CMS-

Because the referenced comment number does not pertain to the subject matter for CMS- , it is not included in the electronic public comments for this regulatory document.

#2

CMS-

Because the referenced comment number does not pertain to the subject matter for CMS- , it is not included in the electronic public comments for this regulatory document.

#3

CMS-

Because the referenced comment number does not pertain to the subject matter for CMS- , it is not included in the electronic public comments for this regulatory document.

#4

CMS-

Because the referenced comment number does not pertain to the subject matter for CMS- , it is not included in the electronic public comments for this regulatory document.

#5

CMS-

Because the referenced comment number does not pertain to the subject matter for CMS- , it is not included in the electronic public comments for this regulatory document.

Submitter : Mr. Craig Becker **Date:** 07/06/2007

Organization : Tennessee Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-FC-6-Attach-1.DOC

#6

July 6, 2007

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

Re: Provisions of the Final Regulations CMS – 2258 - FC

Dear Ms. Norwalk:

The Tennessee Hospital Association (THA), on behalf of our over 200 member healthcare facilities, including hospitals, home care agencies, nursing homes, and health-related agencies and businesses, and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other health professionals, appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the final regulations. **We oppose the proposed definition of unit of government and would like to highlight the harm this proposed policy change would cause to Tennessee hospitals and the patients they serve.**

Since the beginning of the TennCare program in 1994, CMS has approved Tennessee's use of certified public expenditures to support the TennCare program. A portion of the public hospitals in Tennessee would meet the more restrictive definition of "unit of government" that CMS proposes; however, many would not. All of the Tennessee public hospitals were created by governmental entities following the laws of the State of Tennessee. These hospitals were created and have been maintained to support the mission of Tennessee communities to insure healthcare is available to all residents, especially the most vulnerable and needy. Although they may not be funded directly through tax revenues and may have chosen to organize themselves as a separate corporation in order to be able to function more efficiently, they are still owned and governed by government bodies and officials. We do not believe that CMS should penalize Tennessee because these public hospitals have attempted to become operationally more efficient and to depend less on public subsidy.

The Final Rule's definition of a unit of government runs exactly counter to this decades-long trend in the provision of governmental health care. Only the most traditional of public hospitals would qualify as a governmental entity capable of contributing to the non-federal share of Medicaid funding. Others simply would not be deemed an "integral part" of a unit of government under the strict criteria set forth in the Final Rule.

The impact on TennCare of losing the ability to rely on certified public expenditures would result in the program losing approximately $250 million in FFP a year. We believe that CMS has severely underestimated the impact of this change. CMS states in the rule that the implementation would not result in more than $120 million savings for the federal government in the first year and would not have an impact on the coverage or eligibility requirements under Medicaid. In Tennessee alone, the impact in the first year would be in excess of $120 million and the TennCare program will have to seriously look at the design of the program including eligibility, covered services and provider reimbursement. It is not possible to take a cut of this magnitude without some major restructuring. Considering the major restructuring of the TennCare program that just occurred in Tennessee and the resulting savings to the federal government, we do not believe that it is appropriate for CMS to attempt to further cut the program through the definition of unit of government.

Further, we believe 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 SSA. Section 1903(w)(7)(G) of the SSA already defines a "unit of local government," in the context of contributing to the non-federal share of Medicaid expenditures, as "a city, county, special purpose district, or other governmental unit in the State." The Final Regulation 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 taxing authority or direct access to tax revenues.*" In narrowing this statutory definition, without instruction by Congress, CMS has eliminated the ability of states to define units of government consistent with their state statutes.

There are a number of long-standing provisions of the Medicaid program that have sanctioned public entities not funded by state appropriations to contribute to the non-federal share of Medicaid expenditures. Section 1902(a)(2) authorizes a state plan to provide for local participation in as much as 60 percent of the non-Federal share of total Medicaid expenditures, as long as the lack of adequate funds from local sources does not result in lowering the amount, duration, scope or quality of care and services under the plan. There is no requirement in this section of the law that such funds come from sources determined to be "units of government."

We are also concerned that this overly restrictive approach would exclude the "governmental entities" approved by CMS in Tennessee's existing section 1115 demonstration. We strongly believe CMS has failed to consider that there is a broad range of mechanisms and relationships beyond taxing authority or direct subsidy, including contractual arrangements, grants, sale or lease of land, litigation funds, and many other that link governmental entities to the Medicaid program.

The definition of unit of government in the final rule would undermine the efforts of Tennessee state and local governments to deliver public health care services more efficiently and effectively, and penalize those that have reduced their reliance on taxpayer support. Local governments in Tennessee that have restructured their public hospitals deliberately to retain their nature as a governmental entity under state law, in part so that they could continue contributing to funding the non-federal share of Medicaid expenditures, will find the rules suddenly switched on them as the federal government substitutes its judgment for state and federal law regarding whether they remain public or not. As stated above, we believe CMS's restrictive definition of unit of government is fatally flawed and should be abandoned in favor of permitting state discretion.

Sincerely,

Craig A. Becker, FACHE
President
Tennessee Hospital Association

Submitter : Ms. Elizabeth Ward **Date:** 07/12/2007

Organization : Moses Cone Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-FC-7-Attach-1.DOC

#7

July 11, 2007

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

Re: (CMS-2258-FC) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (Vo. 72, N0. 102), May 29, 2007

Dear Ms. Norwalk:

I am the Chief Financial Officer and Treasurer of Moses Cone Health System, a multi-campus teaching hospital and health system serving Greensboro, North Carolina and surrounding areas. Moses Cone Health System opposes the revised proposed definition of Unit of Government that was published in the Federal Register on May 29, 2007 and wishes to provide comments as to how the regulation might be improved.

The proposed definition of Unit of Government 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 the application of this definition 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.

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 the State, and is required either by statute, ordinance, by-law, or other controlling instrument to serve a public purpose.

Under the proposed new definition North Carolina's public hospitals will have to meet the new definition Unit of Government in order to continue to certify their public expenditures to draw down matching federal funds. Because the new definition imposes the requirement that a Unit of Government 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 which has the effect of wiping out entire valuable programs that are otherwise fully consistent with all of the Medicaid statutes is unreasonable and objectionable. Moses Cone Health System 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 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 implementing new regulations before October 1, 2009 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. A date no earlier than October 1, 2009 is necessary for the affected stakeholders to try to mitigate the detrimental impact of the changes.

Moses Cone Health System urges CMS to withdraw its proposed definition of Unit of Government, 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, Moses Cone Health System urges CMS to adopt a more reasonable implementation schedule that allows until October 1, 2009 before the new definition takes effect. Thank you for your consideration.

Respectfully Submitted,

Elizabeth S. Ward, CPA
CFO and Treasurer

Submitter : Ms. Gina Ramsey **Date:** 07/12/2007

Organization : North Carolina Baptist Hospital

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Unit of Government Definition

Unit of Government Definition

see attachment

CMS-2258-FC-8-Attach-1.PDF

CMS-2258-FC-8-Attach-2.PDF

#8

Gina B. Ramsey
Vice President, Financial Services
Chief Financial Officer
North Carolina Baptist Hospital
Telephone: (336) 716-3005
Fax: (336) 716-2067

July 12, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: (CMS-2258-FC)
200 Independence Avenue, S.W. Room 445-G
Washington, DC 20201

Dear Ms. Norwalk:

North Carolina Baptist Hospital (NCBH) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) 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," (Vo.72, No. 102), May 29, 2007." NCBH is part of Wake Forest University Baptist Medical Center, an academic health system comprised of 1,157 acute care, psychiatric, rehabilitation and long-term care beds located in the northwestern section of North Carolina, the region's main tertiary referral center.

We are writing to oppose the revised proposed definition of "Unit of Government" published in the Federal Register on May 29, 2007.

Under the proposed new definition North Carolina's 43 public hospitals will have to meet the new definition Unit of Government in order to continue to certify their public expenditures to draw down matching federal funds. Because the new definition imposes the requirement that a Unit of Government 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 which has the effect of wiping out entire valuable programs that are otherwise fully consistent with all of the Medicaid statutes is unreasonable and objectionable.

