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UNIVERSITY OF COLORADO
HOSPITAL

March 19, 2007

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

Re: 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" (Vol. 72, No. 11), January 18, 2007 ("Rule")

To Whom It May Concern:

Thank you for the opportunity to provide comment regarding the above cited Rule as proposed by the Centers for Medicare and Medicaid Services. As a general opening statement, we oppose the portion of the Rule that proposes to change the definition of "unit of government." Its implementation would have a devastating impact on the University of Colorado Hospital and more than 20 additional "safety net" providers in the State of Colorado greatly compromising our overall ability to care for the State's medically underserved population.

Background:
Since 1921, the University of Colorado Hospital (UCH) has served as the major teaching hospital for the University of Colorado, including its schools of medicine, dentistry, nursing, and pharmacy. UCH has historically been one of Colorado's leading providers of care for the state's medically underserved population – today UCH is the state's second largest "safety net" provider.

Until 1991, UCH was a component of the University of Colorado, a "state institution" governed by the University of Colorado Board of Regents. In 1991, the Colorado General Assembly enacted a statute creating the "University of Colorado Hospital Authority" as a "body corporate ***and political subdivision***" of the State of Colorado. The primary rationale behind this statutory/structural change was to permit UCH to operate more independently in a rapidly changing healthcare environment and continue to serve as the major teaching hospital for the healthcare professions education programs offered by the University of Colorado.

Office of the President Box 6508-Mail Stop F417; Aurora, CO 80045-0508 Phone: 303.724.5337-Fax: 303.724.5838

In addition, when the state legislature changed the statutory structure of UCH a provision was included in state law (**Colorado Revised Statutes 23-21-504. Mission of the authority – obligation to provide uncompensated care – action of the board of directors**) mandating UCH to provide care for the State's underserved population – now numbering more than 770,000 in Colorado. Not only does UCH have this statutory obligation, but we have historically maintained a strong moral and philosophical commitment to serve the State's medically indigent population. In fiscal year ending June 30, 2006, UCH admitted over 2,000 inpatients, qualifying under our State's Colorado Indigent Care Program (CICP), totaling nearly 11,000 patient days. In addition, UCH saw a total of more than 48,000 CICP outpatient visits during that same fiscal year. In total UCH wrote-off nearly $168 million in net charges for indigent/charity care in FY 2006.

This background is important to set the foundation for our opposition to the change to the definition of "unit of government" proposed by the Rule 42 CFR – CMS-2258-P.

Proposed Rule 42 CFR – CMS-2258-P:

University of Colorado Hospital expresses its strong objection to this proposed CMS Rule and its scheduled implementation on September 1, 2007. Should this proposed Rule take effect our hospital stands to lose about $30 to $35 million each year in federal Medicaid Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) funds based on our unreimbursed Medicaid and low-income uninsured costs. In addition the State of Colorado as a whole would stand to lose as much as $140 million in federal funding that supports the State's safety net and long term care providers. This loss of federal funding would be devastating to UCH's and the rest of the State's safety net providers' ability to provide care for Colorado's medically underserved population.

Specifically, by CMS's narrowly defining "government" or "public" hospital to be only those supported by "units of government having taxing authority", or hospitals that "have access to a unit of government that has taxing authority", and such taxing authority is "responsible for the expenses, liabilities and deficits" of such hospitals, it excludes Colorado's two largest indigent care providers, University of Colorado Hospital and Denver Health (DH) (also a "state authority"). Through Certification of Public Expenditures (CPE), it is our two hospitals together that have been able to acquire the federal Medicaid matching funds that have supported our institutions and many other safety net hospitals in Colorado. As "public authorities" neither UCH nor DH would meet the proposed definition and thus would not qualify as eligible providers to continue to participate in federal DSH and UPL funding. As statutory "public authorities" in Colorado our hospitals would still be expected to remain as significant providers of care for the medically indigent in the state. However, should the Rule take effect, it would be extremely difficult for UCH (and DH) to continue to serve as models in Colorado as dominant safety net providers. Subsequently, care for our state's medically underserved would be severely compromised; likely reducing access for thousands of Colorado's most medically vulnerable.

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Also, the timing of the September 1, 2007 proposed effective date makes it very difficult for UCH and the State of Colorado to react, develop, and implement appropriate alternatives.

CMS notes in the "Background" discussion accompanying the Rule that title XIX of the Social Security Act (the "Act") requires that states share in the cost of Medicaid expenditures but permits the states to delegate some responsibility for the non-Federal share of the Medicaid expenditures to units of local governments under some circumstances. The Rule's revision to 42 C.F.R. section 433.50 would re-define when a hospital will be considered a "unit of government" and thus eligible to certify public expenditures. The Rule would do this by limiting the "unit of government" definition to a hospital that (1) has "generally applicable taxing authority" or (2) is able to access funding as an integral part of a unit of government that both has taxing authority and is legally obligated to fund the hospital's expenses, liabilities and deficits. The consequence of this re-definition is that a hospital that previously was considered a "unit of government" would no longer be one (in the eyes of CMS) if it is not able to satisfy one of these two new criteria and, significantly, would no longer be able to certify public expenditures.

UCH would not be able to satisfy either of the two new criteria and thus would not be able to certify public expenditures even though it is a political subdivision of the State of Colorado and incurs substantial expenditures from providing medical care to Medicaid and medically indigent patients. The Rule offers no statutory basis to support this proposed change in the definition of "unit of government" nor CMS's authority to make this change through administrative rule making. Further, the Rule offers no public policy rationale for why a hospital that has taxing authority or a hospital that is a component of a taxing authority entity that provides the hospital with funding and is legally obligated for its liabilities should be permitted to certify public expenditures but all hospitals that are a unit of government, but for this re-definition, should not be able to certify public expenditures.

The Rule cites and relies extensively on the fundamental principle of the Act that the Federal government is to pay only its proportional cost of the delivery of medical services under the Medicaid Program and is not to pay more. This principle can hardly be used to support the proposed change to the definition of "unit of government" because UCH and other hospitals that today are units of government and have been certifying their public expenditures have indeed incurred those expenditures which the Federal government is required to match. The Federal government has not been paying these hospitals more than its statutorily-required fifty percent match so, possibly unlike the situation with intergovernmental transfers, this proposed re-definition cannot be justified as needed to ensure that the Federal government is paying more than its match amount. The proposed re-definition will not change the fact that UCH and the other hospitals still have the costs of the medical expenditures but will eliminate the Federal government's payment of the federal match.

It is for the above stated reasons that we strongly encourage CMS to reevaluate the proposed Rule taking into consideration current statutory status of University of Colorado Hospital and the negative fiscal impact on our hospital, the State of Colorado, and numerous other hospitals in our

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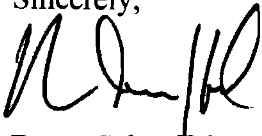
State and throughout the country. Accordingly we urge CMS to withdraw this Rule or, at the very least, amend the Rule to broaden the definition of "government" or "public" hospital such that those traditional and statutorily recognized public hospitals, that have demonstrated a long history and commitment to treating Medicaid patients, and the under- and uninsured can continue to provide this much needed care.

Sincerely,



Bruce Schroffel
President & CEO

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ALAMEDA COUNTY MEDICAL CENTER

Highland Hospital Campus ~ Fairmont Hospital Campus
John George Psychiatric Pavilion
Ambulatory Health Care Services

March 16, 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 Alameda County Medical Center (ACMC), I am writing to express our opposition to CMS' Proposed Rule CMS 2258-P, which imposes cost limits on Medicaid payments to public providers. Alameda County Medical Center 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 hospital safety net and the patients and communities they serve. If the rule is implemented, ACMC anticipates that it will lose upwards of $21 million per year in Medi-Cal funding primarily related to costs associated with our uninsured patient population. If this were to happen, we would expect the following potential impacts:

1) Longer waits in the emergency department for inpatient beds - aggravating an already significant problem for ACMC;
2) Longer wait times in the clinics for specialists and primary care, and delayed surgeries, and potentially the closure of some outpatient primary and specialty clinics – further exacerbating the existing paucity of access for Medi-Cal recipients and the uninsured;
3) Potential closure of inpatient bed capacity;
4) An unbalanced focus on acute services rather than preventative services.

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

It will limit our Medi-Cal reimbursement to the costs of providing services to our Medi-Cal patients. This will eliminate funding for our Medi-Cal and uninsured patients, who make up 67% of our patient population and whose costs are currently 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.

Alameda County Medical Center provides a full range of services to vulnerable populations and specialty services to both the uninsured and insured that are not provided elsewhere in our communities.

If the rule is applied to the waiver, ACMC could be forced to limit critical services to our patients, including care for the uninsured, trauma care, specialty services, acute rehabilitation inpatient services, acute psychiatric services, and outpatient specialty clinics, including Cardiology, Orthopedics, Podiatry, Oral Surgery, Ophthalmology, Endoscopy and Urology, to name just a few.

These limitations also could result in an increased number of uninsured patients seeking care in private hospitals, creating a domino effect that could be harmful to California's entire health care system.

In addition, the proposed rule inappropriately limits 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 public funds for the Medicaid program. The impact of these restrictions will be dramatic for the ACMC and for California's Medi-Cal program as a whole. Notwithstanding the clear intent of Congress to allow states to use public teaching hospital dollars to fund their Medicaid expenditures, the proposed definition would preclude ACMC from participating in Medi-Cal financing in California. For over a decade, the ACMC has contributed its funds to help the State finance its Medi-Cal program. Currently ACMC, through its hospitals, makes approximately $204 million in expenditures annually for services to Medi-Cal beneficiaries and the uninsured that are matched with federal dollars under the hospital waiver. The loss of the related $78+ million in federal Medicaid matching funds will be devastating for State, ACMC and for the patients we serve.

This substantial loss of federal funds would be caused by the proposed amendments to sections 433.50 and 433.51, which inappropriately limit those entities qualified to provide the nonfederal share of Medicaid expenditures to units of government with generally applicable taxing authority. A provider will be treated as a unit of government only if it is operated by, or is an integral part of, a unit of government with taxing authority. Based in the language of the proposed rule and the discussion in the preamble, ACMC is concerned that it will not meet these narrow requirements under its current structure.

The Alameda County Medical Center, a public hospital authority, is the independent legal entity that operates ACMC. The Authority was established pursuant to State law and County ordinance. (See, Health & Safety Code Section 101850.) The medical center, formerly owned and operated by the County of Alameda, was transferred to the Authority in an effort to improve the efficiency, effectiveness and economy of the community health services provided at the medical center. Alameda County owns the medical center's land and buildings and the County's Board of Supervisors appoints ACMC's governing board. However, the Authority, which is the legal entity that holds the license for ACMC, is separate and apart from the County of Alameda. Although the County helps finance ACMC through payments for services and provides loans for ACMC's operations, the liabilities and obligations of ACMC are liabilities of the Authority, not of the County. Based on the proposed rule and the preamble discussion, it appears that CMS is attempting to exclude public entities, like ACMC, from participating in funding the Medi-Cal program, because ACMC has no independent taxing authority and it is not sufficiently integrated with Alameda County, which clearly has the requisite taxing authority.

CMS has provided no rationale; however, that justifies this restriction on the use of ACMC's public funds in support of Medi-Cal services in California. Moreover, the legal analysis presented in support of the proposed rule is seriously flawed. First, there is nothing in Section 1902(a) (2) of the Social Security Act that supports restrictions on the types of units of government that can make Medicaid CPEs or IGTs. That section of the Medicaid statute, which has remained unchanged since 1967, recognizes the states' authority to use public funds, in addition to state funds, to finance Medicaid expenditures. The current regulation at Section 433.51 properly reflects the longstanding interpretation that allows a broad range of public agencies to do so.

Second, the proposed regulatory definition is inconsistent with the plain language of the statutory definition of unit of government. The proposed rule simply adds the requirement of "generally applicable taxing authority" to the statutory definition in Section 1903(w) (7) (G) of the Act. If Congress had intended to impose this additional requirement, it would have done so. Instead, Congress adopted a broad definition, which includes "a special purpose district, or other governmental unit." Congress clearly was aware that it could not expressly identify all types of public agencies that can properly fund the nonfederal share of Medicaid and that a narrow definition could inadvertently exclude unique governmental structures like ACMC. As a result, Congress was careful to adopt a broad, inclusive definition that would protect entities, like ACMC, that were properly participating in Medicaid funding under then-existing Medicaid policy.

Third, the rule would apply the term "unit of government" well beyond its stated applicability. Section 1903(w) (7) expressly limits the scope of the terms defined there to be used only "for purposes of this subsection." CMS goes far beyond this limitation and would apply the term and its statutory definition to change the interpretation of Section 1902(a) (2) of the Act to limit the use of local funds under a completely different section of the Medicaid law.

