valley Council of Governments, representing Southern Oregon's major population center, cannot agree with the proposed strategies. The draft rule changes appear to be nothing more than a mechanism for dramatically reducing Medicaid funding for some of the most vulnerable populations in the United States, something we cannot countenance.

Although we have issues with practically every aspect of the proposed changes, there are two major pieces we wish to highlight here – the questions of what is an appropriate source of match and what is a suitable definition of a unit of government.

The first, the proposed restriction of Medicaid match to only monies directly derived from state and local tax revenue, is incomprehensible. There are a variety of clean sources of matching funds that are neither tax-based nor recycled Federal funds that should continue to be allowed as local match for Medicaid, including fees and local grants. Until now, these funds have been considered legitimate sources of match, and have been instrumental in allowing for much needed, and entirely appropriate, expansions of Medicaid services to vulnerable citizens. If accountability is the real issue behind the proposed match restrictions, we are certainly open to increased reporting requirements on the presently acceptable sources of match, as long as we can all agree on a system that does not unduly increase administrative costs.

The second major issue we have is the proposal for a severely restricted definition of a unit of government. From the wording of the rule changes, and in using the questionnaire, it is obvious that the nation's vast array of Regional Councils of Governments would not be considered governmental providers, and thus would not be eligible to provide matching funds. For almost 50 years, Councils of Governments across the nation have been partners in every major federal program in which effective and efficient regional implementation has been a priority. Never before has there been a serious challenge to the governmental status of a Council of Governments; that such a challenge would come from an agency of the federal government, which created Councils of Governments in the first place to assist in the implementation of programs such as Medicaid, makes no sense to us. The decision of where to place the operational responsibility for the Medicaid program has always been, and should remain, the prerogative of state and local governments. These proposed rules damage that right to local decision-making by compromising the ability of Councils of Governments to function as they were originally intended.

After much local discussion and analysis, we have come to the inescapable conclusion that the proposed rules are inherently flawed, and that they would create major hardships to the economically disadvantaged and elderly in our region and across the United States. We urge you to cancel these rule changes, and instead request that you address the issue of Medicaid match by tasking your partners across the nation – entities like the Rogue Valley Council of Governments - with providing real recommendations for better control and oversight. We feel that to continue as you are suggesting would constitute nothing less than a fundamental breach of trust with the American public, and an abrogation of the Centers for Medicare and Medicaid Services' institutional mission and vision.

Sincerely,

Jim Lewis, Board Chair
Rogue Valley Council of Governments

cc: Congressman Greg Walden
2nd Congressional District
1210 Longworth House Building
Washington, DC 20515

Senator Gordon Smith
U.S. Senate
404 Russell Building
Washington, DC 20510

Senator Ron Wyden
U.S. Senate
230 Dirken Senate Office Building
Washington, DC 20510-3703

Forms Response:
Attn: Kathryn P. Astrich
Office of Information and Regulatory Affairs
Office of Management and Budget
Room 1023 New Executive Office Building
Washington, DC 20503

Attn: Melissa Musotto
Centers for Medicare and Medicaid Services
Office of Strategic Regulations and Regulatory Affairs
Division of Regulatory Development
CMS-2258-P
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

MONTEREY COUNTY

THE BOARD OF SUPERVISORS

February 28, 2007

Leslie V. Norwalk, Esq. - Administrator (Acting)
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2258-P
P.O. Box 8017
Baltimore, MD 21244-8017

SUBJECT: Proposed CMS Rulemaking (CMS-2258-P)
Lowering Medicaid caps to reimbursement to Public Hospitals in the US

Dear Administrator Norwalk:

The Centers for Medicare and Medicaid Services (CMS) is in the midst of public comment period on a rule to materially lower Medicaid "caps" to reimbursement for public safety net hospitals all across the US. The national reimbursement reduction totals $3.8 billion, which equates to a $550 million reduction for the State of California, and an $8 million annual reduction in funding for each of the next three years for Natividad Medical Center (NMC), Monterey County's only public safety net hospital. The comment period for this very concerning rule ends March 19, 2007.