As NCBH stated in our comment letter to you dated March 19, 2007, if this regulation were to go into effect as planned, North Carolina could face a $340,000,000 shortfall. With

insufficient financing for its share of Medicaid, North Carolina would be forced to find new funding sources or make cuts to the program, which would directly affect participant eligibility and a reduction in benefits and services provided. These types of cuts would threaten our ability to continue to provide health care to our Medicaid and uninsured population.

At NCBH we fulfill a unique and critical role in the health care system by providing high intensity services, such as trauma and neonatal intensive care to the entire community and the western region of our state while also ensuring that Medicaid recipients and the uninsured have access to all medical services. In fact, the number of Medicaid inpatient admissions for NCBH has grown from 5,028 admissions in 2001 to 7,198 in 2006; an increase of 43.2%. In 2001, Medicaid admissions represented 16.3% of our total admissions. In 2006, it represented 20.8% of our total admissions. The number of our uninsured patient admissions from 2001 to 2006 has grown by 75.5% from 1,225 admissions in 2001 to 2,150 in 2006. To help put this in perspective, our total admission grew only 12% from 2001 to 2006, from 30,828 in 2001 to 34,525 admissions in 2006. The Medicaid and uninsured patient population admissions have significantly outpaced our overall growth rate.

It is estimated if the new definition of unit of government in the proposed rule goes into effect, NCBH would lose approximately $25,000,000 annually in supplemental Medicaid funding, which is crucial to our ability to fulfill our mission as an academic medical center. We will be forced to eliminate needed services and eliminate jobs.

NCBH respectfully requests the CMS rescind the revised proposed definition of "Unit of Government".

NCBH remains committed to working with CMS, other health care organizations, such as the American Hospital Association (AHA), Association of American Medical Colleges (AAMC), National Association of Children's Hospitals (NACH), the National Association of Public Hospitals (NAPH) and the National Governors Association (NGA) to ensure that Medicaid beneficiaries have continued access to high quality, efficient and effective health care. We look forward to a continuing dialog as it relates to this proposed rule.

If you have any questions concerning these comments, please contact Joanne C. Ruhland, Vice President, Government Relations at jruhland@wfubmc.edu or 336-716-4772.

Sincerely,

Gina B. Ramsey

C: Senator Elizabeth Dole
Senator Richard Burr
Representative Virginia Foxx
Representative Mel Watt

Submitter : Mr. Tom Carlin **Date:** 07/12/2007

Organization : New Hanover Regional Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attached

Unit of Government Definition

Unit of Government Definition

Please see attached.

CMS-2258-FC-9-Attach-1.DOC

#9

July 13, 2007

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

Re: (CMS-2258-FC) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (Vo. 72, N0. 102), May 29, 2007

Dear Ms. Norwalk:

New Hanover Regional Medical Center, a 769 bed teaching hospital and trauma center serving a 9 county area in Southeastern North Carolina appreciates the opportunity to express our opposition to the revised proposed definition of Unit of Government that was published in the Federal Register on May 29, 2007.

The proposed definition of Unit of Government 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 the application of this definition 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.

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 the State, and is required either by statute, ordinance, by-law, or other controlling instrument to serve a public purpose.

Under the proposed new definition North Carolina's public hospitals will have to meet the new definition Unit of Government in order to continue to certify their public expenditures to draw down matching federal funds. Because the new definition imposes the requirement that a Unit of Government 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 which 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.

If CMS elects to go forward 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 implementing new regulations before October 1, 2009 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. A date no earlier than October 1, 2009 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 definition of Unit of Government, or in the alternative revise it substantially by among other things adopting applicable State law to define the public hospitals (or units of government).

Thank you for your consideration.

Respectfully Submitted,

Susan Shovlin, Director of Reimbursement
Tom Carlin, Reimbursement Accountant

Submitter : Mr. Loren Dyer **Date:** 07/12/2007

Organization : Tampa General Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-FC-10-Attach-1.DOC

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

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

A. Applicability to Waiver States and DSH Payments

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

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

B. "Unit of Government"

Title XIX defines a "unit of local government" as "a city, county, special purpose district, or other governmental unit in the State."[5] The Proposed Rule significantly narrows this definition by establishing a "unit of government" (emphasis added) as a "State, a city, a county, a special purpose district, or other governmental unit in the State (including

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[1] Proposed rule at 2240.

[2] *See, e.g., Proposed Rule* at 2240 (emphasis added, "...all Medicaid payments (***including disproportionate share hospital payments***) made under the authority of the State plan ***and under Medicaid waiver and demonstration authorities*** are subject to all provisions of this regulation."

[3] Proposed Rule at 2248.

[4] Proposed Rule 2247.

[5] 42 U.S.C. § 1396b(w)(7)(G).

Indian tribes) *that has generally applicable taxing authority."*[6] By including the catchall "other governmental unit" in its definition without further restricting the designation to only those units of government with taxing authority, Congress provided the leeway to recognize the many ways in which states have created local governmental units, including governmental units without taxing authority. The Proposed Rule also uses the new "unit of government" definition to restrict the providers operated by such to only those providers with a) taxing authority or b) "unit of government" funding for its expenses, liabilities, and deficits.[7]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Retention Requirement:

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

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

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

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

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

Sincerely,

Loren M. Dyer
Director of Revenue & Reimbursement
Tampa General Hospital

Submitter : Mr. Bradley King **Date:** 07/12/2007

Organization : Oregon Health & Science University

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

Unit of Government Definition

Unit of Government Definition

Comments on Unit of Government Definition (? 433.50) contained in CMS 2258 FC: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748 (May 29, 2007).

CMS-2258-FC-11-Attach-1.PDF

#11

OREGON HEALTH & SCIENCE UNIVERSITY

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Vice President and Chief Financial Officer
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July 13, 2007

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

Re: Comments on Unit of Government Definition (§ 433.50) contained in CMS–2258–FC: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748 (May 29, 2007).

Dear Ms. Norwalk:

On behalf of Oregon Health and Science University (OHSU), I am submitting comments on the new definition of a unit of government contained in 42 C.F.R. § 433.50 of the regulation published by the Centers for Medicare and Medicaid Services (CMS) as CMS-2258-FC (the Final Rule). Although OHSU appreciates the fact that the Final Rule clarifies the status of state university teaching hospitals such as OHSU as units of government, OHSU continues to believe that the regulation impermissibly narrows the statutory definition of a unit of government and is an inappropriate intrusion into state prerogatives.

OHSU is the only academic health center in the State of Oregon, consisting of hospitals and clinics, schools of medicine, dentistry, nursing, science and engineering, as well as operations with major grant awards for health related research. In addition, OHSU serves as the tertiary care center for the State of Oregon and southwest Washington State, is a Level 1 trauma center and a major transplant center, and trains over 350 medical residents annually. OHSU also serves a significant safety net role in Portland and in Oregon, both in terms of providing care to large numbers of underserved Medicaid and uninsured populations and in terms of providing specialized services not available from other hospitals in the state. As a result, OHSU relies heavily on Medicaid program funding. We continue to believe that the Final Rule will cut up to $36 million in annual funding to OHSU, and will compromise our ability to continue our public mission.

1. **The Final Rule's definition of a unit of government continues to exceed CMS's statutory authority and intrudes on State prerogatives.**

In the Final Rule, CMS modified the definition of a "unit of government" included in the proposed regulation to clarify the governmental status of an undetermined number of additional entities, including certain teaching hospitals and Indian tribes. OHSU supports and appreciates the inclusion of State university teaching hospitals in the definition of a unit of government. In addition, in its responses to comments on the proposed rule, CMS stated that "inclusion in a State's consolidated financial report is also indicative of a unit of government." OHSU also supports inclusion of that indicator in the Final Rule.

Notwithstanding the changes and the clarifications made in the Final Rule and the preamble, OHSU reiterates its basic opposition to CMS' definition. Notwithstanding the inclusion of teaching hospitals, CMS' definition impermissibly narrows the definition of a unit of government adopted by Congress and inappropriately intrudes into state prerogatives. The Medicaid statutory definition of unit of local government includes "or other government unit" as part of its definition. 42 U.S.C. 1396b(w)(7)(G). CMS' new Final Rule introduces new conditions — specifically taxing authority, direct access to tax revenues, receipt of direct appropriations by state teaching hospitals, or status as an Indian tribe —that are not included in the Medicaid statute.