Fourth, the proposed rule is directly inconsistent with the reason that Congress included these provisions in the 1991 Medicaid amendments. While Section 1903(w) generally, was designed to limit certain types of Medicaid financing methods, paragraphs (6) and (7) (G) were intended to protect the states' ability use of local public funds to finance the nonfederal share of Medicaid expenditures. The purpose of these provisions was to make it clear that IGTs were not to be restricted like provider related taxes and donations, which were considered abusive. 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.
>
> H.R. CONF. REP. No. 102-409 (1991).

By limiting the definition of unit of government, the proposed rule is directly contrary to this Congressional directive and would result in the denial federal financial participation for legitimate Medicaid expenditures made by ACMC.

There is no legitimate federal interest in imposing these restrictions on California's ability to fund its Medi-Cal program and the proposed rule should be withdrawn. In the event that CMS goes forward with these rules, however, it should modify the definition of unit of government to exclude the taxing authority requirement.

A related concern is based on language in the preamble, where CMS states that tax revenue is the only valid source of intergovernmental transfers. 72 Fed. Reg. 2238. While neither current law nor the proposed regulations expressly impose 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 seriously limit the ACMC's ability to participate in Medi-Cal funding, would be directly inconsistent with the long-standing implementation of the Medicaid statute, and would negate the protections intended by Congress in Section 1903(w)(6) of the Act.

Section 1902(a) (2) is the statutory provision that has long been interpreted as granting states authority to use public funds, in addition to state funds, to finance Medicaid expenditures.

Beyond a broad reference to the adequacy of "local sources" of funds, the provision imposes no restriction on the sources of local funds that may be used by the states. Until 1991, when Congress imposed strict limitations on federal financial participation designed to preclude the use of provider-related taxes and donations to finance Medicaid expenditures, there were no statutes or regulations in place that imposed any such restrictions. At the same time, however, Congress chose to protect, rather than restrict, the use of public funds for Medicaid expenditures.

CMS has expressed no rationale for, or legitimate federal interest in, limiting Medicaid funding to tax revenues. Public entities obtain funds from a number of sources. For example, ACMC earns interest on amounts deposited in financial institutions, receives donations from individuals, and earns revenues from the operation of the medical center. CMS has identified no valid policy reason to preclude California form using these public funds to support the Medicaid program.

Again, Alameda County Medical Center 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 on our community's health care system and stop its efforts to move forward with the rule.

Sincerely,

Wright L. Lassiter III
Chief Executive Officer

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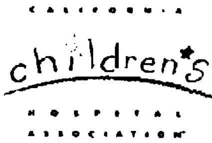


P.E.A.C.H., INC.
Private Essential Access Community Hospitals

CALIFORNIA ASSOCIATION OF
PUBLIC HOSPITALS AND HEALTH SYSTEMS

March 14, 2007

MAR 1 4 2007

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

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

Dear Ms. Norwalk:

On behalf of California's safety net hospitals, the California Hospital Association Disproportionate Share Hospital (DSH) Task Force submits the following comments on the proposed rule that would restrict Medicaid payments to public providers. We oppose the rule for the reasons outlined below and urge that it be withdrawn.

Members of the DSH Task Force include the California Hospital Association (CHA), the California Association of Public Hospitals (CAPH), Los Angeles County Department of Health Services, Private Essential Access Community Hospitals (PEACH), the California Children's Hospital Association (CCHA), the University of California medical centers and the Association of California Healthcare Districts (ACHD).

These hospitals comprise the state's safety net and provide essential health care services to millions of Californians, such as emergency and trauma care, highly specialized pediatric care to very ill children, large amounts of inpatient and outpatient care to Medicaid and uninsured patients, training of new physicians and other health care professionals and adult specialty care not otherwise available in the community.

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 California's safety net hospitals and the patients we serve. Furthermore, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions. While we support CMS' goal to address state financing abuses, it is clear that the agency already has addressed the majority of state integrity issues and that proposed limits on state flexibility are overreaching and unnecessary.

CMS estimates that the rule will cut $3.9 billion in federal Medicaid spending over five years on a national basis. We estimate that California could lose approximately $550 million per year for the next three years, and potentially millions more beyond that period. The enormity of this loss amounts to a budget cut for safety-net hospitals and to California's Medi-Cal program that bypasses the congressional approval process and comes on the heels of strong bipartisan congressional opposition to the Administration's plans to regulate Medicaid financing practices. Last year 300 members of the House of Representatives and 55 senators signed letters to Health and Human Services Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. More recently, Congress echoed that opposition, with 226 House members and 43 Senators having signed letters urging their leaders to stop the proposed rule from moving forward.

California's safety net hospitals are highly concerned about the potential negative impact of a number of provisions of the rule.

Limitations on Payments to Safety Net Providers

The rule proposes to limit Medicaid reimbursements to the cost of Medicaid services to Medicaid recipients. The cost limit rule would contradict the last 27 years of Medicaid policy during which Congress has moved away from cost-based reimbursement to prospective payment systems. Further, the proposed rule would directly controvert the rate-setting flexibility granted to the states by Congress.

The proposed payment limits would preclude funding to safety net hospitals for treatment of indigent non-Medicaid patients whose costs are currently reimbursed under California's hospital financing waiver. We estimate that California's safety net hospitals could lose approximately $550 million per year for the next three years, and potentially millions more beyond that period.

If the rule is implemented, Californians that rely on the state's safety net hospitals, both uninsured and insured, could experience reduced access to necessary hospital and other health care services. The magnitude of the anticipated losses could result in hospital closures and the diminished ability to provide services to the vulnerable populations that depend upon us. In addition, entire communities could be negatively impacted by the loss or reduction of emergency, trauma, burn, and other essential life saving services that safety net hospitals provide. While the rule could directly and immediately impact public safety net hospitals, we alsoare concerned that it could create a domino effect that would be damaging to California's entire health care system, both public and private.

Limitations on States' Abilities to Fund Medicaid due to New Definition of "Unit of Government" and Unauthorized Restrictions on Funding of Non-Federal Share

We further oppose a new definition in the rule that severely restricts which safety net providers qualify as "unit[s] of government" for purposes of determining which providers can use CPEs and IGTs to draw down available federal funding Under this new definition, the University of California medical centers and Alameda County Medical Center do not appear to meet the stringent requirements and could lose essential funding. This could result in severely reduced

dollars available to pay for needed care for our state's most vulnerable residents. Additionally, the rule proposes to restrict the state's ability to use certain local public funding as the non-federal share for the Medicaid program. These restrictions are not authorized by statute and are inconsistent with congressional intent.

Retention Requirement

The proposed retention requirement, which applies to both public and private safety net hospitals, is unduly superfluous and vague, and serves no legitimate purpose. Congress has never granted CMS the authority to regulate how providers use the Medicaid revenues they receive for Medicaid services they have already rendered. This rule is yet another example of an administrative attempt to thwart the legislative privilege of Congress.

Impact on California's Hospital Financing Waiver

As CMS is aware, Medicaid funding to California's safety net hospitals is based on a waiver negotiated between the state and CMS itself in June 2005. 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 provision 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, and that CMS must adjust the budget neutrality cap to take into account reduced spending that would be anticipated under new regulations. (See, Section II, paragraphs 2 and 4 of the Special Terms and Conditions.) Hence, the DSH Task Force is highly concerned that, when the rule is applied to our state's hospital financing waiver, California will no longer be able to provide specific funding to safety net providers for their otherwise unreimbursed costs of treating indigent, non-Medicaid patients.

Specifically, the rule will limit Medicaid payments to the cost of Medicaid services to Medicaid recipients. This will eliminate funding for indigent non-Medicaid patients whose costs are currently covered under the Safety Net Care Pool, which is an integral part of California's Hospital/Uninsured Care Demonstration Project, approved under Section 1115 of the Social Security Act. Based on the impact on the Hospital Waiver, we estimate that California's safety net hospitals will lose $550 million per year for the next three years, and additional funds beyond that period.

Though staff from CMS verbally has advised the State that the regulation will not affect California's waiver, the potential harmful effects on our represented hospitals are such that we cannot rely on verbal assurances alone. We urge that the rule be withdrawn. If this does not occur, CMS must make substantial changes to its provisions in the final regulations to make the rule consistent with those promises.

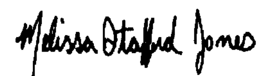
Concluding Comments

California's safety net hospitals oppose the rule and strongly urge that CMS permanently withdraw it. If these policy changes are implemented, California's health care safety net will be put at risk, and health care services for millions of Californians will be jeopardized.

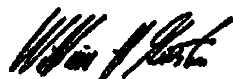
We appreciate the opportunity to comment on this proposed rule. If you have any questions, please contact Anne O'Rourke at aorourke@calhospital.org or 202-488-4494.

Sincerely,

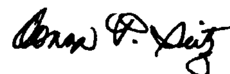
California Hospital Association



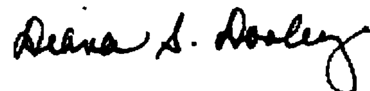
California Association of Public Hospitals and Health Systems



University of California



Los Angeles County



California Children's Hospital Association

Private Essential Access Community Hospitals

Association of California Healthcare Districts

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STATE OF COLORADO

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MAR 15 2007

March 14, 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, NO. 11), January 18, 2007

Dear Ms. Norwalk:

The General Assembly for the State of Colorado is in the process of considering a Senate Joint Memorial (SJM 07-004) memorializing Congress to enact legislation to prevent the Centers for Medicare and Medicaid (CMS) from promulgating rules that interfere with Colorado's definition of local units of government and Colorado's ability to provide funding for public hospitals.

By sponsoring SJM 07-004 the Colorado Joint Budget Committee is expressing our strong opposition to CMS's proposed rule (CMS-2258-P). This rule represents a substantial departure from long-standing Medicaid policy by imposing new restriction 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 would hurt providers and beneficiaries alike. Furthermore, the timing of the rule's implementation does not allow Colorado adequate to react to the proposed change.

The State of Colorado has state constitutional requirements to balance our state budget each year within specific spending and taxing limitations. Our state budget can not absorb the potential loss of $128.0 million in federal funds to our public hospitals without major reductions in other essential state services. Because of Colorado's unique spending and taxing limitations, Colorado must have a vote of the people before any new taxes can be enacted. Therefore, an effective date of September 1, 2007 ensures that Colorado's public hospitals would suffer major funding cuts if this rule is promulgated in its present form. This would result in some of our public hospitals, in both the

major metropolitan areas of our state as well as rural communities, having to curtail their missions of serving the medically indigent and uninsured. As a result, Colorado's indigent care program could lose critical access to our current safety net hospitals. As state policy makers, we can not let this happen.

We urge CMS to permanently withdraw this rule. We would like to outline our most significant concerns, which include: (1) Changes of this magnitude for federal Medicaid reimbursement should be made by Congress; (2) Colorado is about to adopt the SFY 2007-08 budget and we do not have adequate time to make funding adjustments to the state budget to react to the potential loss of federal funds for our Medicaid program; and (3) the potential loss of funding for our public hospitals will severely hamper the state's ability to provide essential services to the medically indigent and uninsured.

Change Should be Enacted by Congress

We are aware that Colorado, as well as other states, would receive large reductions in their federal funds for their Medicaid program if this proposed rule becomes effective. Because of the magnitude of this change to long-standing practices at CMS, we believe this rule is outside the agency's rule-making authority. This change should be enacted as legislation. While President Bush has asked Congress to enact legislation capping Medicaid payments to public providers and restricting the options for financing the non-federal share of their medicaid programs, Congress has decided not to act on these proposals. The Joint Budget Committee strongly objects to the administration's effort to bypass the regular legislative process for such an important change in policy direction for the Medicaid program. We question CMS's legal authority to proceed with such a rule.

Colorado State Budget for SFY 2007-08

Pursuant to the Colorado Constitution, the Colorado General Assembly must complete its work by May 9, 2007 for the current legislative session. By the time the Colorado General Assembly adjourns, we will not know the final status of this proposed rule. Therefore, the Joint Budget Committee can not make a financial plan for the ***potential*** loss of federal funds. The Joint Budget Committee is in the process this week of finalizing our state budget for SFY 2007-08. Pursuant to the Colorado Constitution, Colorado's state General Fund budget can not increase by more than 6.0 percent over the previous year's budget. In addition, Colorado must balance our state budget every year. With a General Fund budget of only $7.7 billion for FY 2007-08, we can not make up a loss of $128.0 million in federal funds without cutting other essential state programs. We strongly object to a rule change at CMS that limits our state budgeting flexibility without adequate time notice to adjust our state spending for this federal fund reduction.

Potential Funding Loss for Our Public Hospitals

Colorado has 24 public hospitals that could see a reduction in federal funds if this proposed rule is promulgated. We estimate that Denver Health, our largest public hospital, could lose $73.0 million in federal funds because of this rule. Throughout the entire hospital system, we estimate that the state would lose $128.0 million in federal funds. This rule will put at risk the financial stability of some of our public hospitals, including Denver Health. Without our public hospital network, the State of Colorado can not provide essential services for our indigent and uninsured populations.

We oppose this rule and strongly urge CMS to permanently withdraw it in a timely fashion.