Important Facts About NMC:

- NMC receives approximately $23.4 million in safety net care pool (SNCP) monies annually for Medicaid. Even after including these special SNCP monies, NMC loses $10 million annually on its Medicaid book of business.
- NMC loses $9 million annually on its Medicare population, as reimbursements do not cover the full cost of care to Medicare enrollee's.
- NMC loses $8 million annually on its growing uninsured population.
- In 2005, based on the California Office of Statewide Health Planning and Development (OSHPD) discharge data, NMC treated 92% of all of the indigent discharges receiving hospital care in Monterey County.
- Medicaid, Medicare and self-pay clients comprise 85% of all of NMC's business.
- As a result of these payor mix challenges, NMC lost $25 million in fiscal year 2006.
- NMC is the only teaching hospital for physician residents in Monterey County.
- Further material cuts will not allow this 125-year-old facility to survive.

Important Facts About California's 21 Public Safety Net Hospitals:

NMC is one of California's 21 public safety net hospitals. These 21 public safety net hospitals:

- Represent less than 6% of the state's total hospitals, yet they operate more than 60% of the state's top-level trauma centers;
- Train half of all the physician residents in California;
- Provide over 11 million outpatient visits per year to patients;
- Provide over 60% of the state's emergency psychiatric care; and
- Provide over 85% of all indigent care in their respective counties across California.

In summary, the County of Monterey requests that the proposed CMS Medicaid rule lowering the reimbursement "cap" to NMC be retracted and not implemented. Your careful consideration and acceptance of this request is critical to the survival of NMC.

Sincerely,

Dave Potter

Dave Potter
Chair, Board of Supervisors

cc: Herb B. Kuhn, CMS Deputy Administrator (Acting)
Senator Dianne Feinstein
Senator Barbara Boxer
Congressman Sam Farr
Assembly Member Anna Caballero
Assembly member John Laird
Senator Jeff Denham
Senator Abel Maldonado
John Freshman, Troutman Sanders Public Affairs Group LLC
John Arriaga, JEA & Associates
Monterey County Board of Supervisors
Lew C. Bauman, CAO-Monterey County
Nicholas E. Chiulos, Interim Chief of Intergovernmental Affairs-Monterey County

03-07-2007
WEDNESDAY

To: Centers For MEDICARE & MEDICAID SERVICES
H.H.S. DEPT. ATTN: CMS-2258-P
P.O. BOX 8017
BALTIMORE, MD. 21244-8017

From: MARK A. HILL, DC.# 280806
1760 HIGHWAY 67-NORTH
DORM # C-2157-S
CALHABELLE, FLA. 32322

SUBJECT: PROPOSED RULE CHANGE, BY MEDICARE ADMINISTRATORS

TO: WHOM IT MAY CONCERN. MYSELF AS A RESIDENT OF THE STATE OF FLORIDA, THINKS, THAT YOUR CURRENT PROPOSAL TO CHANGE THE RULES ON THE FUNDING FORMULAS, IS NOT A GOOD IDEA. I AM OPPOSED TO THIS. THIS IS ANOTHER OF THIS BUSH ADMINISTRATION, FROM JAN. 2001 ON THIS ADMINISTRATION HAS BEEN SYSTEMATICALLY ABANDONING ITS FEDERAL RESPONSIBILITY TO CUT FUNDING FOR HEALTHCARE COSTS NEEDS, FOR THE SENIORS, AND LOWER INCOME EARNING CITIZENS OF THIS NATION. MY STATE OF FLA. CANNOT AFFORD TO LOSE ANYMORE OF OUR FEDERAL DOLLARS FOR HEALTHCARE COST. SO I URGE YOU, TO NOT CHANGE THE RULES. IF ANYTHING WE NEED INCREASED FUNDING, AND WE NEED IT NOW. THANK YOU FOR YOUR TIME AND ATTENTION

NO to PROPOSED RULE CHANGES

MARK A. HILL

MARK A. HILL, DC.# 280806
DORM # C-2157-S
1760 HIGHWAY 67-NORTH
CALHABELLE, FLA.
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FLOYD Medical Center

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706.509.5000 Phone
www.floyd.org

MAR 19 2007

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 Floyd Medical Center, I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes $10,068,055 in critical Medicaid support payments for the Medical Center, funding that has been essential to our ability to serve as a major safety net health care system in Georgia.