On behalf of OHSU, I urge CMS to show genuine deference to state law in the determination of a unit of government for purposes of Medicaid financing. This requires more than the nominal deference incorporated into the Final Rule by allowing states to make an initial determination subject to being overturned by CMS.

2. **Providers determined to be units of government under this Final Rule should not be subject to a cost limit.**

Limiting Medicaid payments to governmental providers to cost will erode the supplemental payments that support OHSU's hospital. The Oregon Medicaid agency, since 2001, has paid Pro-Share payments to OHSU up to the UPL in recognition of OHSU's public mission and role as a public academic teaching hospital. CMS reviewed and approved State plan amendments authorizing these payments. Since Medicare pays OHSU more than most calculations of cost, CMS' rule will significantly lower reimbursement to OHSU. As CMS has not fundamentally altered the provisions of the Proposed Rule, our conservative estimates are that OHSU would likely lose at least $2.8 million in Pro-Share related revenues under the Final Rule.

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

* * *

In summary, I appreciate the opportunity to submit these additional comments and to reiterate OHSU's strong opposition to the provisions of this Final Rule, in particular the definition of a unit of government. I appeal to CMS to defer to states regarding governmental status and to withdraw the Final Rule.

Respectfully submitted,

Bradley N. King

Bradley N. King, C.P.A., M.B.A., M.P.A.
OHSU Vice President and Chief Financial Officer

Submitter : Mr. Bruce Goldberg **Date:** 07/13/2007

Organization : American Public Human Services Association

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2258-FC-12-Attach-1.DOC

#12

APHSA
American Public Human Services Association

NASMD
National Association of State Medicaid Directors
an affiliate of the American Public Human Services Association

July 13, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Attention: **CMS–2258-FC**

Re: Final rule with comment period: 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:

The American Public Human Services Association (APHSA) and its affiliate, the National Association of State Medicaid Directors (NASMD), respectfully submit this comment letter on the final rule regarding the public provider cost limit that was published in the May 29, 2007 edition of the Federal Register for the Centers for Medicare and Medicaid Services (CMS).

As noted in our March 19, 2007 comment letter to the proposed rule published in the January 19, 2007 edition of the Federal Register (72 FR 29,784), the state Medicaid agencies share the federal government's strong commitment to protecting the fiscal integrity of the Medicaid program. However, the comments expressed in our March 19, 2007 letter regarding the agency's proposed rule hold equally true to nearly all provisions of the final rule and CMS' response to comments. We continue to hold that the regulation is a fundamentally flawed approach to achieve the stated goal.

In addition, APHSA and NASMD question the appropriateness of the timing of CMS' actions in publishing the final rule given Congress's staunch opposition to the agency taking any further action. As noted in our March 19, 2007 comment letter, a bipartisan majority of Members of Congress had contacted Secretary Leavitt regarding their opposition to the changes contained within this proposed rule. Subsequently, on May 24, 2007, both bodies of Congress approved language in Section 7002 (a)(1) of the U.S. Troop Readiness, Veterans' Health Care, Katrina Recovery and Iraq Accountability

Appropriations Act of 2007 (P.L. 110-28) that imposed a moratorium on any action related to the regulation under discussion. Enactment of the statutory language preceded publication of the final rule on May 29, 2007 (72 FR 29,784).

It is disconcerting that in light of the concerns of Congress, CMS would proceed to publish this regulation, and, in essence, cause a impasse in the agency's ability to further discuss this issue. The timing of enactment and CMS' steps to submit the final rule to the Office of the Federal Register provide reasonable justification to question the legality of the agency's actions and, as a result, the standing of the final rule.

For these reasons, we request that CMS withdraw the final rule. We believe that CMS should not move forward with this new regulation as currently written. In addition, states are concerned that, once the moratorium expires, CMS will not have had an opportunity to thoroughly consider any further deliberations and review by Congress.

In the interim, we wish to respond to CMS' request for comments on the definition of unit of government.

§ 433.50 Unit of Government Definition

We recognize that CMS attempted to provide some flexibility by permitting states to make the initial determination of governmental status and its clarification that university teaching entities may be considered a governmental entity for purposes of Medicaid financing and payment determinations. However, the concerns of our March 19, 2007 letter hold in light of CMS' rote response to commenters' questions and suggestions regarding the definitions of governmental unit.

Despite the assertion that the final rule will clarify the universe of governmentally operated health care providers for purposes of Medicaid financing and payment, we states still submit that CMS exceeds its authority by intervening in the states' unique role in defining the criteria for a unit of government. We recognize that CMS made some minor changes, yet the final rule still inappropriately limits the types of entities that could be considered a unit of government and fails to accommodate the various legitimate governmental authority arrangements established by individual states.

Specifically, we believe that the agency has improperly interpreted and applied Section 1903(w)(6) of the Social Security Act in issuing the interim final regulation. This section does not limit which providers can participate in the non-federal share of Medicaid expenditures. As a result, under the interim final regulation, the Medicaid expenditures of many providers and entities are likely to be inappropriately prohibited from being counted as the non-federal share. Further, the agency's application of Section 1903(w)(6) will reverse innovative – and appropriate – efforts by states, providers, and other entities

to implement and pursue sustainable funding sources for their respective Medicaid programs.

In addition, states believe that the justification provided in the response to commenters fails to consider Section 5(b) of P.L. 102-234. This section granted states the authority to use public funds as the non-federal share of Medicaid expenditures. No restriction was included that explicitly states or could reasonably be interpreted to limit the source of the non-federal share of Medicaid expenditures to tax-generated funds.

We ask that the agency review this section in conjunction with further development of the regulation and specifically with the definition of unit of government. We would be happy to provide you with additional information on our comments as you go forward. Please contact Martha Roherty, Directory of NASMD, at (202) 682-0100 if we can be of further assistance.

Sincerely,

Bruce Goldberg
Chair, Policy Committee
American Public Human Services Association

David Parrella
Chair, Executive Committee
National Association of
State Medicaid Directors

Submitter : Mr. Joseph Parker **Date:** 07/13/2007

Organization : Georgia Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2258-FC-13-Attach-1.DOC

#13

July 13, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2258-FC
P.O. Box 8014
Baltimore, MD 21244-8014

Re: **Final Rule: Medicaid Program; Cost Limit for Providers Operated by Units of Government (CMS-2258-FC)**

Dear Sir or Madam:

The Georgia Hospital Association (GHA), on behalf of its 173 member institutions, appreciates this opportunity to comment on the above-captioned Final Rule imposing Medicaid cost limits on governmental providers.

Analysis of CMS's Responses to Public Comments

Our comments today will focus solely on the definition of "unit of government" as modified by CMS from its earlier definition in the Proposed Rule. While CMS touts its Final Rule as more flexible than its proposed version, the new definition offers no help whatsoever to Georgia's governmental hospitals. Indeed, the Final Rule is so restrictive that only one general acute care hospital in Georgia (which is owned directly by the State) would qualify as a "unit of government." GHA respectfully suggests this Final Rule exceeds CMS's statutory authority, violates Congressional intent, and disserves those governmental safety net hospitals which are the core of the Medicaid program.

For the reasons specified below, and in the interest of protecting our most vulnerable citizens, we respectfully urge CMS to permanently withdraw this Rule and to instead follow the letter and intent of the Medicaid statute.

1. The Final Rule Exceeds CMS's Statutory Authority

As a threshold matter, we must reassert our argument (contained in our previous comment letter on the Proposed Rule) that the Final Rule surpasses CMS's legal authority by attempting to impose unauthorized limits on intergovernmental transfers. Section 1903(w)(6)(A) of the Social Security Act specifically provides "the Secretary ***may not restrict*** States' use of funds where such funds are...transferred from...units of government within a State." Yet the Final Rule does precisely what is statutorily prohibited, by placing unprecedented restrictions on a state's ability to utilize funds transferred from local governmental units such as Georgia hospital authorities. This is something CMS cannot do without the consent of Congress. If CMS wishes to impose new obstacles on the accepted

and long-established practice of intergovernmental transfers, then it should ask Congress to amend the law. Any attempt to do so through administrative regulation is illegal.