Sincerely,

Abel Tapia
Chairman of the Colorado Joint Budget Committee

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Northeast Georgia Medical Center, Inc.™

MAR 15 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 Northeast Georgia Medical Center, Inc. ("NGMC"), I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes $11.8 million in critical Medicaid support payments for NGMC, funding that has been essential to our ability to serve as major safety net health care system in Georgia.

NGMC is owned by The Hospital Authority of Hall County and the City of Gainesville ("the Authority") and operated pursuant to a lease with the Authority to provide health care services to our community. NGMC is a regional referral center and as a sole hospital provider of services located in Hall County it offers a full range of healthcare services through two hospital campuses. Together, these facilities, along with two long-term care centers and a mental health and substance abuse treatment center, offer Northeast Georgia residents comprehensive health care. Specialty services include advanced cardiovascular diagnostic and treatment, advanced cancer treatment, level III neonatal intensive care, neurosurgery, CARF accredited rehabilitation, emergency services and trauma care, bariatric surgery and mental health and substance abuse services. Northeast Georgia Medical Center provides clinical training for students in a number of nursing programs and other allied health programs throughout Northeast Georgia.

Services are provided regardless of the patient's ability to pay. Governmental payor-mix for FY2006 was 53.7% of Gross Patient Charges while self-pay was at 8.7% with bad debts at 5.0%.

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.

743 Spring Street • Gainesville, Georgia 30501-3899 • 770-535-3553 • www.nghs.com VHA

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"). NGMC 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 $11.8 million 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 NGMC 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 unreimbursed or under-reimbursed. For example, in SFY 2006 we provided $25.8 million in care to the uninsured, providing access to those who often have nowhere else to turn. In addition, NGMC and its Lanier Park campus are the only general acute care facilities located in Hall County. As the regional referral center, NGMC serves 13 counties in its primary and secondary service area. The population in NGMC's service area has increased by 4.2% annually from 2000 to 2006 and is expected to increase 3.5% annually between 2006 and 2011. In 2005, NGMC received CON approval to increase the licensed bed capacity to 557 beds. In 2006, construction began on the North Patient Tower (NPT). The project includes a 464,000 square foot expansion and renovation to the main hospital building. Inpatient rooms at NGMC currently are housed in buildings originally built from 1949 to 1985. Although NGMC has undergone numerous interim renovations and additions, the main campus facilities are undersized and inefficiently designed for its current and projected

volumes. The NPT facility will address critical capacity issues by redesigning and modernizing NGMCs current licensed beds. Upon completion of the project, the NPT will house 128 inpatient beds, including 96 medical/surgical beds and 32 intensive care unit beds. In addition, the NPT project will relocate and expand the Medical Center's surgical beds and 32 intensive care unit beds. Also in 2007 construction will begin on expansion of the Women and Childrens Pavilion that consists of 120,000 square feet. Included in this project is the addition of five triage / observation rooms and two labor, delivery and recovery rooms as well as the replacement of 12 general acute care beds with four post-partum rooms and eight ante-partum rooms, an increase in c-section rooms from two to four, and the doubling of the size of the neonatal unit with the addition of five neonatal intermediate beds. In November 2006, NGMC filed a certificate of need application with the State of Georgia to construct 100-bed replacement hospital for Lanier Park Hospital in south Hall County located in a high growth area. These capital expansions are necessary to continue meeting the growing needs of the community.

Partnering to Reach the Uninsured: Health Access Initiative, HealthShare, Good News Clinics and the Hall County Health Department.
NGMC continues partnering with others in the community on the issue of reaching the uninsured or underserved with the healthcare they need. NGMC is an active member and partner with initiatives aimed at this important issue such as Health Access Initiative (HAI) and HealthShare. In 2006, Health Access Initiative benefited from major funding through The Medical Center Foundation's Healthy Journey II Campaign. HAI clients utilize both inpatient and diagnostic services at the MedicalCenter.
Funding from The Medical Center Foundation's Healthy Journey II Campaign also helps provide medications, medical supplies and other support for Good News Clinics. Founded in 1992, the Good News Clinics is a Christian ministry that provides medical care to the indigent and uninsured population at no charge. FY06 is the third year of a $1 million commitment over three years for the Good News Clinics by The Medical Center Foundation's Healthy Journey II Campaign.

The HealthShare project was initiated by representatives from local healthcare and social services providers to help the community understand the needs of the uninsured (medically indigent) people in Hall County. They seek to improve community health by:

- Researching and telling the story of how community organizations are attempting to meet the healthcare needs of low-income people who are uninsured.

- Educating the community and business leaders on issues related to indigent care.

- Educating consumers about how to access health care services in the most effective and productive ways possible.

- Securing additional funding from government and philanthropic resources to support indigent healthcare.

- Promoting access to insurance and coverage through employers.

The Hall County Health Department works with NGMC to get non-emergent primary care needs met at the health department instead of the emergency department. ICTF funding has always been used to assist the health department in providing this service.

The Medical Center participates on a state, regional, and local level for disaster preparedness. The LEPC (Local Emergency Preparedness Council) provides a Hazard Vulnerability Analysis to the Medical Center detailing potential biological and/or chemical releases from local/regional businesses. In order to meet the needs of the community during release, the organization must commit countless hours to mitigation, preparedness, response, and recovery plans. As a participant of the All Hazards Council, NGMC develops response plans for potential threats such as; SARS, Anthrax, Pandemic Flu, and any other chemical, biological, radiological, nuclear, or explosive attack.

Disaster Preparedness plans are best driven by mitigation activities. In order to mitigate potential threats to the community, NGMC must conduct, at a minimum, two (2) community-wide disaster drills per year. Cost of each drill can often exceed any grant re-imbursement, and the Medical Center relies on it's operating budget to supplement supplies, staffing and any other cost associated with conducting the drill. This cost would be significant in the event of a true disaster.

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 $ 1.6 million 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.

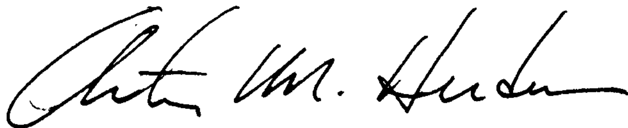
Direct Payments for Medicaid Managed Care Patients

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 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 $3.2 million 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 Linda Nicholson at 678-897-6622.

Sincerely,



Anthony M. Herdener
VP, Systems and Finance/CFO

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Donalsonville Hospital
Seminole Manor
102 Hospital Circle
Donalsonville, Georgia 39845

MAR 15 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 Donalsonville Hospital, Inc., I am writing to oppose the proposed Medicaid regulation published on January 18, CMS-2258-P ("the Proposed Rule"). The Proposed Rule jeopardizes $1,510,658 million 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.

Donalsonville is a 501.C.3 Private not for Profit Corporation that provides health care services to our community. Last calendar year, Donalsonville Hospital delivered 302 babies provided by two OB/GYN's in a underserved community. Our hospital treated over 6,000 E. R. patients and saved countless lives due to farming and car accidents in the past year. Donalsonville Hospital has assisted five physicians with medical training through our scholarship program, so that they may return to our rural community in Southwest Georgia.

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.

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 and expecting mothers– 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 $1,598,710 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

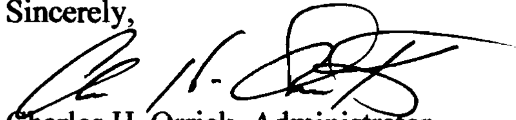
Georgia recently established Georgia Families, a program to enroll Medicaid recipients into private care management organizations ("CMOs"). As CMO enrollment grows, it has a direct impact on our supplemental UPL payments, as CMS regulations prohibit states from providing supplemental payments for Medicaid patients who are enrolled in private plans. Based on preliminary projections of SFY 2007 UPL payments, we expect to lose approximately $ -0- 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 myself at (229) 524-5217 ext. 351.

Sincerely,



Charles H. Orrick, Administrator
Donalsonville Hospital, Inc.
Seminole Manor Nursing Home
Women & Children's Center

CC: Michael Bryant, Field Rep. for Rep. Sanford Bishop

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American Hospital Association

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MAR 19

March 15, 2007

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

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

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule restricting how states fund their Medicaid programs and pay public hospitals. The AHA opposes this proposed rule and would like to highlight the harm it would cause to our nation's hospitals and the patients they serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid programs. The rule further restricts how states reimburse safety-net hospitals. In addition, CMS fails to provide data justifying the need or basis for these restrictions. This unauthorized and unwarranted shift in policy will have a detrimental impact on providers of Medicaid services, particularly safety-net hospitals, and on patient access to care.

CMS estimates the rule will cut $3.9 billion in federal funds over five years. This amounts to a budget cut for safety-net hospitals and state Medicaid programs that bypasses the congressional approval process and comes on the heels of vocal congressional opposition to the Administration's plans to regulate in this area. Last year, 300 representatives and 55 senators signed letters to Health and Human Services (HHS) Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. Recently, Congress restated its position with 226 representatives and 43

senators having signed letters to the House and Senate leadership urging them to stop this proposed rule from moving forward.

Policy changes of this magnitude must be made in a way that will ensure the health care needs of Medicaid recipients are met. Historically, whenever there has been a substantial change to Medicaid funding policy – such as prohibiting provider-related taxes and donations, modifying disproportionate share (DSH) hospital allotments, or modifying application of Medicaid upper payment limits (UPLs) – those changes have been made, or at the very least, supported by Congress. If CMS intends to make further sweeping changes to Medicaid, they should first be made by legislation, not regulation. Indeed, the Administration recognized this in its fiscal year 2006 budget submissions to Congress, where it proposed that Congress pass legislation to implement the very policy changes contained in this rule.

The AHA also is concerned that in several places in the preamble discussion, CMS describes its proposed changes as "clarifications" of existing policy, suggesting that these policies have always applied, when in fact, CMS is articulating them for the first time. By describing many changes as clarifications, CMS appears to be trying to do an "end run" around the notice-and-comment process. Any attempt to implement these proposals in a retrospective nature would violate the *Administrative Procedures Act.*

Attached to this letter is a detailed discussion of our concerns relating to:

- The cost-based reimbursement limitation and the individual provider-based UPL to be applied to government-operated providers;
- The proposed narrowing of the definition of "unit of government;"
- The proposed restrictions on intergovernmental transfers and certified public expenditures and the characterization of CMS' proposed changes as "clarifications" rather than changes in policy; and
- The absence of data or other factual support for CMS' estimate of savings under the proposed rule.

If these policy changes are implemented, the nation's health care safety net will unravel, and health care services for millions of our nation's most vulnerable people will be jeopardized. We urge CMS to permanently withdraw its proposed rule.

If you have any questions, please feel free to contact me or Molly Collins Offner, senior associate director for policy, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

The American Hospital Association's Detailed Comments on CMS-2258-P

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Cost LIMIT FOR PUBLIC HOSPITALS

The rule proposes to limit reimbursement for government-operated hospitals to the cost of providing Medicaid services to Medicaid recipients. In addition, the rule restricts states' ability to make supplemental payments to providers with financial need by setting the Medicaid UPL for government-operated hospitals at the individual facility's cost. This proposal is effectively a cut in funding for those public hospitals[1] and safety-net providers that – as CMS has recognized – are in stressed financial circumstances and are most in need of enhanced payments. These cuts will undermine the ability of states and hospitals to ensure quality of care and access to services for Medicaid beneficiaries, as well as to continue their substantial investments in health care initiatives to promote HHS' policy goals, including adoption of electronic health records, reducing disparities in care provided to minority populations, and enhancing access to primary and preventative care.

As explained below, the AHA believes that it is arbitrary and capricious to impose a cost-based limitation on hospital reimbursement and to deny states the flexibility to reward hospitals – both public and private – whose costs for services are less than the rates states might pay, for example, under a prospective payment system. Further, imposing a hospital-based UPL is contrary to the requirement of the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000* (BIPA) that CMS establish an aggregate UPL, and it will create an unwarranted burden on providers and states.

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable costs. The AHA is very concerned that in CMS' zeal to reduce federal Medicaid spending, important costs, such as graduate medical education, physician on-call services or clinic services, would not be recognized and therefore would no longer be reimbursed. The AHA is further concerned that the Administration plans to eliminate all federal funding for Medicaid graduate medical education as outlined in the president's fiscal year 2008 proposed budget. Congress should have the opportunity to review any change to the Medicaid program's support for graduate medical education, and we urge CMS not to move forward with any proposed rule that would implement the president's budget proposal.

COST LIMIT

In the preamble to the proposed rule, CMS says that it does not find Medicaid payments in excess of cost to government-operated health care providers to be consistent "with the statutory principles of economy and efficiency as required by section 1902(a)(30)(A)" of the *Social Security Act* (the "Act"). If CMS' goal is to assure that Medicaid payments are consistent with economy and efficiency, then there is no basis for imposing a cost-based reimbursement system to only government-operated hospitals. The AHA, however, opposes limiting any individual hospital's reimbursement to 100 percent of costs.