The Medical Center is owned by the Hospital Authority of Floyd County ("the Authority") and operated by Floyd Healthcare Management Inc., a non-profit corporation created by the Authority, pursuant to a *lease agreement* with the Authority to provide health care services to our community. The Floyd family of healthcare services has been responding to the healthcare needs of Rome and surrounding communities in Northwest Georgia and Northeast Alabama for nearly 65 years, since July 4, 1942. At the hub of Floyd is a 304-bed full-service, acute care hospital and regional referral center, Floyd provides sophisticated medical services and the latest technology to support centers of excellence in trauma and emergency care. Floyd offers level II neonatal intensive care, adult intensive care, adult coronary care, women and infants care, pediatrics, inpatient and outpatient adult and pediatric rehabilitation specialties, inpatient and outpatient surgery, oncology, diabetes, pulmonology, orthopedics and cardiology. In addition Floyd has partnered with Harbin Clinic to create a Bariatric Center and is an accredited Joint Commission Primary Stroke Center.

Floyd's innovative Indigent Care Task Force has worked to reinforce Floyd's role as the area's safety net provider, making quality health care accessible to the poor and uninsured through the establishment of the Floyd County Clinic, which is operated by Floyd Medical Center's Family Medicine Residency Program, financial counseling services and a highly successful prescription reimbursement program. The 3-year residency program attracts recent medical school graduates from across the country and maintains an enrollment of 21 residents annually.

As a key safety net provider in our community, and as a member of the Georgia Coalition of Safety Net Hospitals, we strongly oppose the Proposed Rule, and respectfully request 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 each of these provisions would impact our hospital, our patients and our community.

Defining a Unit of Government (§ 433.50)

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

Georgia Medicaid has recognized our key role as a safety net provider for years, and has provided crucial financial support for this role through Georgia's Indigent Care Trust Fund and through supplemental "upper payment limit" ("UPL") payments, totaling $4,004,078 in FY 2006. The Hospital Authority, a public entity under Georgia law, has provided the non-federal share of these support payments through IGTs. In 2005, we were asked by the Georgia Department of Community Health to complete a questionnaire describing in detail the governmental structure of the hospital, the relationship between the Medical Center and the Hospital Authority, the Hospital Authority's access to tax revenues and the community services we provide. It is our understanding that, based on our survey responses, CMS approved the Hospital Authority's governmental status and ability to provide intergovernmental transfers to help fund the Medicaid program. At the same time, Georgia restructured its IGT program in response to CMS concerns so that now none of the transfers exceed the non-federal share of the supplemental payments they support. Despite the "clean bill of health" that Georgia's IGTs have received, the Proposed Rule would nevertheless upend our system, calling into question a fact that has never been doubted under Georgia law – that hospital authorities such as ours are units of government.

As a result of this sharp change of course, the Hospital Authority would no longer be able to support our Medicaid payments through IGTs, and we stand to lose the very payments that have allowed us to so successfully serve as the safety net provider in our community. Our Indigent Care Trust Fund and UPL payments provide the financial backbone for so many of the services we provide that are un-reimbursed or under-reimbursed. For example, in SFY 2006 we provided

Due to the aforementioned adverse economic and social consequences of the proposed rule, Advocate urges CMS to withdraw its proposal rule and subsequently conduct additional economic and social analyses of the costs to the country of providing health care to those impoverished individuals and families who inevitably will lose their Medicaid coverage due to the significant reduction in federal Medicaid expenditures. We believe an analysis of this type likely would demonstrate that the cost of the proposed rule far outweighs any perceived benefit.