2. The Final Rule Refuses to Recognize Georgia Hospital Authorities As Clearly Governmental

Several times in its preamble, CMS claims this Final Rule is "designed to ***protect*** health care providers, including the safety net providers." (72 Fed. Reg. at 29755.) Unfortunately, the exact opposite will occur in Georgia because of the structure utilized by the Georgia Legislature to provide health care for its indigent population.

CMS acknowledges the term "other governmental unit" should be interpreted to include those entities which "have qualities that are generally shared by" states, counties and cities. (72 Fed. Reg. at 29752.) Yet CMS thereafter states it will only look to ***one*** trait common to governmental entities – their "financial organization," and specifically their method of accessing tax revenues. (72 Fed. Reg. at 29759.)

Georgia hospital authorities share abundant qualities in common with states, cities and counties: e.g., the power of eminent domain; significant public funding; publicly-appointed governing boards; and an exemption from federal income tax as governmental entities under §115 of the Internal Revenue Code. As far as Georgia law is concerned, hospital authorities are deemed governmental entities under both statutory and judicial authority. *See, e.g.,* O.C.G.A. §31-7-72(a) (describing a hospital authority as "a public body corporate and politic"); O.C.G.A. §31-7-75 (every hospital authority is "deemed to exercise public and essential governmental functions"); *Cox Enterprises, Inc. v. Carroll City/County Hospital Authority*, 273 S.E.2d 841 (Ga. 1981) (hospital authority, which lacked some of the attributes of sovereignty such as the power to tax, but which was a creature of statute, was defined as a "public body corporate and politic," was tax exempt, was deemed to exercise public and essential governmental functions, exercised power of eminent domain and received tax revenues, and whose board was appointed by governing body of the relevant political subdivisions, was a "governmental entity").

Similarly, under federal law, virtually every agency or department of the federal government considers Georgia hospital authorities to be governmental entities. Indeed, we cannot think of a single federal or state agency that refuses to recognize hospital authorities as units of government.

Under Georgia law, hospital authorities are "agencies or instrumentalities" of the county or municipality that created them. *See, Cox Enterprises, supra* at 273 S.E.2d 845; *Fulton-DeKalb Hosp. Auth. v. Gaither*, 247 S.E.2d 89 (1978). Therefore, hospital authorities are closely related to such counties and cities, and irrefutably one of the "other governmental units in the State" described by Congress in Section 1903(w)(7)(G) of the Social Security Act. It is unreasonable for CMS to suddenly and unilaterally declare such entities to be non-governmental.

3. CMS' Refusal to Recognize Contractually-Obligated Funding Is Inconsistent with the State of Georgia's Health Care Structure

CMS states in the Preamble that it has modified the definition of governmental unit to also include an entity that has "either taxing authority ***or*** direct access to tax revenues." (72 Fed. Reg. at 29757.) However, the actual regulatory language at §433.50(a)(1)(ii)(B) effectively eviscerates this purported expansion by requiring the funding to come from a governmental entity which is "legally obligated" to pay the hospital's expenses, liabilities and deficits without any separate contractual arrangement. In CMS's view, contractual obligations cannot form the sole or primary source of public funding.

GHA fails to understand why it should matter whether public funding is contractually-based or the result of direct appropriations. Either way, the funds are "legally obligated" and the duty to pay them is legally enforceable. CMS's refusal to recognize contractual funding is a distinction without a difference, which bears no logical relationship to an entity's governmental status.

As explained in our earlier letter concerning the Proposed Rule, the Georgia General Assembly granted counties and municipalities the power to impose taxes and to agree **by contract** to utilize those tax revenues to reimburse hospital authorities for their construction, maintenance and cost of providing indigent care. *See* O.C.G.A. §31-7-85. But since the Final Rule stipulates that a "contractual arrangement" cannot be the primary or sole basis for receiving tax revenues, virtually every hospital authority in the state will be disqualified as a unit of government. This includes Grady Memorial Hospital in Atlanta, Georgia's largest hospital, which in 2005 alone received $103 million in tax revenues from its sponsoring counties and provided $45.3 million in indigent and charity care.

The situation involving Georgia hospital authorities is specifically mentioned by CMS in Comment 31C at page 29757. CMS begins by agreeing its insistence on non-contractual funding would effectively disqualify all hospital authorities in the State as units of government. As justification for this disastrous result, CMS states the following:

> "However, if the only way for a health care provider to access general tax revenue is under a contract for services with a unit of government, then the health care provider is likely not a unit of ***that*** government." (Emphasis supplied)

This comment reflects a fundamental misunderstanding of Georgia's Hospital Authorities Law. The proper question to be determined is whether the hospital authority is ***itself*** a unit of government. Instead of focusing on an authority's own independent governmental status (which it clearly enjoys), CMS improperly focuses on the authority's relationship with the city or county which provides it tax revenues. GHA respectfully submits that the focus on tax revenues has caused CMS to misanalyze the real issue. Contractually-obligated funds ***are*** "derived from state or local taxes" and thus constitute permissible funds for intergovernmental transfers.

Conclusion

CMS's Final Rule will punish all but one of Georgia's governmental hospitals, not because of their governmental status (which is unassailable), but simply because of the method through which they receive their funds – through contract rather than direct appropriation. Such a result is totally irrational, contrary to our country's principles of

federalism, and threatens states' autonomy of decision-making on how to treat their low income populations.

In summary, the Final Rule lacks legal, logical and moral support. CMS cannot adopt a regulation that conflicts with a federal statute. The financial impact of the Rule will devastate our "safety net" hospitals, unravel state budgetary efforts, and most importantly, deprive thousands of Medicaid recipients with adequate access to treatment. The Georgia Hospital Association therefore respectfully urges CMS to permanently withdraw this flawed Rule.

Sincerely,

Joseph Parker
President

Submitter : Mr. Greg Gombar **Date:** 07/13/2007

Organization : Carolinas HealthCare System

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

(See Attachment)

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

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

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

Submitter : **Christine Bronson** **Date: 07/13/2007**

Organization : **Minnesota Department of Human Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-FC-15-Attach-1.PDF

#75

Minnesota Department of **Human Services**

July 13, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
PO Box 8017
7500 Security Boulevard
Baltimore, MD 21244-8017

Minnesota Department of Human Services Comments on:
Docket: CMS-2258-FC, Cost Limit for Government Providers

Dear Ms. Norwalk:

Thank you for the opportunity to comment on the final rule. As noted in our March 15, 2007 letter providing comments on the proposed rule, Minnesota shares the goal of promoting fiscal integrity in the Medicaid program. However, we have several concerns regarding the agency's actions in finalizing this rule, its approach to setting payment policy and its interpretations of section 1903(w)(6) of the Social Security Act. We reiterate the concerns expressed in our earlier comment letter that the policies contained in this rule represent an ineffective, inefficient and flawed approach to the agency's stated goals and we recommend that CMS withdraw this final rule.

Minnesota has concerns regarding the appropriateness of the agency's actions in publishing the final rule prior to the enactment of the legislative moratorium. Publication of the final rule will delay discussions between CMS and affected stakeholders and has created genuine doubts as to the agency's willingness and ability to engage in those discussions in a meaningful and open manner.

CMS has restricted the solicitation of comments to proposed definition of units of government and has moved to finalize the remaining provisions of the proposed rule. Finalizing the other provisions of the proposed rule was premature. Given the short amount of time between the end of the comment period and the publication of the final rule, the complexity of the issues under discussion, and the repetitive and incomplete nature of the agency's responses to the submitted comments on the policies contained in the proposed rule, it is apparent that CMS did not give due consideration to the comments.

We have the following comments on the definition of "unit of government."

§ 433.50 – Defining of Unit of Government

In this section CMS limits the definition of units of government to entities that have access to tax revenue. CMS points to section 1903(w)(6) as the basis for that limitation. We believe the agency's interpretation of this section of the statute is in error. The clear purpose of this provision was to protect states' ability to require local government entities to share in the cost of providing Medicaid services. Far from limiting state's rights to determine which entities may share in the cost of providing Medicaid services, the provision is an affirmation of the right of states to impose responsibilities on local governmental entities.