In the Regulatory Impact Analysis of its January 2001 final rule modifying the Medicaid UPL, CMS concluded:

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[1] Although the AHA confines its comments to hospitals, it recognizes the broader implications of the proposed rule for non-hospital providers of Medicaid services.

> While a facility-specific limitation may be the most effective method to ensure state service payments are consistent with economy and efficiency, when balanced against the additional administrative requirements on states and HCFA, coupled with congressional intent for states to have flexibility in rate setting, *we are not sure that the increased amount of cost efficiency, if any, justifies this approach as a viable option.*

66 Fed. Reg. 3148, 3174 (Jan. 12, 2001) (emphasis added).

In the preamble to its January 18, 2002 final rule removing the 150 percent UPL for hospital services furnished by non-state, government-owned or -operated hospitals, CMS stated that the revised UPL of 100 percent for non-state government providers "will assure that payments will be consistent with 'efficiency, economy and quality of care' as required by section 1902(a)(30)(A) of the *Social Security Act*." 67 Fed. Reg. 2602, 2608 (Jan. 18, 2002).

CMS does not provide any explanation in the proposed rule why the 100 percent aggregate UPL is now insufficient to meet the efficiency and economy requirements of section 1902(a)(30)(A) and must be replaced with a UPL based on each individual provider's costs and a cost-based reimbursement limit. As CMS is aware, Congress moved away from cost-based reimbursement under Medicaid when it adopted the so-called "Boren Amendment" in 1980. Since then, hospital reimbursement systems have evolved following the model of the Medicare program and its use of prospective payment systems. These reimbursement systems are intended to improve efficiency by rewarding hospitals that can keep costs below the amount paid. Many state Medicaid programs have adopted this method of hospital reimbursement, yet CMS is proposing to resurrect a cost-based limit.

CMS says that it has examined state Medicaid financing arrangements and found that "many" states are making supplemental payments to government-operated providers in excess of cost, and that this excess payment is used to subsidize health care operations unrelated to Medicaid, or is returned to the state as a source of revenue. The agency provides no data or factual support for how many states are making such "excess payments" nor any specific information regarding how providers in these states are using these excess payments. Moreover, as CMS has repeatedly recognized, the aggregate UPL system affords states the flexibility to tailor reimbursement policy to meet local needs by making supplemental payments to particular hospitals in financial stress.

In a brief filed in federal court litigation over the 2002 UPL rule[2] (the "UPL Brief"), CMS described the "concept" behind the UPL as being able "to set aggregate payment amounts for specifically-defined categories of health care providers and specifically-defined groups of providers, but leave the states considerable flexibility to allocate payment rates <u>within</u> those categories and groupings." UPL Brief, page 9. In the preamble to the 2002 final rule, CMS stated that, under the 100 percent UPL, "states also retain some flexibility to make enhanced payments to selected public hospitals under the aggregate limit." 67 Fed. Reg. at 2603. CMS

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[2] Defendant's Memorandum in Support of His Motion for Summary Judgment and in Opposition to Plaintiffs' Motion for a Permanent Injunction, *Ashley County Medical Center v. Thompson*, 205 F. Supp. 2d 1026 (E.D. Ark.) (No. 4:02CV00127).

reiterated this position on pages 3-4 of the UPL Brief, stating that "[t]he new rules leave states considerable flexibility to direct higher Medicaid payments to particular hospitals that may be in stressed financial circumstances."

CMS also has expressly recognized the potential financial implications of limiting reimbursement to an individual provider's costs, and the importance of the aggregate UPL system for preserving access to Medicaid services, particularly with regard to safety-net hospitals. In the UPL Brief on page 39, CMS pointed out that "the upper payment limit is an aggregate limit for all institutions in the category of non-state public hospitals, not an individual limit for each hospital." Responding to the allegation that several public hospitals in Arkansas would be jeopardized by the 100 percent UPL, CMS reasoned that

> the state could increase payments for those particular hospitals and decrease payment levels at other county and local hospitals (perhaps in more affluent parts of the state) where the low-income patient load was less heavy. . . There is no reason to merely suppose that state governments will be indifferent to the special needs of particular urban or rural hospitals in deciding how aggregate Medicaid payments will be allocated among non-state public hospitals. An equal and across-the-board reduction in Medicaid payments for county and local hospitals – the assumption on which all of plaintiffs' fiscal speculations are apparently premised – is neither mandated nor even contemplated by the 100 percent rule.

Id. at 39-40 (emphasis in original).

CMS is now mandating just such an "across-the-board reduction," disregarding without explanation its prior statements regarding the importance of the flexibility allowed states under the UPL system to make enhanced payments to hospitals in special need. This policy change will penalize states and providers that have never utilized abusive or inappropriate funding mechanisms by denying those states the ability to pay public hospitals more than 100 percent of costs. Moreover, CMS has not provided clear direction in the proposed rule as to which costs CMS will permit states to reimburse.

CMS' proposal will directly harm the ability of states to meet their statutory obligation to ensure access to care for Medicaid beneficiaries. Under section 1902(a)(30)(A) of the Act, states must assure that Medicaid payments "are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." By prohibiting states from reimbursing a provider for more than costs, and restricting states from making enhanced payments to providers in financial need, CMS is imposing a funding restriction that will ultimately be passed on from the states to government providers. To the extent that these cuts in funding will lead to a curtailment in beneficiary care and services, it is the states – and not CMS – that will be subject to challenge or complaint by beneficiary advocates and to witnessing their citizens' care compromised.

DIFFERENTIAL TREATMENT OF PUBLIC AND PRIVATE HOSPITALS

Under CMS' proposal, the cost-based limit on reimbursement and the individual provider-based UPL, will apply only to government-operated providers. States will continue to be able to make Medicaid payments to private hospitals that exceed costs, and private hospitals will continue to be reimbursed under an aggregated UPL. If, as CMS suggests, its policy is consistent with the requirements of economy and efficiency under section 1902(a)(30)(A) of the Act, there is no rational basis for distinguishing between public and private hospitals. Requiring differential treatment of public and private Medicaid hospitals also is inconsistent with the equal protection clause of the Constitution, as well as CMS' own repeated statements regarding the importance of payment equality for all categories of Medicaid hospitals.

As discussed above, CMS' rationale for proposing a cost limitation on reimbursement for government-operated providers is the requirement of economy and efficiency in section 1902(a)(30)(A) of the Act. CMS does not provide any explanation of why subjecting public, but not private, hospitals to a cost limitation is economic and efficient. To the contrary, CMS has repeatedly emphasized the importance of payment equality among categories of Medicaid providers. Restoring such "payment equity" was one of the Secretary's stated rationales for implementing the 100 percent UPL in the 2002 final rule. CMS agreed with the statement of commenters to the 2002 final rule that "one group of providers should not have a financial benefit over another group of providers who provide the same type of services." 67 Fed. Reg. at 2604. CMS went on to explain that its intent in the rule was "to treat all facilities equally, and apply the same aggregate UPL to each group of facilities, regardless of who owns or operates the facilities." Id. This notion of payment equity across groups of Medicaid providers is repeated throughout the preamble to the 2002 final rule,[3] and the "equity rationale" was highlighted in CMS' 2002 UPL Brief as "standing alone . . . sufficient to sustain the 100 percent rule against a claim that it is arbitrary and capricious, in violation of the Administrative Procedures Act." CMS provides no explanation for how it is now consistent with economy and efficiency to reverse its stance on the importance of payment equity by imposing a discriminatory and unfair reimbursement limit on government-operated providers. There is no rational basis for a policy that prevents public Medicaid providers from availing themselves of the same benefits afforded private Medicaid providers, and it is contrary to the equal protection afforded under the Constitution. Moreover, the AHA opposes limiting any individual hospital's Medicaid reimbursement to 100 percent of costs.

REQUIREMENTS OF THE MEDICARE, MEDICAID AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000

Section 705(a) of BIPA required CMS to issue a final regulation modifying the UPL test applied to state Medicaid spending "by applying an *aggregate* upper payment limit to

[3] *See, e.g.,* 67 Fed. Reg. at 2604 ("this rule is critical for maintaining the fiscal integrity of the Medicaid program and ensuring that all facilities are treated equally under Federal Medicaid UPL regulations"); *id.* at 2605 ("We believe the reduction of the UPL from 150 percent to 100 percent will be sufficient to maintain the fiscal integrity of the Medicaid program and ensure that all facilities are treated equally under the Federal Medicaid UPL regulations").

payments made to government facilities that are not state-owned or -operated facilities." (Emphasis added.) Section 701(a)(3) of BIPA, which addressed modifications to DSH payments, used the same language in describing the final regulation required under section 705(a), as "relating to the application of an *aggregate* upper payment limit test for state Medicaid spending . . . [for services] provided by government facilities that are not state-owned or -operated facilities." (Emphasis added.) Congress explicitly contemplated that CMS' final regulation regarding UPLs would apply an aggregate limit. CMS' proposed rule, which removes the aggregate UPL and imposes a limit based on the individual provider's costs, is precluded by the clear statement in BIPA that UPLs be based on an aggregate limit for each provider class.

PROPOSED DEFINITION OF "UNIT OF GOVERNMENT"

CMS proposes to define the term "unit of government" by reference to a provision of the Medicaid statute that defines the distinct and more narrow term "unit of *local* government." Both of these terms are used in the subsection of the statute regarding provider donations and taxes, but by picking and choosing which provisions it will apply, CMS has ignored both the statutory framework and purposes of these distinct terms. Moreover, even if the statutory definition of "unit of local government" were applicable to CMS' proposal, it cannot reasonably be read to have the narrow meaning that CMS sets forth in the proposed rule.

CMS proposes to add new language to its rules governing state financial participation in Medicaid. Specifically, CMS proposes to define a unit of government to "conform" with the definition of "unit of local government" in the provider tax and donations provisions of the Medicaid statute (1903(w)(7)(G)). Under the proposed rule, only those entities that meet CMS' new definition of "unit of government" will be permitted to fund the state's share of Medicaid expenditures. CMS inappropriately limits its definition of "unit of local government" to entities with "generally applicable taxing authority." There is no basis for this restriction in the Medicaid statute. CMS' proposed definition ignores the principles of federalism that afford states discretion in structuring their political subdivisions and will impose substantial harm on public hospitals. We urge CMS not to finalize this proposal.

In the rule, CMS proposes to use Congress' definition for a unit of *local* government as the basis for its proposed definition of the broader term "unit of government." Section 1903(w)(7)(G) of the Act defines the term "unit of local government." This term is used in subsection 1903(w)(1)(A) of the Act, which reduces the federal contribution to Medicaid by revenues received by states or units of local government from certain provider donations or health care-related taxes. The proposed rule has no connection to this subsection. Rather, CMS is using the definition of unit of local government to define a different, broader term – "unit of government" – which is the term used in the subsection 1903(w)(6)(A) of the Act restricting CMS' authority to regulate intergovernmental transfers (IGTs).

CMS' reliance on the definition of unit of local government is misplaced. "Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the

disparate inclusion or exclusion."[4] Congress used the narrower term "unit of *local* government" to define those government entities subject to the prohibition on provider donations and taxes (1903(w)(1)(A)), but recognized that other government entities may permissibly make IGTs, and thus purposely used the broader and different term "unit of government" in the IGT section of the statute (1903(w)(6)(A)).

Not only is CMS basing its proposal on the wrong statutory definition, it has narrowed the definition in a way that is incompatible with the terms of the statute. Section 1903(w)(7) (G) defines a unit of local government to mean, "a city, county, special purpose district, or other governmental unit in the state." The proposed rule, by comparison, limits the definition of a unit of government to those entities that have "generally applicable taxing authority." It further states that a health care provider may be considered a unit of government,

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

CMS states in its preamble discussion that the proposed provisions are modified "to be consistent" with the statute. The AHA respectfully disagrees with this characterization. The definition of "unit of government" in section 1903(w)(7)(G) does not include the words "generally applicable taxing authority" nor any of the other restrictive language that CMS proposes. Instead, Congress defined the term in a way that affords deference to the states' right to structure their own governmental subdivisions, in accordance with the constitutional principles of federalism. Rather than "conforming" the regulation to this statutory definition, CMS narrows it in a manner that is not authorized by the plain text of the statute and intrudes upon the traditional authority of the states.

The deference that Congress provided to states under its definition of unit of local government is reinforced by section 1903(d)(1) of the Act, which requires the Secretary to estimate the amount of the federal Medicaid payment based on the state's reported estimate of Medicaid expenditures for the quarter and the amount "appropriated or made available by the state and its political subdivisions for such expenditures in such quarter." There is no limitation in section 1903(d)(1) on which political subdivisions may make funding available for Medicaid expenditures, and certainly no requirement that such subdivisions have "generally applicable taxing authority."

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[4] *Russello v. United States*, 464 U.S. 16, 23 (1983) (quoting *United States v. Wong Kim Bo*, 472 F. 2d 720, 722 (5th Cir. 1972). "[C]ourts must presume that a legislature says in a statute what it means and means in a statute what it says there." *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992).