We appreciate your consideration of our views on this critical issue regarding the Medicaid program. Should you have any questions, please do not hesitate to contact me, Meghan Clune – Advocate Director of Government Relations (630/990-5514, meghan.clune@advocatehealth.com) or our Washington representative, Ilisa Halpern Paul (202/230-5145, ilisa.paul@dbr.com).

Sincerely,

Tony Mitchell
Senior Vice President
Communications & Government Relations

2025 Windsor Drive
Oak Brook, Illinois 60523
Telephone 630.572.9393

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Advocate Health Care

January 31, 2007

2007 FEB 14 PM 12: 14

Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Room 445–G, Hubert H. Humphrey
Building, 200 Independence Avenue,
SW., 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

Dear Acting Administrator Norwalk:

On behalf of Advocate Health Care (Advocate), the largest integrated health care system in the state of Illinois, I am writing to express deep concern regarding the Centers for Medicare and Medicaid Services' (CMS) Proposed Rule, "Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership," published in the Federal Register on January 18, 2007 (Vol. 72 FR 2236 – 2248). Advocate respectfully suggests that CMS has failed to consider adequately the financial cost to the nation's health care system and providers if its recommended changes to the Medicaid program are implemented.

Advocate – a non-profit, faith-based organization of physicians and health care professionals dedicated to serving the health needs of individuals, families, and communities in northern Illinois – is recognized as one of the top ten health care systems in the country. It maintains eight adult hospitals and two children's hospitals with 3,500 beds in addition to having the state's largest privately held full -service home health care company among more than 200 sites of care. Advocate's core values of compassion, equality, excellence, partnership, and stewardship guide its actions in the provision of health care to the communities it serves.

Given Advocate's size and scope, we play a unique and critical role in the provision of care to Illinois' residents, particularly those who rely on the presence of a strong health care safety net, such as individuals served by the Medicaid program. As such, we fear that the proposed rule's estimated reduction in federal Medicaid expenditures will significantly undermine our nation's health care safety net and negatively impact vulnerable populations in Illinois and across the country.

Advocate recognizes and appreciates that in promulgating the proposed rule CMS is attempting to restrict certain state spending practices that the agency believes may not meet the spirit of the Medicaid statute. We abstain from offering judgment or comment on the validity of certain states' use of the upper payment limit (UPL) or intergovernmental transfers (IGT) to maximize federal resources. However, by CMS's own estimation, the proposed rule will lead to a reduction in federal Medicaid expenditures of $3.87 billion over five years. We have serious concerns that this severe funding cut will harm many impoverished and indigent individuals – the population the Medicaid program is designed to protect.

Faced with its share of these funding cuts – combined with the other Medicaid cuts already imposed by the Deficit Reduction Act (P.L. 109-171) – Illinois likely will have to make painful reductions to its Medicaid program that will lead to many Illinoisans losing their Medicaid coverage and joining the growing ranks of the uninsured. The burden then will fall upon the health care system at large and providers such as Advocate to provide and finance their health care.

supplemental payments for Medicaid patients who are enrolled in private plans. Based on preliminary projections of SFY 2007 UPL payments, we expect to lose approximately $1,534,572 because of the loss of UPL payments associated with CMO enrollees. One way to temper the cut that is being imposed by the Proposed Rule is to relax your regulatory prohibition on direct payments to providers for managed care enrollees (42 C.F.R. §438.6; 438.60). We urge you to consider this refinement to the regulation.

In sum, we are deeply concerned about the impact that the Proposed Rule will have on our institution and the essential services we provide to our community. The impact on our patients will be very swift and very severe. We urge you to withdraw the regulation immediately.

If you have any questions about this letter, please feel free to contact Richard T. Sheerin, Vice President and Chief Financial Officer of Floyd Medical Center, at 706-509-6079.

Sincerely,

Kurt M. Stuenkel, FACHE
President and CEO

$18,592,524 in care to the uninsured, providing access to those who often have nowhere else to turn.