CMS has consistently maintained that the provisions of the rule will not create an undue administrative burden on states or providers. We disagree. As noted in our earlier comment letter, Minnesota has over 2,000 providers that currently self-report as being related to government entities. Given that Minnesota has only a handful of institutional governmental providers, the vast majority of those 2,000 governmental providers are non-institutional providers. We anticipate that many of these smaller providers will find it difficult to answer the questions posed in the survey. Minnesota will have to devote considerable time and resources to helping these small local government providers complete the survey. Establishing the governmental status of 2,000 providers will impose a significant administrative burden on the state and its providers.

The rule will have a disproportionate administrative impact on states that have sizable rural populations. Given the scarcity of providers in rural localities, these states must routinely rely on local governments to serve as the provider of last resort for critical services that are not otherwise available through the private sector. The administrative and financial burdens imposed by this rule will have a detrimental effect on states that have developed a safety network of local government providers and will limit states' options for ensuring that all Medicaid beneficiaries have access to needed services. Moreover, the costs of the imposed administrative burdens in the rule will not result in commensurate savings.

For all of these reasons, Minnesota recommends that CMS withdraw this final rule with comment and engage in further discussions with Congress, states and other stakeholders.

Sincerely,

for Ann Berg

Christine Bronson
Medicaid Director

Submitter : Mr. Rick Pollack **Date:** 07/13/2007

Organization : American Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-FC-16-Attach-1.DOC

#16

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

July 13, 2007

Leslie Norwalk, Esq.
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-FC) Final Rule - Medicaid Program; Cost Limit for Providers Operated by Units of Government (Vol. 72, No. 102), May 29, 2007

Dear Ms. Norwalk:

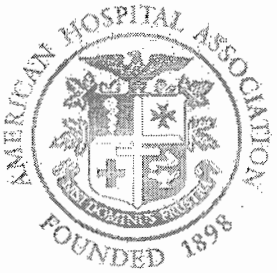
On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) submits the following comments on the Centers for Medicare & Medicaid Services' (CMS) final rule restricting how states fund their Medicaid programs and pay public hospitals.

Congress' one-year moratorium on the final rule, we believe, precludes CMS from taking action regarding this rule. As a result, the agency should withdraw the rule. However, CMS has chosen to publish the final rule and is soliciting comments on the definition of units of government while noting that it cannot move forward until May 2008. The AHA opposes CMS' policy changes set forth in the rule.

CMS' new definition of "unit of government" will determine which government hospitals and other providers are eligible to participate in funding states' non-federal share of their Medicaid programs. The new definition also will determine which providers will be subject to further restrictions on the Medicaid payments they receive.

The final rule makes the following changes from the proposed rule in the definition of "unit of government":

- **Providers with direct access to revenue**. The final rule allows providers that do not have taxing authority, but have direct access to tax revenue, to be defined as "units of government."



- **State university teaching hospitals**. The final rule recognizes state teaching hospitals with direct appropriations from the state as a "unit of government." The rule also recognizes that state university teaching hospitals that are receiving appropriated funding and provide supervised teaching experiences to graduate medical school interns and residents enrolled in a state university as providers that are operated by a unit of government.

Through these changes from the proposed rule, CMS has slightly broadened the definition of "unit of government," which may allow a few more providers to qualify as governmental. However, the underlying rationale upon which CMS has based its change to the definition of "unit of government" remains flawed. CMS continues to ignore the principles of federalism that afford states discretion in structuring their political subdivisions, and will impose substantial harm on our public hospitals.

ANALYSIS OF AND RESPONSES TO PUBLIC COMMENTS – "UNIT OF GOVERNMENT" DEFINITION SECTION 433.50

CMS continues to base its definition of "unit of government" on a subsection of the Medicaid statute regarding provider donations and taxes, which, in fact, define the distinct and more narrow term "unit of *local* government." The AHA, in this letter, reiterates the arguments outlined in our March 15 comment letter on the proposed rule regarding the definition of "unit of government."

CMS defines 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 this final 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 "taxing authority or direct access to tax revenues." There is no basis for this restriction in the Medicaid statute.

In fact, CMS acknowledges in the final rule that the term "unit of government" is not specifically defined in the statute. CMS uses the definition of a different term, "unit of local government," in section 1903(w)(7)(G) of the *Social Security Act* as the basis for its proposed definition of the term "unit of government." CMS' rationale for this approach is the agency's consideration of the "characteristics generally shared by the entities specifically referenced in the statute" and the statute's "underlying intent."

CMS uses circular reasoning to justify its decision. Without explanation or support, the agency concludes that taxing authority is the "shared" characteristic of the entities in section 1903(w)(7)(G) of the Act as well as the "underlying intent" of Congress in section 1903(w)(6)(A) of the Act. CMS then explains in the final rule that, in order for the statute to be implemented consistently, it must read a link to taxing authority in both the definition of "unit of government" and "unit of local government."

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."[1] 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 intergovernmental transfers (IGT), 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 final rule on the wrong statutory definition, but 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." CMS is proposing to limit the definition of a "unit of government" to entities that have taxing authority or direct access to tax revenues. This approach appears to be the agency's interpretation of the "overall statutory rationale" and its reading of "the statutory definition of governmental entities to require certain common qualities, such as taxing authority, or the ability to directly access tax funding." The AHA respectfully disagrees with this characterization of the statute's plain language.

The definition of "unit of government" in section 1903(w)(7)(G) does not include the words "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 "taxing authority."

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[1] *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 our nation's public hospitals. 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 final 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

Submitter : Nancy Linehan **Date:** 07/13/2007

Organization : NYS Dept. of Health

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-FC-17-Attach-1.WPD

CMS-2258-FC-17-Attach-2.WPD

#17

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

July 13, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-FC
P.O. Box 8014
Baltimore, MD 21244-8014

To Whom It May Concern:

On March 16, 2007, the State submitted comments on the Centers for Medicare & Medicaid Services' (CMS's) proposed Medicaid financing rule published in the January 18, 2007, Federal Register, which added 42 CFR sections 447.206 and 447.207 and modified 42 CFR sections 433.50, 433.51, 447.271, 447.272, 447.321, 457.220, and 457.628. The State's comments regarding the proposed rule apply equally to all aspects of the final rule, which was published in the May 29, 2007, Federal Register.

CMS is inviting further comments solely on the "Unit of Government" definition (42 CFR 433.50) in the final regulation. Providers meeting this definition are considered public entities that may: (1) use certified public expenditures (CPEs) for Medicaid claiming and (2) transfer funds to state and local governments in support of the non-federal share of Medicaid and S-CHIP expenditures. The final regulation is slightly modified, but it continues to require such providers to have taxing authority or be an integral part of a unit of government with taxing authority that is legally obligated to fund the health care provider's expenses, liabilities and deficits. The State stands by its original opposition to this rule, for the same reasons as were articulated in our comments to the proposed regulation, which are repeated below:

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

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

- The requirement that states and public providers complete and submit answers to questionnaires to determine whether they meet CMS's definition of "unit of government" is an administrative and financial burden. In place of these requirements, the State recommends that CMS require certifications and assurances from providers and state and local governments regarding their governmental status. Further, the State believes the Federal Government should fund one hundred percent of all costs associated with any new mandate.

Questions regarding these comments may be addressed to John E. Ulberg, Jr., of my staff, at (518) 474-6350.

Sincerely,

Deborah Bachrach

Deborah Bachrach
Deputy Commissioner
Office of Health Insurance Programs

Submitter : Mr. Larry Gage **Date:** 07/13/2007

Organization : NAPH

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Unit of Government Definition

Unit of Government Definition

See Attachment

CMS-2258-FC-18-Attach-1.DOC

#18

National Association of Public Hospitals and Health Systems

1301 Pennsylvania Avenue, NW
Suite 950
Washington, DC 20004
202 585 0100 tel / 202 585 0101 fax
www.naph.org

July 13, 2007

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

Re: Comments on Unit of Government Definition (§ 433.50) contained in CMS–2258–FC: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748 (May 29, 2007).