CMS' restrictive definition will have significant practical implications for public hospitals, particularly those that have restructured to achieve gains in efficiency. For example, the University of Colorado Hospital Authority was established as a quasi-governmental and corporate entity based on a finding by the Colorado General Assembly that the University of Colorado University Hospital Authority was "unable to become and remain economically viable due to constraints imposed by being subject to various kinds of government policy and regulation." Colo. Rev. Stat. § 23-21-501(1)(d). In a February 20 letter to Colorado Gov. Bill Ritter, University of Colorado Hospital President and CEO Bruce Schroffel stated that the University of Colorado Hospital could lose $30 million in funding a year because it would not meet CMS' restrictive new definition of "unit of government" and would be unable to generate certified public expenditures (CPEs). Similarly, in a March 14 letter to CMS Acting Administrator Leslie Norwalk, the California Hospital Association Disproportionate Share Task Force noted that the University of California's medical centers and Alameda County (CA) Medical Center may be at risk of losing essential funding because they would appear not to meet CMS' stringent proposed definition.

LIMITATIONS ON INTERGOVERNMENTAL TRANSFERS AND CERTIFIED PUBLIC EXPENDITURES

CMS' proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through IGTs and CPEs, including limiting the source of IGTs to funds generated from tax revenue. The AHA believes these proposed restrictions directly conflict with the purpose and plain language of the Medicaid statute. In 1991, Congress identified certain provider donations and provider-related taxes as an inappropriate means of funding the non-federal share of Medicaid payments and restricted the use of these financing mechanisms. In doing so, however, Congress included a specific provision in section 1903(w)(6)(A) of the Act to make clear that these restrictions would not affect the use of IGTs. CMS is now using this provision, which was intended to limit the Secretary's authority to regulate IGTs derived from state or local taxes, as the basis for a new requirement that *all* IGTs must be made from state or local taxes.

In the proposed rule's preamble, CMS states that it has systematically eliminated inappropriate financing arrangements, such as recycling mechanisms, through the state plan amendment process. If these abusive practices have been addressed, it is unclear why CMS is proposing an unauthorized restriction on the source of IGTs. This proposal is inconsistent with Medicaid law and historic CMS policy.

RESTRICTIONS ON IGTS

Under the proposed rule, only entities that meet CMS' restrictive new definition of "unit of government" are permitted to make IGTs. As discussed above, CMS says that it has based this definition on section 1903(w)(7)(G) of the Act, which defines a unit of *local* government, not a "unit of government." Additionally, in the preamble to the proposed rule, CMS claims that, "generally," for the state to receive the federal match where a government-operated heath care provider has transferred the non-federal share, the state must demonstrate "(1)

[t]hat the source of the transferred funds is state or local tax revenue (which must be supported by consistent treatment on the provider's financial records); and (2) that the provider retains the full Medicaid payment and is not required to repay, or in fact does not repay, all or any portion of the Medicaid payment to the state or local tax revenue account." This fundamental change in IGT policy appears to be discussed only in the preamble and is not addressed in the text of the proposed regulations. The use of the term "clarify" suggests that CMS views the fundamental changes it is proposing as merely clarifications of existing Medicaid funding policy. However, CMS is articulating for the first time a substantial shift in Medicaid policy. The proposed changes go far beyond mere clarifications and, as a result, any attempt to implement them on a retrospective basis would be contrary to the notice and comment requirements of the *Administrative Procedure Act.*

As noted above, CMS claims that the basis for these new limitations on the use of IGTs is the agency's intent "to conform" its regulatory language to section 1903(w)(6)(A) of the Act, which sets forth an exception from restrictions on provider-related donations and taxes. Rather than "conforming" the proposed rule to this statutory exception, CMS does the opposite. Congress included this statutory exception to permit states to continue using state or local taxes to make IGTs. It did not authorize CMS to require states to only use state or local taxes to make IGTs, nor did it preclude the use of other sources of funds, such as patient care revenues.

Section 1903(w)(6)(A) is not the only place where Congress made clear that the state share of Medicaid payments could come from local sources other than local tax revenue. Section 1902(a)(2) of the Act permits up to 60 percent of the state's share of financial participation to come from "local sources," without restriction. If Congress had wanted to limit state financial participation to funding from state or local tax revenue, it would have included that requirement explicitly.

CMS itself has acknowledged that it has limited authority to regulate IGTs. In the 2002 final rule, CMS stated that, "[u]nder section 1903(w)(6)(A) of the Social Security Act, the Congress limited [CMS'] authority to regulate states' certain uses of IGTs." 67 Fed. Reg. at 2606. CMS stated further, in response to a comment that public hospitals be required to have a net gain of at least two-thirds of additional federal funds collected under hospital-based UPL plans, "[i]t is not clear what the commenter believes would be the legal authority for CMS to limit a hospital's use of its own funds." Id. at 2605. Moreover, although CMS "gave consideration to formulating a policy with respect to" IGTs in the Regulatory Impact Analysis of its 2001 final rule, CMS said that it "did not pursue this alternative because we recognize that states, counties, and cities have developed their own unique arrangements for sharing in Medicaid costs. Furthermore, there are statutory limitations placed on the Secretary which limit the authority to place restrictions on IGTs." 66 Fed. Reg. at 3175. Now, contrary to these prior statements, CMS is inappropriately construing the same statutory terms to impose restrictions on states that Congress did not authorize or intend.

RESTRICTIONS ON CPES

The AHA is troubled by CMS' new standards for generating and documenting CPEs and is concerned about the administrative burden on both hospitals and states. CMS proposes new standards for the documentation of CPEs that are used to fund the non-federal share of

expenditures. The government entity will be required to submit to the state Medicaid agency a certification statement including an attestation regarding compliance with the Medicaid state plan and the Medicaid regulations. The certification must be submitted by the state to CMS as the basis for the state claim for federal funds within two years of the date of the expenditure. In addition, CMS states that a public provider may generate a CPE from its own costs only if the state plan contains an actual cost reimbursement methodology.

Under the proposed rule, in order for the states to develop interim payment rates for providers that are paid using a cost reimbursement methodology funded by CPEs, the state must undertake two separate reconciliations. Additionally, while generating little real benefit, the new documentation standards are likely to result in substantial administrative burden on hospitals and may even subject Medicaid providers to unwarranted allegations of *False Claims Act* violations. AHA members take seriously their obligations to report Medicaid expenditures properly, and CMS can ensure the accuracy of Medicaid claims without imposing this burdensome certification requirement.

INSUFFICIENT DATA TO SUPPORT CMS' ESTIMATE OF SPENDING CUTS

The proposed rule is subject to the arbitrary and capricious standard of review under the *Administrative Procedure Act.* Before a rule is finalized, an agency "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.'"[5] CMS says that the proposed rule is estimated to result in $3.87 billion in savings over five years, but does not provide any relevant data or facts to support this conclusion. The basis for this estimate appears to be that CMS has "examined Medicaid state financing arrangements across the country" and, in doing so, has "identified numerous instances in which state financing practices do not comport with the Medicaid statute." CMS does not indicate what these financing practices might be or how many states are currently employing them. Moreover, CMS expressly says that it has systematically required states to eliminate problematic financing arrangements through the state plan amendment process. This raises further questions about the estimated savings and casts doubt on the rational upon which CMS has based these sweeping policy changes to how states finance their share of Medicaid and how states reimburse their public providers.

[5] *Ashley County Medical Center v. Thompson*, 205 F. Supp. 2d 1026, 1048 (E.D. Ark. 2002)

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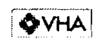

MAR 16 2007

March 16, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
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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, 72 Fed. Reg. 2236 (Jan. 18, 2007)

Dear Ms. Norwalk:

On behalf of Lee Memorial Health System (LMHS), I am submitting comments in opposition to the above captioned proposed rule issued by the Centers for Medicare and Medicaid Services (CMS), published in the January 18, 2007 Federal Register and relating to the Medicaid program (CMS-2258-P) (the "Proposed Rule").

LMHS has served a critical role in the public health system in Southwest Florida for over forty years. At the time of LMHS's creation, Lee County had approximately 55,000 residents; by 2005, that population had grown tenfold to 550,000 residents, and LMHS' public health obligation likewise grew. Currently, LMHS incurs over $50 million annually in charity care costs (actual costs, not charges) and is a key source of safety net care in the region. LMHS relies upon supplemental Medicaid payments, including Medicaid disproportionate share hospital (DSH) payments and payments from Florida's Low Income Pool (LIP), to offset the significant losses associated with providing services to Medicaid patients and the uninsured. In 2005, these losses were more than $38 million. The

cuts in Medicaid reimbursement that could result from the proposed regulation would be financially devastating to LMHS. Implementation of the Proposed Rule would have the effect of pushing LMHS' marginally positive financial bottom line into the negative and would dramatically compromise its ability to continue serving many of Florida's neediest residents. Current reimbursement rules already force hospitals such as LMHS to shift costs to private third party payors. A further forced "cost shift" cannot be sustained.

Defining a Unit of Government (§ 433.50)

The Proposed Rule would impose on states a new definition of a "unit of government," requiring a provider to either have generally applicable taxing authority or be an integral part of a unit of government with generally applicable taxing authority in order to be considered governmental. Providers that are *not* determined to be units of government under this new definition would be prohibited from contributing funding to the non-federal share of Medicaid expenditures.

It is clear from LMHS' enabling legislation, as well as state-specific and federal case law, that LMHS is a public entity. In 1963, the Florida Legislature enacted House Bill 1635 which created the Hospital Board of Directors of Lee County (Board) and authorized the Board to establish a "public hospital" in the county for "public and county purpose."[1] In subsequent legislation that officially changed the hospital's name, the Legislature confirmed that LMHS is indeed "a public body."[2] Further, the citizens of Lee County own and operate LMHS through a publicly-elected board of directors, the number, term limit, composition, and eligibility requirements of which are specified in state law. Finally, LMHS was originally funded through a Lee County bond issuance and the Board is now authorized to issue its own notes or bonds to carry out the operation of LMHS. LMHS is authorized, by virtue of its enabling legislation, to receive appropriations, which it does on a sporadic basis. Clearly, pursuant to both the explicit terms of LMHS' creation and based on the level of state oversight to which LMHS is subject, LMHS is a public agency.

[1] 1963 Fla. Laws ch. 1552, §§1, 7.
[2] 2000 Fla. Laws ch. 439.

LMHS has also been consistently treated as a public entity by federal and state courts. More specifically, a decision by the federal Eleventh Circuit of Appeals identified LMHS as a "political subdivision" of the state in holding that the Board, unlike private companies, was entitled to state action immunity from antitrust liability. Similarly, in holding that LMHS is subject to Florida's Public Records Law, a Florida state court declared that LMHS was a "public agency".

The public status of LMHS has been conclusively and comprehensively established through its creation by the Florida Legislature, the public election of its governing board of directors, its judicial treatment by state and federal courts as a state agency, and by its important role in the community as a safety net provider willing to treat all residents regardless of their ability to pay. Accordingly, it seems to confound common sense to believe that CMS now intends, by virtue of the Proposed Rule, for LMHS to be considered *not* public, simply because LMHS does not possess generally applicable taxing authority and is not part of another governmental entity that does have such authority.

CMS has never claimed that the funding mechanisms utilized by Florida (including intergovernmental transfers made by LMHS) were abusive. Adopting an unnecessarily restrictive definition of "unit of government" for Florida will not eliminate any perceived or real abuse. It will simply deprive Florida Medicaid of an important and legitimate source of public funding. On behalf of LMHS, I urge you to defer to state law in the determination of "unit of government" for purposes of Medicaid financing.

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

The preamble to the Proposed Rule states that "all Medicaid payments . . . made under . . . Medicaid waiver and demonstration authorities are subject to all provisions of this regulation."[3] In 2005, Florida successfully negotiated an extremely complex Section 1115 demonstration program designed to significantly revise the ways in which care for the uninsured is delivered and reimbursed in

[3] 72 Fed. Reg. 2240.

Florida. The underpinning of this demonstration project is the establishment of a Low Income Pool intended to help safety net hospitals in Florida continue their mission to serve Medicaid individuals and the uninsured in the midst of changes to the Medicaid program. Funding for this demonstration has been authorized by CMS through its authority under Section 1115(a)(2) of the Social Security Act to provide federal financial participation for expenditures that are not otherwise matchable. Under the terms of the demonstration, Florida has agreed to limit Medicaid reimbursement to governmental hospitals to costs, similar to the limit now being put forward in the Proposed Rule. The savings generated from this voluntary agreement to keep payments lower than what would otherwise be allowed under the upper payment limit regulations have been reinvested in the Low Income Pool.