Recognizing the challenge of providing care to the growing number of individuals who cannot afford to pay, Floyd's Indigent Care Task Force brought to the table key health care providers to look for solutions to ensure care is available. The Task Force established the Floyd County Clinic, provided services to help those qualify to enroll in government assistance programs and researched solutions to meeting the health care maintenance needs of these populations through prescription assistance programs.

None of this would have been possible without supplemental Medicaid payments funded through Hospital Authority IGTs. The impact to our facility of the loss of these payments is unthinkable. More importantly, however, our patients – especially those on Medicaid or who are uninsured – are most likely to suffer from the loss of access to care that will result from this new policy. Georgia's IGTs are not abusive and have been approved by CMS. There is no justification for adopting a restrictive definition of "unit of government" that will simply deprive Georgia Medicaid of an important and legitimate source of local public funding. We urge you to defer to state law in the determination of "units of government."

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

We are equally opposed to the Proposed Rule's new cost limit on Medicaid payments to governmental providers. This limit puts us in a box – either we are considered to be a private entity and therefore the Hospital Authority will be unable to provide IGTs to fund our supplemental payments, or we are considered to be governmental but are then subject to a limit to cost. This is an untenable "Catch-22" that again is unwarranted by the existence of any inappropriate financing mechanisms in Georgia – Georgia's IGTs have been deemed by CMS to be appropriate. Instead, the limit would impose a $1,571,577 cut to our Medicaid payments (which currently are based on Medicare rates). This cut, while not as substantial as the loss of all of the supplemental payments funded by IGTs that would result from a determination that the Hospital Authority is no longer governmental, would nevertheless be substantial. This aspect of the rule should be withdrawn as well.

Direct Payments for Medicaid Managed Care Patients

Georgia recently established Georgia Families, a program to enroll Medicaid recipients into private care management organizations ("CMOs"). As CMO enrollment grows, it has a direct impact on our supplemental UPL payments, as CMS regulations prohibit states from providing

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Mar-12-07 04:47pm From- T-313 P.001/005 F-309

Please use this version for my comments.

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Congress of the United States

House of Representatives

Washington, D.C. 20515

COMMITTEE ON ENERGY AND COMMERCE
110th Congress
2125 Rayburn House Office Building, Washington, D.C. 20515

FAX COVER SHEET

DATE: The Hon. Michael O. Leavitt

TO: 3/12/07

FROM: 690.7703, 690.6351

FAX NUMBER: Rep. John D. Dingell

NUMBER OF PAGES: 5
(Including Cover)

COMMENTS: Please contact christie.houlihan@mail.house.gov / 6-9771 should ya have problems with transmission.

(If there are problems with this transmission, please contact us at (202) 225-2927)

CONGRESS OF THE UNITED STATES
Washington, D.C

March 12, 2007

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

Re: File Code CMS-2258-P

Dear Mr. Secretary:

As the chairmen of the House and Senate committees and subcommittees with jurisdiction over both the Medicaid program and the Health and Human Services' administration or its oversight, we have grave concerns about the proposed rule (CMS-2258-P) entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership," issued January 18, 2007, and its effects on safety net providers throughout the country.

As currently proposed, the rules to implement this provision are not sufficiently clear and in addition will result in unintended harmful consequences. We request that you respond to the attached questions no later than Monday, March 26, 2007, and that our comments be placed in the public record of the rulemaking.

The proposed rule seeks to narrow the definition of government-related health providers and thus limits the funding sources available to States to finance Medicaid, and singles out public providers to limit their reimbursement to cost through the use of certified public expenditures. We are chiefly concerned that the proposed rule will have a severe adverse affect on the nation's public safety net and its ability to continue delivering critical health services to Medicaid beneficiaries and the uninsured. It could also lead to widespread bed closures and loss of vital but generally unprofitable services that benefit everyone in the community, such as trauma centers, burn units, and emergency departments.