Dear Ms. Norwalk:

The National Association of Public Hospitals and Health Systems (NAPH) writes to convey its continued serious concerns regarding the Centers for Medicare and Medicaid Services' (CMS) proposed definition of a unit of government under 42 C.F.R. § 433.50 as published in CMS-2258-FC (the Final Rule). The Final Rule does not fundamentally change the most damaging provisions of CMS-2258-P (the Proposed Rule) to which NAPH and a diverse group of other commenters expressed considerable opposition. ***NAPH reiterates its strong request that CMS withdraw the entire Final Rule, including the definition of a unit of government.***

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, receiving on average 35% of their net revenues from Medicaid, and for many of the more than 46 million Americans without insurance. Our hospitals represent only 2 percent of the acute care hospitals in the country but provide 25% of the uncompensated hospital care.

As you know, Congress has prohibited CMS from taking any steps to implement this rule until May 25, 2008.[1] NAPH does not believe that CMS has the authority to receive or review comments during the period of the legislative moratorium, and therefore submits

[1] Pub. L. No. 110-28, § 7002.

this letter under protest. If the moratorium does expire without further action from Congress, we believe that the public should be permitted a fresh opportunity to comment on the definition of a unit of government based on circumstances in effect at that future time.

Furthermore, if the moratorium expires without further Congressional action, CMS must take into consideration Congress' intent in enacting the moratorium when implementing the effective dates outlined in this Final Rule. The moratorium provides a clear indication that Congress views the issues raised by the rule as being within the legislative domain and intends to address these issues itself. Congress was clearly concerned about CMS implementation of the regulation. An overwhelming bipartisan majority of Congress (65 Senators and 263 members of the House) has gone on record in opposition to the regulation since its release in proposed form in January 2007. The legislative moratorium passed Congress with significant bipartisan support.

In rushing to submit the Final Rule to the Office of the Federal Register *after* Congress had already approved a legislative moratorium and just hours before the President signed it into law, CMS deliberately defied clear Congressional intent to prevent implementation from moving forward and allow Congress to consider the issues raised. When Congress passed the moratorium, the regulation was in proposed form; before it could become effective, the regulation would have needed to be finalized and sixty days would have had to elapse after publication.[2] CMS' clever administrative timing should not undo what Congress thought it had accomplished– providing a year for it to consider alternatives to the regulation, followed (if necessary) by an additional sixty days for Congress to consider whether to reject a final regulation through the procedures outlined in the Congressional Review Act (CRA).[3] Following Congressional intent, no provision of the regulation should become effective prior to sixty days after the moratorium expires. Moreover, States cannot be expected to take any steps before May 25, 2008 towards implementing a regulation that is unlikely to go into effect in its current form.

As solicited in the Final Rule, NAPH and its member hospitals provide the following comments to continue to urge CMS to reconsider its new definition of a unit of government. Despite the significant concerns raised in the hundreds of comment letters submitted in response to the Proposed Rule, CMS has not fundamentally altered this new definition. NAPH's previous comment letter laid out in extensive detail the flawed legal and policy assumptions underlying the proposed imposition of a narrow and inappropriate definition on States, and our concerns continue to apply in large part to the revised definition. We therefore are attaching our previously-submitted comments to this letter in the hopes that CMS will reconsider this ill-advised approach. Specifying any definition of a unit of government would usurp the traditional authority of States to identify their own political subdivisions, exceed the authority provided in the Medicaid statute, and undermine past and future efforts to date by States to make units of government more efficient and less reliant on public tax dollars.

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[2] Congressional Review Act § 801(a)(3), 5 U.S.C. § 801(a)(3)(2006).
[3] *Id.* §§ 801-808.

The comments in this letter focus on the modifications to the unit of government definition between the Proposed and Final Rules. Our comments center around five themes:

1. The modifications of the unit of government definition are insufficient to address the legal and policy concerns underlying the original proposal.

2. Allowing States only to make an initial determination of the governmental status of their providers based on the CMS form does not show adequate deference to State law interpretations of governmental status.

3. CMS does not adequately acknowledge the burden of identifying all governmental providers within 90 days.

4. CMS's clarification regarding the scope and prospective application of the unit of government definition is appropriate.

5. CMS should acknowledge the impact of the one-year moratorium on the effective dates of the provisions of the Final Rule and ensure adequate time for Congressional review and State and provider compliance.

We elaborate on each of these points below.

1. The modifications of the unit of government definition are insufficient to address the legal and policy concerns underlying the original proposal.

In the Final Rule, CMS modified the definition of a "unit of government" included in the proposed regulation in a manner that will allow an undetermined number of additional entities to qualify as governmental, including certain teaching hospitals and Indian tribes. The modifications adopted by CMS merely tinker around the edges of the definition and do not address the underlying fundamental flaws of CMS' attempt to impose a uniform and restrictive Federal definition on States.

a. CMS has impermissibly narrowed the statutory definition

Notwithstanding the changes made in the final regulation, CMS has still impermissibly sought to impose a narrow definition of a unit of government that is inconsistent with the statutory definition at Section 1903(w)(7)(G) of the Social Security Act.[4] The Medicaid statute defines the term "unit of local government" to mean "with respect to a State, a city, county, special purpose district, or other governmental unit in the State."[5] The Final Regulation defines it as these same types of entities but narrows the universe of units of government by requiring the entity to meet further criteria in order to qualify – the entity must also have "direct access to tax revenues, [be] a State university teaching hospital

[4] 42 U.S.C. § 1396b(w)(7)(G).
[5] *Id.*

with direct appropriations from the State treasury, or [be] an Indian tribe...."[6] While the Final Rule expands the definition to include entities with direct access to tax revenues, State university teaching hospitals and Indian tribes, the definition is still significantly more narrow than that adopted by Congress, and would still impermissibly exclude a wide range of entities that are clearly governmental under State law but that do not have direct access to tax revenues or otherwise meet CMS' additional criteria. The statutory definition includes an undefined catchall category of "other governmental unit[s] in the State," indicating Congress' recognition of the wide variety of structures into which a State may subdivide itself. The Final Rule continues to override the statutory deference granted to various forms of units of government and imposes a single, narrow Federal standard.

b. State University Teaching Hospitals May Be Units of Government without Direct Appropriations

NAPH supports CMS' recognition that State university teaching hospitals are included in the definition of a unit of government, but believes that CMS has not gone far enough. As with other governmental hospitals, State university teaching hospitals have been established through (or in some cases converted to) a wide variety of organizational structures, many of which would not meet CMS' narrow definition of a unit of government. Some of these governmental teaching hospitals receive direct appropriations, some do not. Some are considered units of government by States, while others are not. There is no statutory basis for requiring the receipt of appropriations as a prerequisite to being governmental. The reference to "funds appropriated to State university teaching hospitals" in the statute does not appear in the section defining a unit of government; it is included as an example of the types of protected funds that the Secretary may not restrict from use as the non-Federal share. The Medicaid statute requires CMS to defer to States in determining which State university teaching hospitals should be defined as governmental.

c. The addition of "direct access to tax revenues" to the proposed definition is one of form, not substance.

CMS has proposed to include in the "unit of government" definition at 42 C.F.R. § 433.50(a)(1)(i) entities that do not have taxing authority but do have "direct access to tax revenues" of a related unit of government. This change does not, however, substantively expand the universe of health care providers that would be considered governmental, as the definition in the Proposed Rule had already regarded providers with such direct access to tax revenues as "operated by" units of government and therefore considered units of government under § 433.50(a)(1)(ii). This modified regulation in the Final Rule therefore does not provide any additional flexibility to include a broader group of public providers, and NAPH continues to object to CMS' proposed definition as impermissibly narrowing the statutory limitation on units of government.

[6] 42 C.F.R. §433.50(a)(1)(i) (as included in the Final Rule).

d. CMS' deviation from a narrow unit of government definition with respect to Indian tribes should be extended to all entities

NAPH supports the inclusion of all Indian tribes regardless of taxing authority in the definition of a unit of government. We note, however, that there is no statutory basis for treating Indian tribes any differently from other entities that are units of government under State law, and CMS does not attempt to base its exception on any statutory language. Rather, CMS appears to have adopted an expansive and deferential unit of government definition for Indian tribes based solely on its policy preferences. We agree with the policy choices adopted by CMS for Indian tribes. We submit, however, that CMS' recognition that its proposed definition was too narrow an interpretation of the statute with respect to Indian tribes is simply more evidence that Congress did not intend such a narrow definition in the first place.

2. Allowing States only to make an initial determination of the governmental status of their providers based on the CMS form does not show adequate deference to State law interpretations of governmental status.