Given that the Special Terms and Conditions of the Medicaid Reform Demonstration in Florida require CMS to incorporate any changes in federal law into the budget neutrality expenditure cap, I seek clarification, on behalf of LMHS, as to whether implementation of the Proposed Rule will result in the reduction of funding available for the demonstration. Such an outcome would be unthinkable particularly given that Florida negotiated the waiver, in good faith, for a five year term with the expectation that CMS would honor the painstakingly negotiated deal and highly resource-intensive implementation process associated with the demonstration. Although we hope and anticipate that the Proposed Rule will not vitiate the terms of that deal, the unconditional preamble statement that payments made pursuant to waiver and demonstration authorities are subject to provisions of the Proposed Rule is deeply concerning. Therefore, I am requesting that CMS state, unequivocally and without qualification, that the funding authorized for the Low Income Pool will be neither reduced nor eliminated.

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

CMS proposes to implement the Proposed Rule as of September 7, 2007. Doing so suggests an astonishingly ambitious implementation schedule, particularly given the sweeping and substantive nature of the changes proposed. Assuming that a final regulation is not issued until this summer, states will have very little time to adopt

the changes necessary to come into compliance. The Florida Legislature has traditionally had a very abbreviated Spring schedule. As a practical matter, it is difficult to imagine the Legislature being able to appropriately react to the financing shortfall that will inevitably be caused by the inability of hospitals, such as LMHS, to make intergovernmental transfers in support of the non-federal share of Medicaid financing. Further, it is highly unlikely that the Florida Medicaid agency would have time to develop and obtain approval for any state plan amendments that may be required or to adopt changes to state rules and provider manuals. Indeed, establishing appropriate cost-reporting mechanisms, as envisioned in the Proposed Rule, will, in and of itself, require months of diligent work.

Moreover, given the longstanding payment policies and financing arrangements that would be substantively disrupted by implementation of the Proposed Rule in its current form, CMS should provide a generous transition period for states and providers to adjust to these enormous changes. I would recommend a minimum transition period of ten years

* * *

I appreciate the opportunity to comment on the Proposed Rule. Given the devastating impact that it would have on LMHS, on our patients, and on the greater community in Southwestern Florida, I respectfully request that you withdraw the regulation immediately.

If you have any questions about the content of this letter, please feel free to contact me at (239) 985-3502.

Respectfully submitted,

James R. Nathan
President

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MAR 19 2007

March 16, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
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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 Columbus Regional Healthcare System and The 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 $12.9 million in critical Medicaid support payments for the Medical Center, funding that has been essential to our ability to serve as major safety net health care system in Georgia.

The Medical Center is owned by The Medical Center Hospital Authority ("the Authority") and operated pursuant to a lease with the Authority to provide health care services to our community. The Medical Center (TMC) is a tertiary hospital providing a wide array of highly sophisticated services to residents of a broad geographic region of west central and southwest Georgia as well as much of east central Alabama. Much of TMC's service area is severely economically depressed resulting in a high level of Medicaid, self pay, indigent and charity care. TMC treats more than 95% of the indigent and charity patients that receive care in our community. TMC cares for nearly 90% of the Medicaid patients in our community. These Medicaid patients comprise nearly 30% of TMC's total patient admissions. TMC receives only 82% of our cost of caring for Medicaid patients. The annual cost to care for the uninsured exceeds $20 million per year. The Medical Center is the essential provider of emergency, trauma, maternal, pediatric, perinatal, high risk neonatal and cancer care for this wide area. Georgians residing in this large geographic area are highly dependent upon TMC for these complex services but also depend upon TMC programs for care as basic as management of hypertension and diabetes.

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

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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 $12.9 million 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 unreimbursed or under-reimbursed. For example, in SFY 2006 we provided $21.5 million in care to the uninsured, providing access to those who often have nowhere else to turn. DSH and UPL funds sustain programs such as neonatal intensive care and trauma services. As physicians have developed office based and freestanding centers that meet their practice needs some have actually resigned from the medical staff of the hospital to avoid taking emergency call. We are left with a difficult situation that requires us to try and employ physicians to cover some key emergency and trauma services. We spend more than $2 million a year paying physicians to take call to cover vital emergency services. Our community probably has the highest number of orthopedists per capita in the state, but we have had to recruit an

employed orthopedist and depend upon locum tenens coverage (traveling part time physicians) most nights for basic trauma coverage.

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 $7 million 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 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 $1.5 million 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.

* * *

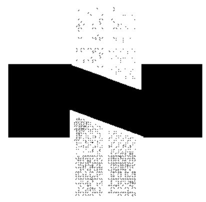
In sum, we are deeply concerned about the impact that the Proposed Rule will have on our institution and the essential services we provide to our community. The impact on our patients will be very swift and very severe. We urge you to withdraw the regulation immediately.

If you have any questions about this letter, please feel free to contact me at 706-571-1200.

Sincerely,

Roland Thacker, FHFMA
Senior Vice President/CFO
Columbus Regional Healthcare System

91



MAR 15 2007

MAR 15 2007

March 14, 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, NO. 11), January 18, 2007

Dear Ms. Norwalk:

On behalf of our Board of Trustees, our employees, our patients and our community, please allow me to express New Hanover Regional Medical Center's opposition to the proposed regulations that were published on January 18, 2007. We appreciate the opportunity to be heard on this matter.

The proposed rule will have serious adverse consequences on the medical care North Carolina's poor and uninsured receive, and on the many safety net hospitals that provide that care. The estimated impact on our state's Medicaid program is that $340 million in annual federal funding to provide care to the poor and underserved will disappear overnight, creating immense problems with the ongoing viability of safety net hospitals and their ability to deliver health care to the communities they serve.

In the case of our hospital, the rule would have cost us $17.7 million in FY 2006, which is 95 percent of our bottom line. In five of the past seven years, our payments from this program have exceeded our bottom line. Without the program, we would likely either break even or operate in the red.

Although there are many troublesome aspects of the proposed regulation, the provision that will have the most detrimental effect in North Carolina is the proposed definition of "unit of government." Presently, North Carolina's 43 public hospitals certify their public expenditures to draw down matching federal funds to make enhanced Medicaid payments and DSH payments to the public and non-public hospitals that provide hospital care to Medicaid and uninsured patients.

Our understanding is that all of these 43 public hospitals are in fact public hospitals under applicable state law. Substantially all of them have been participating in Medicaid programs as public hospitals for more than a decade with the full knowledge and approval of CMS. Each public hospital certifies annually that it is owned or operated by the state or by an instrument

New Hanover Regional Medical Center
Jack Barto – *President & Chief Executive Officer*
P.O. Box 9000 / Wilmington, NC 28402-9000
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[illegible] Office 910-343-[illegible]
[illegible]

or unit of government within the state, and is required either by statute, ordinance, by-law, or other controlling instrument to serve a public purpose.

Yet, under the proposed new definition requiring all units of government to have generally applicable taxing authority or to be an integral part of an entity that has generally applicable taxing authority, virtually none of these truly public hospitals will be able to certify their expenditures. Imposing a definition that is so radically different and has the effect of wiping out entire valuable programs that are otherwise fully consistent with all of the Medicaid statutes is unreasonable and objectionable. New Hanover Regional Medical Center respectfully requests that CMS reconsider its position on the definition of unit of government and defer to applicable state law.

Any suggestion that we are other than a public hospital is ironic, to say the least. New Hanover Regional, licensed for 769 beds in southeastern North Carolina, was built by public referendum and has been owned by the residents of New Hanover County since it opened in 1967. Our business matters are public record, our board meetings are open to the public, our employees are considered public employees and we are regulated by the county and state as though we were a unit of government.

We have taken our public mission seriously in 40 years of operation. As the primary safety-net hospital for a seven-county region, we will provide more than $100 million worth of uncompensated care this year. Many of the services we provide simply to benefit the community we serve, though they lose substantial amounts of money. These include graduate medical education, emergency medical services, trauma services, outpatient clinics, and, perhaps most notably, an inpatient psychiatric facility.

We are on the cusp of building a 62-bed replacement facility for our psychiatric unit but have decided to hold off breaking ground until this issue can be resolved. If we no longer are considered a "public" hospital, we will have to compete even more vigorously for paying patients and adjust our services accordingly in order to protect our primary mission of providing hospital care to the sick and injured.

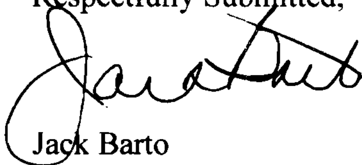
If CMS elects to go forward with the proposed regulation and with the proposed new definition of unit of government, it is absolutely critical that the effective date be extended significantly to allow for a reasonable organized response by the state and participating hospitals. We believe the consequences of allowing anything less than two full years before the rule takes effect will be catastrophic.

North Carolina's indigent patients, the hospitals that provide care for these patients, the state legislature and our state's Department of Health and Human Services need time to

adequately prepare, because the new regulations totally eliminate what has always been considered to be a legal and legitimate means for providing the non-federal share of certain enhanced Medicaid payments and DSH payments to the state's safety net hospitals. At least two years is necessary for the affected stakeholders to try to mitigate the detrimental impact of the changes.

New Hanover Regional Medical Center urges CMS to withdraw its proposed regulation, or in the alternative revise it substantially by among other things adopting applicable law to define the public hospitals (or units of government). If the regulation is not withdrawn or adequately revised, New Hanover Regional Medical Center urges CMS to adopt a more reasonable implementation schedule that allows for at least two full years before the changes take effect. Thank you for your consideration.

Respectfully Submitted,



Jack Barto
President and CEO
New Hanover Regional Medical Center

JB:sw

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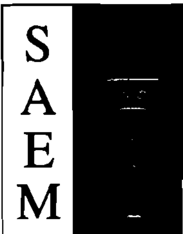

Society for Academic Emergency Medicine

901 N. Washington Ave. • Lansing, MI 48906 • (517) 485-5484 • FAX (517) 485-0801

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Jeanette Ebarb, MD
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Executive Director
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www.saem.org
saem@saem.org

March 16, 2007

MAR 20 2007

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

Attention: CMS-2258-P

Re: Medicaid Cost Limits 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 Society for Academic Emergency Medicine (SAEM) and its 6000 members, we ask CMS to rescind the Medicaid cost limit draft regulation published January 18, 2007 in the *Federal Register* and replace it with a more modest proposal that reduces negative financial effects on safety net providers and the patients they serve. SAEM represents the emergency physicians, students and residents who practice and are trained in academic medical centers, teaching hospitals, and safety net hospitals. As such, these proposed changes are critical to the welfare of our members and, most importantly, their patients.

The issue of eligible state funds used for the non-federal share of Medicaid has been under increasing scrutiny over the past several years. As you know, Medicaid provides access to health care for over 50 million Americans and is critical to safety net hospitals and other providers serving this vulnerable population. SAEM understands the Administration's goal of improving the fiscal integrity of the Medicaid program and in ensuring that states are held accountable for sources and amounts of funds used to secure federal matching dollars. However, we take issue with the restrictions in the proposed definitions of the sources of eligible state funds and what is considered as an allowable payment to public providers. There is no question that this proposal will jeopardize the viability of public and other safety net hospitals. It will also jeopardize the viability of our emergency medicine teaching programs, which has long-reaching downstream effects on the quality of emergency care in this country.

For a number of years, Medicaid payment policy permitted payment to public hospitals that was greater than actual costs in recognition of the burden public hospitals bore for uncompensated care and for the fact the Medicaid payment rates are often below provider costs. In many cases these policies have been approved by CMS in annual state plan amendments. This regulation is estimated to reduce payments by nearly $5 billion over the next five years with no transition period whatsoever. It is unrealistic for the federal government to expect that states will be able to

fund this shortfall and we are concerned that states will limit eligibility, further reduce provider payments, or be forced to reduce benefits.

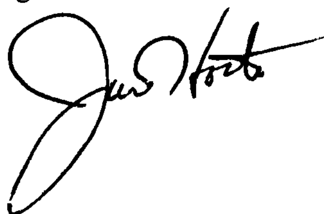
In addition to safety net hospitals, cuts of this magnitude will have an effect on emergency physicians' ability to provide care. According to the CDC, emergency physicians provided care to over 110 million patients in 2004 representing an average increase of 1.5 million visits per year in the ten previous years. Nearly 25 million of those visits represented Medicaid/SCHIP patients whose visit rate is 80 visits per 100 enrolled persons, much higher than Medicare (47 visits/100 enrollees) or other populations. In addition, the 47 million uninsured use the nation's emergency departments as a frequent source of care, which further burdens the safety net.

As Medicaid physician payment continues to lose ground to growing practice costs, fewer physicians will accept Medicaid and more recipients will end up in the ED, leading to what the recent Institute of Medicine report on the future of emergency care predicts is an over crowded emergency care system staggering under growing levels of uncompensated physician and hospital care. This burden will fall disproportionately on public providers, and we believe that Medicaid cuts of the magnitude projected under this proposed rule will adversely affect access and the viability of our nation's safety net providers.

We therefore recommend that the Agency meet with various stakeholders to discuss challenges to the program from both state and federal funding perspectives, and draft a new regulation that phases in some of the policy proposals described in this draft.