We have concerns that limiting reimbursement to Government healthcare providers to "cost" as defined in the proposed rule will prohibit the ability of States to sufficiently fund their portion of Medicaid matching funds, effectively limiting the delivery of necessary healthcare services to low-income Americans. Additionally, we are concerned that the narrow definition of Government healthcare providers will eliminate or reduce funding to State university hospitals, public nursing homes, and other providers, thereby eliminating or reducing access to health care for millions of the Nation's lowest income beneficiaries and the uninsured.

Finally, we are concerned that the policy could adversely affect inpatient capacity and community access to vital services such as trauma centers at a time when our Nation is faced with significant threats to the public.

The attached questions should help clarify the scope of the rule and the effect it will have on these providers and the low-income and uninsured beneficiaries they serve.

If you need further information, please contact any of us, or have your staff contact Bridgett Taylor with the House Committee on Energy and Commerce at (202) 225-2927, Karen Nelson with the House Committee on Oversight and Government Reform at (202) 225-5051, or Alice Weiss with the Senate Committee on Finance at (202) 224-4515.

Sincerely,

John D. Dingell, Chairman
House Committee on Energy and Commerce

Frank J. Pallone, Jr., Chairman
Subcommittee on Health
House Committee on Energy and Commerce

Henry A. Waxman, Chairman
House Committee on Oversight and
Government Reform

Max Baucus, Chairman
Senate Committee on Finance

John D. Rockefeller, Chairman
Subcommittee on Health Care
Senate Committee on Finance

Attachment

cc: The Honorable Leslie V. Norwalk, Acting Administrator
Centers for Medicare and Medicaid Services

Attachment
Letter dated 12, 2007

Questions for the Hon. Secretary Leavitt
From Hon. John D. Dingell, Hon. Frank J. Pallone, Jr., Hon. Henry A. Waxman, Hon. Max Baucus, and Hon. John D. Rockefeller

Quantifying the Impact of the Regulation

1. How did the Centers for Medicare and Medicaid Services (CMS) construct the estimate of reduction in Federal Medicaid outlays? Specifically:

   a. What savings are associated with each component of the regulation (i.e., limit to cost, definition of unit of government, retention provision, etc.)?

   b. How were savings estimated for FY2007?

   c. What are the specific policy changes and assumptions that drive differential year-over-year increases? For example, the increase in Federal savings is approximately $300 million between FFY 2008-09 and 2009-10 but the increase is only $30 million between FFY 2010-11.

2. What is the individual state-by-state Federal Medicaid dollar impact by class of facility of: cost limits for public providers; changes in the definition of public hospitals; changes in the definition of certified public expenditures; changes in UPL policy; limits on IGTs and DSH? Please provide answers for both waiver and non-waivered States.

3. Please provide a list of affected States and facilities and a list of States and facilities already in compliance.

4. Please explain how the rule will affect States' existing waiver budget neutrality calculations. Will States have to recalculate their budget neutrality cap as a result of the rule? If so, which States will be adversely affected?

Other Questions and Clarifications

1. The Medicaid program has a longstanding history of serving as the principal financial support of the safety net and ensuring access for vulnerable populations—including Medicaid patients and the uninsured—who might otherwise go without care. The regulatory impact analysis asserts that this rule's effect on actual patient services will be minimal (p.49). Please produce the economic and other assumptions used in arriving at this estimate.

2. Section 1903 defines units of local government as a city, a county, a special purpose district, or other governmental unit of State. This regulation narrows that definition dramatically by requiring the entity to have taxing authority in order to be considered a unit of government. Congress's broader definition provides States with much more leeway to identify for themselves which entities are units of local government. Please justify your policy rationale for such a restrictive definition. Please list the entities that, by this definition, would be excluded that are currently considered a unit of local government.

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner

Sonny Perdue, Governor

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

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March 19, 2007

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

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

Dear Ms. Norwalk:

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

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

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

Impact to the State of Georgia

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

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

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

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

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

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

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

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

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

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

Sincerely,

Rhonda M. Medows, M.D.