CMS acknowledged receiving many comments that the creation of a new Federal regulatory standard to determine which public entities within a State are considered to be "units of government" violates the Federal-State partnership of the Medicaid program and the principles of federalism on which it rests. CMS' response, however, was not to defer to State interpretations, but instead to require that States make the initial determination of the governmental status of their providers subject to the proposed narrow definition and final agency review. If CMS disagrees with the State's determination, the State will be considered out of compliance with Federal statutory and regulatory criteria and may be subject to denial of Medicaid reimbursement, State plan amendments, and/or disallowances of claims for Federal financial participation.

Congress' statutory definition of a unit of government affords due deference to States' determinations of which of their instrumentalities are governmental, as required by Constitutional principles of federalism. CMS shows no such deference by nominally allowing States to make the initial determination but requiring them to do so according to restrictive Federal criteria and with the possibility of their determination being overturned by CMS. The proposed definition continues to be an unprecedented intrusion into the core of States' rights to organize themselves as they deem necessary.

3. CMS does not adequately acknowledge the burden of identifying all governmental providers within 90 days.

In the preamble to the Final Rule, CMS newly requires each State to report its universe of governmentally-operated health care providers with the first quarterly expenditure report due ninety (90) days after the effective date of the regulation. Multiple commenters noted in response to the Proposed Rule that for some health care providers, completion of the form may require extensive legal research and analysis. NAPH underscores this point given the proposed deadline for States to submit the list. Whether an entity has "direct

access to generally applicable tax revenues," whether it is an "integral part" of a "unit of government with taxing authority," whether the unit of government is "legally obligated" to fund the provider's "expenses, liabilities, and deficits," and whether a "contractual arrangement with the State or local government" is the "primary or sole basis for the health care provider to receive tax revenues" are often extremely complex questions under State law, requiring constitutional, statutory, regulatory, administrative and case law research. In many cases the answers are not clear-cut, and they are sometimes contradictory. States and their lawyers will be required to make judgment calls, balancing factors that do not all point in the same direction. To the extent that there are many governmental providers (or potential governmental providers) in a State, the burden of making these determinations could be substantial. Considering the potential complexity of this determination, and that CMS may be issuing additional guidance on use of the "Tool to Evaluate the Governmental Status of Heath Care Providers" form as warranted, States may have difficulty in completing these determinations within the required timeframe.[7]

NAPH believes that ninety days (90) is entirely insufficient to accurately identify all governmental providers. Furthermore, as explained in more detail in Comment 5, CMS should not require or expect States to expend the time and resources necessary to do so during the period of the legislative moratorium. Given the expressed intent of Congress to override at least portions of the regulation, States cannot be expected to take any steps before May 25, 2008 towards implementing a regulation that is unlikely to go into effect in its current form.

4. CMS' clarification regarding the scope and prospective application of the unit of government definition is appropriate.

NAPH supports CMS' clarification in the Final Rule that the new definition of unit of government will be applied prospectively only.

NAPH further appreciates CMS' clarification that the proposed definition of a unit of government is limited to the purposes of financing the non-Federal share of Medicaid payments and application of a Medicaid upper payment limit on such governmental health care providers, and is not intended to otherwise alter Federal or State law interpretations of public or governmental status.

5. CMS should acknowledge the impact of the one-year moratorium on the effective dates of the provisions of the Final Rule and ensure adequate time for Congressional review and State and provider compliance.

Although CMS has not specifically solicited comments on the effective dates of the various provisions of the regulation, given the enactment of a Congressional moratorium on implementation of the regulation within hours of the issuance of the Final Rule, NAPH believes it important to address the impact of the moratorium on the effective

[7] Of course, given the Congressional moratorium on implementation of the regulation, CMS should not expect states to begin to undertake this analysis during the period in which the moratorium is in effect.

dates outlined in the rule. The moratorium prohibits the Secretary of Health and Human Services from taking "*any action* (through promulgation of regulation, issuance of regulatory guidance, *or other administrative action)*" to finalize or "otherwise implement" the Proposed Rule or any "rule or provisions" similar to those in the Proposed Rule.[8]

Congress' concern about implementation of the regulation could not be clearer. Since the proposed Medicaid rule was released in January 2007, an overwhelming bipartisan majority of Congress (65 Senators and 263 members of the House) has gone on record in opposition to it. The moratorium passed Congress with significant bipartisan support. Furthermore, the legislative history of the moratorium provides clear indication that Congress views the issues raised by the rule as legislative domain and intends to address these issues itself during the period of the moratorium. For example, Senator Richard Durbin, Assistant Majority Leader of the Senate and one of the prime sponsors of the moratorium, stated that "the purpose of this amendment is simply to declare a moratorium on this new rule until we can put together this new approach through the Finance Committee."[9] Senator Max Baucus, Chair of the Senate Finance Committee, also suggested that "[i]t is Congress's job to make major changes to the law. A 1-year moratorium will give the Finance Committee enough time to study this issue and determine the right approach."[10] Senator Charles Grassley, Ranking Member of the Finance Committee, stated "If some people think CMS has gone too far, then we should review their actions in the Finance Committee. . . If we think there are things we should have done differently, then we should legislate."[11] Indeed, Sen. Grassley voiced specific concern about the definition of governmental provider and suggested that these concerns should be dealt with in the Finance Committee.[12] In rushing to submit the Final Rule to the Federal Register office *after* Congress had already approved the moratorium and just hours before the President signed it into law, CMS deliberately defied clear Congressional intent to slow down the implementation of the regulation and allow Congress to consider the issues raised.

Notwithstanding CMS' rush toward implementation, Congress' intent in enacting the moratorium must be taken into consideration in implementing the effective dates outlined in the Final Rule. Congress has clearly stated that it does not want implementation of the regulation to move forward in any way during the period of the moratorium. That intent must be respected if the moratorium should expire without further Congressional action.

a. If Congress takes no further action, CMS should provide at least 60 days after the moratorium expires before the provisions of the Final Rule take effect.

When Congress passed the moratorium, the regulation was in proposed form; it would have needed to be finalized and sixty days would have had to elapse before any portion of

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[8] Pub. L. No. 110-28, § 7002 *(emphasis added).*
[9] 153 Cong. Rec. S4026 (Mar. 28, 2007).
[10] 153 Cong. Rec. S5138 (Apr. 26, 2007).
[11] 153 Cong. Rec. S4020 (Mar. 28, 2007).
[12] *Id.*

it could become effective.[13] CMS waited until after final Congressional action on the moratorium but before the President signed the legislation to issue the Final Rule. CMS' clever administrative timing, however, should not undo what Congress thought it had accomplished through the moratorium – providing a year for it to consider alternatives to the regulation, followed (if necessary) by an additional sixty days for Congress to consider whether to reject any final regulation through the procedures outlined in the CRA.[14] At a minimum, no provision of the regulation should become effective prior to sixty days after the moratorium expires.

A sixty day period is the minimum that should be afforded to States to come into compliance as well.[15] Given the existence of the moratorium and the expressed intent of Congress to override at least portions of the regulation, States cannot be expected to take any steps before May 25, 2008 towards implementing a regulation that is unlikely to go into effect in its current form. Furthermore, to the extent that States or providers may require further clarifications from CMS in order to do so (as CMS acknowledges may be necessary related to the form for determining governmental provider status[16]), such guidance cannot be made available until after the end of the moratorium. Basic principles of fairness require CMS to provide a time period after the end of the moratorium before this Final Rule would take effect.

b. The comment period related to the new definition of a unit of government should not begin until after the moratorium expires.

The language of the moratorium clearly prohibits CMS from taking "any action (through promulgation of regulation, issuance of regulatory guidance, or *other administrative action*)" to implement any provisions of this rule.[17] NAPH believes that accepting comments on the definition of unit of government is an "administrative action" prohibited by this language. If the moratorium were to expire without further legislation by Congress, the 45-day comment period should begin on May 25, 2008. Furthermore, it is consistent with the underlying principles of notice and comment rulemaking that the public should be permitted a contemporaneous opportunity to comment based on circumstances in effect at that future time. CMS should initiate a new comment period for the unit of government definition upon expiration of the moratorium.

c. The effective date of the cost limit violates the CRA and should be postponed until at least rate year 2010.