SAEM appreciates the opportunity to offer these comments and looks forward to continuing to work cooperatively with CMS to address these important issues in an equitable manner. Please do not hesitate to contact me at any time if you have any questions about our comments and recommendations.

Regards:



James Hoekstra, MD
President
Society for Academic Emergency Medicine

March 15, 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, NO. 11), January 18, 2006

Dear Ms. Norwalk:

NorthEast Medical Center is a not-for-profit hospital comprised of an extensive inpatient and outpatient network that services the residents of multiple counties in the Piedmont region of North Carolina. Through this network, we provide 447 general acute care beds, 10 psych beds, a comprehensive mix of outpatient services and 26 clinics that provide excellent healthcare to our residents. In addition, we have approximately 350 physicians that are members of NorthEast's medical staff, and the medical center employs greater than 4,200 individuals. We are the safety net provider for the citizens of our region, and as such, in 2006 we provided uncompensated care of more than $49 million on a cost basis. The purpose of this letter is in regard to the regulations that were published on January 18, 2007 (as referenced above) involving the Medicaid Program. NorthEast Medical Center would like to state for the record that we are strongly opposed to the promulgation of these regulations.

The proposed rule will have serious adverse consequences on the medical care that is provided to North Carolina's indigent and Medicaid populations and on the many safety net hospitals that provide that care. It is estimated that the impact of this proposed regulation on the North Carolina Medicaid program is that at least $340 Million in annual federal expenditures presently used to provide hospital care for these populations will disappear overnight creating immense problems with healthcare delivery and the financial viability of the safety net hospitals.

Although there are many troublesome aspects of the proposed regulation, the provision that will have the most detrimental effect in North Carolina is the proposed definition of "unit of government." Presently, North Carolina's 43 public hospitals certify their public expenditures to draw down matching federal funds to make enhanced Medicaid payments and DSH payments to the Public and Non-Public hospitals that provide hospital care to Medicaid and uninsured patients.

Our understanding is that all of these 43 public hospitals are in fact public hospitals under applicable State law. Substantially all of them have been participating in Medicaid programs as public hospitals for over a decade with the full knowledge and approval of CMS. Each public hospital certifies annually that it is owned or operated by the State or by an instrumentality or a unit of government within

920 Church Street, North • Concord, North Carolina 28025 • (704) 783-3000 • www.northeastmedical.org

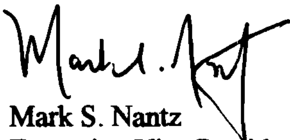
Yet, under the proposed new definition requiring all units of government to have generally applicable taxing authority or to be an integral part of an entity that has generally applicable taxing authority, virtually none of these truly public hospitals will be able to certify their expenditures. Imposing a definition that is so radically different and has the effect wiping out entire valuable programs that are otherwise fully consistent with all of the Medicaid statutes is unreasonable and objectionable. NorthEast Medical Center respectfully requests that CMS reconsider its position on the definition of unit of government and defer to applicable State law.

If CMS elects to go forward with the proposed regulation and with the proposed new definition of unit of government, it is absolutely critical that the effective date be extended significantly to allow for a reasonable organized response by the State and participating hospitals. This hospital believes that the consequences of allowing anything less than two full years before the rule takes effect will be catastrophic. North Carolina's indigent patients, the hospitals that provide care for these patients, the State Legislature and the State Agency responsible for the Medicaid program need time to adequately prepare, because the new regulations totally eliminate what has always been considered to be a legal and legitimate means for providing the Non-federal share of certain enhanced Medicaid payments and DSH payments to the State's safety net hospitals. At least two years is necessary for the affected stakeholders to try to mitigate the detrimental impact of the changes.

NorthEast Medical Center urges CMS to withdraw its proposed regulation, or in the alternative revise it substantially by among other things adopting applicable state law to define the public hospitals (or units of government). If the regulation is not withdrawn or adequately revised, NorthEast Medical Center urges CMS to adopt a more reasonable implementation schedule that allows for at least two full years before the changes take effect. Thank you for your consideration.

Respectfully Submitted,

NorthEast Medical Center



Mark S. Nantz
Executive Vice President/CFO

MSN/jfy

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Jim Doyle
Governor

Celia M. Jackson
Secretary

WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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Madison WI 53708-8935
Email:
web@drl.state.wi.us
Voice: 608-266-2112
FAX: 608-267-0644
TTY: 608-267-2416

March 13, 2007

The Honorable William Dusso
Administrative Law Judge
Office of Legal Counsel
Attention: Joel Garb
Department of Regulation and Licensing
1400 East Washington Avenue
Madison, WI 53708-8935

RE: Wisconsin Society of Anesthesiologists –Petition for Declaratory Ruling
Case No. LS0511012MED

Dear Hon. Judge Dusso:

This is to inform you that the Wisconsin Board of Nursing has no objections to your Proposed Decision on Petitioner's Motion for Summary Judgment and Proposed Order Dismissing Petition for Declaratory Ruling. However, the Board of Nursing does intend to exercise its right to submit a written response to any objections to the Proposed Decision submitted by any interested party, pursuant to the Notice of Extension of Time to File Objections to Proposed Decision.

A copy of this letter has been served by U.S. Mail or hand-delivery to the interested parties in this proceeding.

Sincerely,

Colleen M. Baird

Colleen M. Baird
Legal Counsel
Wisconsin Board of Nursing

Wisconsin Medical Examining Board
Attorney Peggy Wichmann
Office of Legal Counsel
Wisconsin Dept. of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

Podiatrist Affiliated Credentialing Board
Attorney Jacqueline Rothstein
Office of Legal Counsel

Wisconsin Dept. of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Dept. of Regulation and Licensing
Debra Kraft, General Counsel
Wisconsin Dept. of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

cc: Wisconsin Society of Anesthesiologists
Michael G. Laskis, Foley & Lardner, LLP
150 East Gilman Street
P.O. Box 1497
Madison, WI 53701-1497

Governor Jim Doyle
P.O. Box 7863
Madison, WI 53725-9038

Wisconsin Hospital Association
P.O. Box 259038
Madison, WI 53725-9038

Wisconsin Medical Society
330 East Lakeside Street
P.O. Box 1109
Madison, WI 53701-1109

Attorney General J.B. Hollen
P.O. Box 7857
Madison, WI 53707-7857

Wisconsin Dept. of Health & Family Services
One West Wilson Street
Madison. WI 53702

Centers for Medicare & Medicaid Services
314 G. Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Wisconsin Society of Nurse Anesthetists
Attorney Stan Davis
SWD Consulting LLC
1664 Sky Blue Drive
Sun Prairie, WI 53590

Wisconsin Society of Nurse Anesthetists
Attorneys Tony Driessen & Alexis Pheiffer
Quarles & Brady, LLP
1 S Pickney Street, # 600
PO Box 2113
Madison, WI 53701-2113

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March 15, 2007

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

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

Dear Ms. Norwalk:

On behalf of WilMed Healthcare and Wilson Medical Center, let me express our opposition to the above referenced rule. The rule represents a substantial departure from 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.

Based on our latest fiscal year data, the total Medicaid MRI payment for fiscal year 2006 was $2.88 million. Loss of this Medicaid payment would take WilMed Healthcare and Wilson Medical Center from an operating gain of approximately $1.9 million to a loss of over $1 million. Our projections for fiscal year 2007 if this payment is lost would result in an operating loss of over $500,000, assuming we make significant changes in operations to recover.

The impact to WilMed Healthcare and Wilson Medical Center from such a sudden shift in reimbursement policy would result in an operating loss which would undermine our ability to modernize our facility, acquire state-of-the-art technology, and jeopardize a number of other community health programs, such as our outreach clinics and mental health services program which currently already operate at a loss to our organization.

We strongly encourage CMS to permanently withdraw this rule from consideration. Our community healthcare system is at risk should this rule be allowed to stand.

Respectfully yours,

Richard E. Hudson, FACHE
President & CEO

cc: Senator Elizabeth Dole
Senator Richard Burr
Representative G.K. Butterfield
Ms. Suzanne Coker, Director of Advocacy Programs, NC Hospital Association

1705 Tarboro Street SW • Wilson • North Carolina • 27893-3428 • (252) 399-8040

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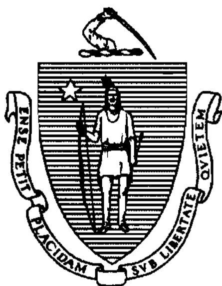


The Commonwealth of Massachusetts
Department of Education

350 Main Street, Malden, Massachusetts 02148-5023

Telephone: (781) 338-3000
TTY: N.E.T. Relay 1-800-439-2370

David P. Driscoll
Commissioner of Education

March 19, 2007

By Electronic and Regular Mail

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

RE: CMS-2258-P – Comments on Proposed Rule Changes for Medicaid

To Whom it May Concern:

The Massachusetts Department of Education ("MADOE") submits the following comments on the proposed rule changes for Medicaid published in the Federal Register on January 18, 2007. These comments are in addition to the comments submitted by the Executive Office of Health and Human Services of Massachusetts. The proposed rule changes would affect significantly the school-based Medicaid program as it operates in Massachusetts and make it more difficult for public schools to meet the needs of their students.

MADOE is particularly concerned regarding three issues in the proposed rule changes. These issues are the unclear definition of a unit of government, the unduly burdensome cost reporting requirements, and the timeframe for implementing these proposed rule changes.

First, with respect to the definition of a unit of government, MADOE seeks clarification regarding whether all 389 school districts in Massachusetts fall within the proposed definition. See 42 CFR 433.50 (proposed). School districts in Massachusetts include 84 regional school districts, 51 Commonwealth charter schools, and numerous municipal districts that currently qualify for and receive federal reimbursement for providing school-based Medicaid services.

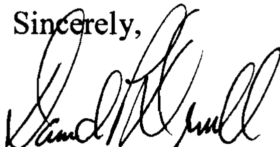
Second, with respect to cost reporting, the proposed rule changes would impose significant new administrative burdens on providers of school-based Medicaid services. See 42 CFR 447.206, 447.271, 447.272, and 447.321 (proposed). In Massachusetts, there

are almost 400 school districts and providers of school-based Medicaid services. Every provider will need cost accounting documentation that provides specific detail for the costs associated with the provided service. It is difficult for MADOE to assess fully the burden of these cost reporting requirements because there are currently no standardized tools for schools to use in reporting their Medicaid costs.

Lastly, MADOE is very concerned about the timeframe for implementing these proposed rule changes. We urge the Centers for Medicare & Medicaid Services to consider grandfathering existing arrangements and gradually phasing-in cost reporting requirements according to a schedule that assures that school-based Medicaid providers can comply with these new requirements. Because the majority of the Medicaid claims submitted by public schools are for students with disabilities, increased paperwork is a real concern. The procedural requirements of special education are already extensive. Requiring individual cost accounting, in addition to documentation already required for Medicaid participation, places a significant burden on school districts that are struggling with increasing educational paperwork requirements under the federal special education law and the No Child Left Behind Act.

Thank you for allowing us the opportunity to comment. MADOE urges modification of the proposed rules to enable public schools and districts to meet the needs of their most needy students in an efficient and uncomplicated manner.

Sincerely,



David P. Driscoll
Commissioner of Education

C: Senator Edward Kennedy
Thomas Dehner, Acting Medicaid Director, Massachusetts
Kristen Reasoner Apgar, General Counsel, Executive Office of Health and Human Services, Massachusetts
Marcia Mittnacht, State Director of Special Education, Massachusetts

City of Chicago
Richard M. Daley, Mayor

Department of Public Health

Terry Mason, M.D., F.A.C.S.
Commissioner

333 South State Street
Chicago, Illinois 60604
(312) 747-9884
(312) 747-9888 (24 hours)

http://www.cityofchicago.org/health

Date: March 19, 2007

To: **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

From: **Terry Mason, M.D., F.A.C.S.**
Commissioner
Chicago Department of Public Health
333 South State Street, Suite 200
Chicago, Illinois 60604

Transmitted electronically to http://www.cms.hhs.gov/eRulemaking

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 Proposed Rule

The Chicago Department of Public Health (CDPH) thanks the Centers for Medicare & Medicaid Services for the opportunity to comment on the Proposed Rule for the Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial partnership Proposed Rule, 42 CFR Parts 433, 447, and 457 (CMS-2258-P).

The Chicago Department of Public Health assures conditions in which Chicagoans can be physically and mentally healthy through promoting health and by providing effective, accessible health services at seven neighborhood health centers, six specialty clinics, and 12 mental health centers.

Given our commitment to providing quality health care for low income Chicagoans, we take a great interest in the Medicaid program. Nearly 60 percent of Chicago's 400,000 Medicaid enrollees are children. The majority of the 75,782 patients receiving care in our neighborhood health centers are very low income, and 24,351 are Medicaid enrollees. We submit certified public expenditures [CPEs], receive matching funds, and depend on them to provide needed health services. In the past two years, we expended $7 million of CPE-eligible taxpayer dollars to provide health services to nearly 100,000 very low income patients.

Illinois currently does not get its fair share of Medicaid. While home to nearly 4 percent of the national Medicaid population, Illinois receives only 3.6 percent of total Medicaid funds. IGTs and CPEs are fundamental and essential ways that Medicaid provides funding for our safety net in Chicago. We and other safety net providers need all of the federal Medicaid funding we currently receive. We will not be able to preserve the level and quality of care if our federal Medicaid funding is cut by $255 million each year. This Proposed Rule asks Chicago to bear more than its share of the $3.87 billion

in cuts expected to be generated over the next five years. Fully one-third of the cuts will be borne by the safety net in Cook County and Chicago. Reducing Medicaid resources in Chicago will severely restrict our ability to provide the level and quality of health care services for our low-income individuals, children, and families. Specifically the Proposed Rule will:

- Reduce the number of entities that will be entitled to contribute to IGTs and CPEs;
- Diminish the amount of local and state funding that will qualify for matching funds;
- Shift the full cost for uncompensated care to the City of Chicago and other underfunded safety net providers;
- Set "allowable" costs through rule and inhibit the ability of the health care marketplace.

As a public agency, we are very mindful of our responsibility to ensure that taxpayers' dollars are spent wisely and well. Federal law and CMS regulation have upheld for ten years the use of intergovernmental transfers [IGTs] and CPEs by us and other safety net entities in Chicago and Illinois. This Proposed Rule fundamentally revises these traditional and legal methods of equitably sharing among local, state, and federal governments the cost and responsibility of providing safety net services. Moreover, it requires that Chicago contribute considerably more than our fair share

Providing quality health care is a goal that we all share. To that goal, the Chicago Department of Public Health offers our comments in support of maintaining the existing provisions of the Medicaid program and trust you will consider our concerns as you deliberate this important issue.

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March 19, 2007

MAR 20 2007

Talbot Building
715 Albany Street
Boston, MA 02118-2393
Tel:617 638 6911
Fax617 638 6905

ELAINE ULLIAN
President
Chief Executive Officer

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

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

Dear Ms. Norwalk:

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

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

Patient Care

With more than 28,035 admissions and 975,301 patient visits annually, BMC provides a comprehensive range of inpatient, clinical and diagnostic services in more than 70 areas of medical specialties and subspecialties, including cardiac care and surgery, hypertension, neurological care, orthopedics, geriatrics and women's health.

With the largest 24hour Level I trauma center in New England BMC had over 128,005 emergency room visits last year.

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

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

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

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

Defining a Unit of Government (§ 433.50)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* * *

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

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

Sincerely,

Elaine Ullian

National Association of Public Hospitals and Health Systems

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March 19, 2007

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

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
Attn.: Katherine T. Astrich, CMS Desk Officer

Re: Document Identifier CMS-10176 (OMB#: 0938-NEW), Governmental Status of Health Care Provider Form

Ms. Musotto and Ms. Astrich:

The National Association of Public Hospitals and Health Systems (NAPH) is pleased to submit comments regarding the above referenced document (the "Governmental Status Form") issued in conjunction with the Proposed Rule issued by the Centers on Medicare and Medicaid Services (CMS) on January 18, 2007, *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*[1] (the "Proposed Rule"). In the Collection of Information Requirements section of the Proposed Rule,[2] and in a separate notice published the same day,[3] CMS offered the separate opportunity to provide comments and recommendations specifically regarding the Governmental Status Form. On March 8, 2007, NAPH provided to CMS extensive comments on the Proposed Rule. To the extent that larger comment letter would be helpful to understanding the comments contained in this letter, the more extensive comments are available at http://www.naph.org/naph/advocacy/NAPHCommentLetter.pdf.[4]

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[1] 72 Fed. Reg. 2236 (Jan. 18, 2007).
[2] *Id.* at 2243.
[3] 72 Fed. Reg. 2532 (Jan. 18, 2007).
[4] The more extensive comments include discussion of the administrative burden imposed by additional cost reporting systems the Proposed Rule may require some states to adopt. NAPH opposes this requirement because of the potential substantial additional burden on providers. The Proposed Rule recognizes that these cost reports could impose an additional paperwork burden on providers of between 10 and 60 hours. 72 Fed. Reg. 2236, 2243.

In summary, NAPH believes that the Governmental Status Form is unnecessary and the burden imposed is substantial, likely underestimated and out of proportion with its utility. NAPH reiterates its comments in its larger letter on the Proposed Rule that CMS should defer to state law determinations of public status and recommends that the Governmental Status Form be withdrawn.

NAPH represents more than 100 metropolitan area safety net hospitals and health systems. Our members fulfill a unique and critical role in the health care system providing high intensity services—such as trauma, neonatal intensive care, and burn care—to the entire community. NAPH members are also the primary hospital providers of care in their communities for Medicaid recipients and many of the more than 46 million Americans without insurance. NAPH hospitals represent only 2 percent of the acute care hospitals in the country but provide 25% of the uncompensated hospital care provided across the nation. Our members are highly reliant on government payers, with nearly 70% of their net revenue from federal, state, and local payers. NAPH strongly believes that the Proposed Rule will very seriously compromise the future ability of NAPH members and other safety net hospitals to serve Medicaid patients and the uninsured and to provide many essential, community-wide services. The harm that will be inflicted on the health safety net by the Proposed Rule will also inflict fiscal crises on many states and increase the numbers of uninsured, at a time when we should be searching for ways to improve (not diminish) access and coverage.

Specifically with regard to the Governmental Status Form, NAPH understands the desire to collect information with regard to the governmental status of health care providers. However, the Governmental Status Form is unnecessary. In addition, the burden imposed on providers is substantial, likely underestimated, and totally out of proportion with the utility of the information collected on the Governmental Status Form.

The Governmental Status Form is Unnecessary

In its comments on the Proposed Rule, NAPH urges CMS to defer to states regarding the definition of a unit of government. If CMS were to adopt this definition, which respects the historic right of states to define its constituent governmental entities, the Governmental Status Form would be unnecessary. Deferring to states to determine which entities are units of government would eliminate the need for the Governmental Status Form and the associated burdens.

NAPH sets forth in its comment letter on the Proposed Rule numerous legal and policy reasons why deferring to states is preferable, including the continued encouragement of marketplace incentives, CMS's statutory authority, and Constitutional principles. For example, NAPH believe firmly that CMS has exceeded its statutory authority in adopting a definition of a "unit of government" more restrictive than that established in Title XIX of the Social Security Act. Section 1903(w)(7)(G) defines a "unit of local government," in the context of contributing to the non-federal share of Medicaid expenditures, as "a city, county, special purpose district, or other

governmental unit in the State."[5] The Proposed Rule narrows the definition of "a unit of government" to include, in addition to a state, "a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) *that has generally applicable taxing authority.*"[6] Congress never premised qualification as a unit of government on an entity's access to public tax dollars. Rather, Congress' formulation, which includes an "other governmental unit in the State," provides appropriate deference to the variety of governmental structures.

The Burden Imposed by the Governmental Status Form is Substantial, Likely Underestimated and Out of Proportion with the Utility of the Form.

CMS does not provide any explicit estimate of the amount of time necessary to prepare and submit the Governmental Status Form annually to state Medicaid agencies.[7] However, the burdens are likely to be substantial. The questions posed by the Governmental Status Form are not simple. Determining the proper answer to questions on the Governmental Status Form may require substantial effort and legal research and analysis. In any event, the burden associated with the Form is totally out of proportion with its utility, which CMS may or may not use to determine governmental status.

A number of the questions on the Governmental Status Form require extensive legal research and analysis. For example, questions 5, 9 and 12 ask whether a governmental unit has an obligation to fund expenses, liabilities, and deficits of the health care provider. Although this question may sound relatively simple, in actuality it may be an extremely complicated legal question. Potential claimants seeking governmental liability for actions occurring in a public hospital file lawsuits precisely to answer this question.[8] Given the time, money and effort that hospitals, units of governments, plaintiffs, and the court system incur considering these questions, it is unreasonable to expect a hospital to easily answer this question on the Governmental Status Form. Similarly, questions 6, 10 and 13 ask whether a contract with the unit of government is necessary in order to for the health care provider to receive tax revenues. This too may have complicated legal implications. A provider and its associated governmental entity may have been using a contract for years without any consideration of whether the contract was or was not legally necessary.

CMS is not entirely clear how it will rely on the information provided on the Governmental Status Form. Although the Proposed Rule states that, in order for a provider to be determined to be a unit of government (or an integral part of a unit of government), a unit of government "must have a greater role in funding the entity's operations, including its expenses, liabilities, and deficits,"[9] it is not clear whether a unit of government must have ***full*** responsibility for ***all three***

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[5] 42 U.S.C. § 1396b(w)(7)(G).

[6] Proposed 42 C.F.R. § 433.50(a)(1)(i) (emphasis added), 72 Fed. Reg. at 2246.

[7] 72 Fed. Reg. at 2243.

[8] Of course, if a court has actually made this determination not limited to the facts of any particular lawsuit, it may be easier to answer the question. However, many lawsuits are limited to specific facts presented and many providers have not faced this sort of lawsuit.

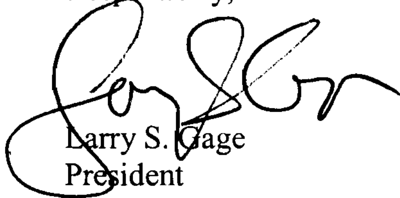
[9] *Id.* at 2240.

of these issues or whether ***partial*** responsibility for ***some*** of these issues would be sufficient. The Form itself provides no guidance to providers or states. It seems likely that despite information gathered on the Governmental Status Form, CMS would still believe it necessary to conduct an individualized investigation and analysis.[10] To the extent CMS conducts individual investigations regardless of the information collection, the Governmental Status Form is unnecessary and duplicative, since the burden of completing the Form will not in any way alleviate the necessity for an additional burdensome investigation by CMS.

In any event, the burden associated with the Governmental Status Form is out of proportion with its utility, and the Form should be withdrawn.

NAPH appreciates the opportunity to submit these comments. If you have any questions, please contact Charles Luband or Barbara Eyman at NAPH counsel Powell Goldstein (202) 347-0066.

Respectfully,



Larry S. Gage
President

[10] *Id.* at 2242 ("With the issuance of this proposed rule, we recognize the need to evaluate individual health care providers to determine whether or not they are units of government as prescribed by the rule.").

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HEALTH

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

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

Dear Ms. Norwalk:

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

Faculty physicians employed by and under contract with USF Health are the state's providers of primary and specialty services for vulnerable populations, including Medicaid and uninsured persons. Through this critical access, USF Health trains and educates a significant portion of Florida's physician workforce, and is committed to developing advances in medicine through both clinical practice and research.

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

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

- Effective Date.

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

I. Certified Public Expenditure

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

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

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

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

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

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

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

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

3. CPEs must be documented as a Medicaid expenditure.

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

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

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

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

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

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

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

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

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

<u>I. State and Local Tax Revenue</u>

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

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

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

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

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

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

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

II. Defining a Unit of Government (§ 433.50)

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

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

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

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

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

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

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

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

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

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

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

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

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

11. The cost limit undermines important public policy goals.

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

For example, the College of Medicine has invested millions of dollars in adopting electronic medical records and other new information systems that have a direct impact on quality of care, patient safety and long-term efficiency, all goals promoted by HHS and AHCA. HHS has focused on expanding access to primary and preventative services particularly for low-income Medicaid and uninsured patients and reducing inappropriate utilization of emergency departments. Council members have been engaged in this effort, establishing networks of off-campus, neighborhood clinics with expanded hours, walk-in appointments, assigned primary care providers and access to appropriate follow-up and specialty care. These initiatives require substantial investments of resources. CMS does not appear to have considered the impact of the cut imposed by the cost limit on shared policy initiatives that HHS itself has established as key goals of America's complex health care system. The only goal achieved by the Proposed Rule would be the dismantling of Florida's safety net.

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

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

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

Because the payments would be based on costs pursuant to the new regulation, there would not be the danger of "excessive payments" that has concerned CMS in the current system. Moreover, to avoid double dipping, states could be required to similarly adjust capitation rates to

[3] 42 C.F.R. §438.60.

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

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

II. Retention of Payments (§ 447.207)

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

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

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

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

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

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

[4] Proposed 42 C.F.R. § 447.207(a).

under the Medicaid program. It does not have authority over providers' use of Medicaid payments received.

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

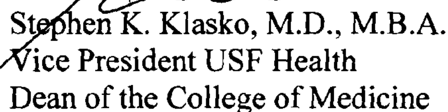
In addition to the issue specific comments, if such a Proposed Rule is to move forward, the Council urges CMS to consider replacement funding or at a minimum a transition period. Many state legislatures do not meet year-round. For instance, Florida just began its 60-day Legislative Session and if the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

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

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

This concludes the comments submitted by USF Health relative to the direct impact on Council members.

Sincerely,



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