The Final Rule indicates that institutional governmentally-operated health care providers must comply with the Medicaid cost limit beginning with the Medicaid State plan rate year 2008. Even absent the moratorium, it is clear that this compliance date violates the

[13] Congressional Review Act § 801(a)(3), 5 U.S.C. § 801(a)(3)(2006).
[14] *Id.* §§ 801-808.
[15] NAPH believes that sixty days is far too short of a time for states to come into compliance with many of the provisions of the regulation, as discussed in our comments to the Proposed Rule.
[16] 72 Fed. Reg. 29748, 29764-65 (May 29, 2007).
[17] Pub. L. No. 110-28, § 7002 (*emphasis added*).

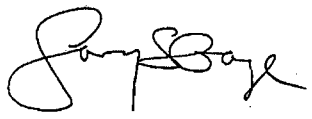
CRA. Section 801(a)(3) of the CRA states that the earliest that a rule may be effective is sixty (60) days from publication.[18] Since the Final Rule was published on May 29, 2007, the earliest it could be effective under the CRA (moratorium aside) is July 30, 2007. In most States, the State plan rate year 2008 begins July 1, 2007 (i.e., prior to July 30, 2007). To the extent that the Final Rule requires compliance as of rate year 2008, the cost limit provision of the Final Rule clearly violates CRA requirements.

Furthermore, if the legislative moratorium expires on May 25, 2008 without further Congressional action, we believe (as explained above) that the regulation could not become effective until 60 days thereafter (or July 24, 2008), which will be after the beginning of rate year 2009 for most States. As a practical matter, therefore, given all of the steps that States need to take to prepare for the implementation of a cost limit (including developing new or modifying existing cost reports, adopting State plan amendments, making changes to their State budgets, etc.) it would be inappropriate to implement the cost limit for institutional providers prior to rate year 2010 (or the first rate year that begins after sixty days after the expiration of the moratorium). With respect to non-institutional providers, the cost limit should be implemented one year after the implementation for institutional providers. Again, basic principles of fairness require that CMS provide States with the time necessary to come into compliance.

* * *

NAPH appreciates the opportunity to submit these additional comments and to reiterate our strong opposition to the provisions of this Final Rule. If you have any questions, please contact Barbara Eyman, Charles Luband or Sarah Mutinsky of NAPH counsel Powell Goldstein at (202) 347-0066.

Respectfully,



Larry S. Gage
President

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[18] 5 U.S.C. § 801(a)(3) (2006).

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
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March 8, 2007

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

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

Dear Administrator Norwalk:

The National Association of Public Hospitals and Health Systems (NAPH) is pleased to submit the attached comments expressing our serious concern about the devastating impact of the above-referenced Proposed Rule on the nation's health system. 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.

We strongly believe 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 this 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.

In 2000, the Institute of Medicine issued a landmark report, *America's Health Care Safety Net: Intact but Endangered*, which recommended that, "Federal and state policy makers should explicitly take into account and address the full impact (both intended and unintended) of changes in Medicaid policies on the viability of safety net providers and the populations they serve." Last fall, the IOM reconvened the commission that produced the report and emphatically restated the findings and recommendations from 2000. Even without the Proposed Rule, the situation of the health safety net is more fragile than ever.

The attached NAPH comments detail many specific concerns about the Proposed Rule. However, please be aware that our primary recommendation is that CMS withdraw the Proposed Rule and work with the Congress and with state and local stakeholders to develop policy alternatives that would strengthen -- not undermine -- the nation's health safety net (and with it, the entire health system).

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

Respectfully,

President

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
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March 8, 2007

COMMENTS BY THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS 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

Prepared on behalf of NAPH by Powell Goldstein, LLP

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

NAPH endorses CMS' stated goal of ensuring accountability and protecting the fiscal integrity of the Medicaid program. Over the years, Congress and CMS have taken a series of steps to advance these goals with respect to both provider payments and non-federal share financing. These efforts have included restrictions on provider taxes and donations, statewide and hospital-specific limitations on Disproportionate Share Hospital (DSH) payments and a series of modifications to regulatory upper payment limits. All of these steps were taken by or with the consent of Congress.

Over the last three years, CMS has significantly increased its oversight of payment methodologies and financing arrangements in state Medicaid programs, working with states to restructure their programs as necessary to eliminate inappropriate federal matching arrangements. Officials from the Department of Health and Human Services (HHS) have repeatedly claimed success from this initiative, stating that they have largely eliminated "recycling" from those programs under scrutiny. Indeed, since the publication of the Proposed Rule, it is our understanding that CMS provided to Members of Congress data indicating that its efforts have been enormously successful, with 22 states listed as using intergovernmental transfers (IGTs) appropriately, 30 listed as having removed

"recycling" from their programs and 23 with no IGT financing.[19] According to these data, there are only three states about which CMS has any remaining concerns. Clearly the steps taken by Congress and CMS to date have addressed the concerns CMS has raised about state financing mechanisms and it is unclear why CMS feels the need to proceed with this rulemaking. Nor does the agency explain how the restrictive policies in the Proposed Rule will further its stated goals. Instead, the Proposed Rule imposes payment and financing policies that go far beyond merely institutionalizing the oversight procedures CMS has used successfully to date. These policies would cut deep into the heart of Medicaid as a safety net support program with no measurable increase in fiscal integrity.

In its Regulatory Impact Analysis, CMS asserts that the Proposed Rule will not have a significant impact on providers for which relief should be granted, and it projects "this rule's effect on actual patient services to be minimal."[20] It estimates $3.9 billion in federal savings from the Proposed Rule over five years, but provides no detail on how it derived this estimate. From NAPH's survey of its own members, it is clear that CMS has significantly understated the impact of the Proposed Rule on providers, on patients and on total federal Medicaid funding provided to states. Although we do not have sufficient nationwide data to estimate the total amount of funding cuts imposed by the Proposed Rule, data from just a few NAPH members and states illustrates how grossly understated CMS' projections of the impact are.

For example, Florida estimates that its hospitals will lose $932 million. The estimated statewide loss of federal dollars is at least $253 million in Georgia, at least $350 million in New York and is $374 million in Texas. These state programs are not ones that CMS has identified as abusive; on the contrary, CMS has reviewed these hospital payment and financing programs and approved them as legitimate. Despite their current legitimacy, the Proposed Rule will cut payment rates and eliminate approved sources of non-federal share funding in each of these programs. As a result, safety net health systems' ability to serve Medicaid and uninsured patients will be compromised and state Medicaid programs will face substantial budget shortfalls with no apparent gain in fiscal integrity. Moreover, CMS would impose these cuts immediately, effective September 1, 2007, providing no time for state legislators to overhaul their program financing to come into compliance with the new requirements.

CMS's response to concerns about lost funding for important health care needs is that it is Congress' job to determine whether such federal support is needed. NAPH respectfully submits that Congress has already determined that such federal support is needed and that states may use their Medicaid programs to provide it. Above-cost Medicaid payments based on Medicare rates have been part of the Medicaid payment

[19] *Summary of State Use of IGTs and Recycling,* as of 11/14/06. Several states are listed in more than one category as they have structured different IGT programs for different types of services.
[20] 72 Fed. Reg. at 2245.

system for years. Congress has explicitly rejected CMS' proposals to impose provider-specific cost-based payment limits;[21] it has required the adoption of regulations with aggregate rather than provider-specific limits;[22] it long ago freed states from mandatory cost-based payment systems to allow for the proliferation of payment systems more tailored to localized needs;[23] and it has acquiesced with no expressed concern in the development of supplemental Medicaid payment systems in which states have used the Medicaid program as the primary source of federal support for safety net health care. If Congress is the only entity that can authorize replacement funding, then Congress should also be the entity to consider the types of sweeping payment and financing changes that CMS proposes.

In the wake of President Bush's FY 2007 budget proposal to restrict funding and payment flexibility by regulation, a substantial majority of the House and Senate went on record urging the Administration not to move forward administratively. Members of the 110th Congress have had a similar response. The National Governors Association has also expressed its deep concern about the impact of the Proposed Rule on the governors' ability to implement health reform options and expand affordable health insurance coverage. Given the overwhelming bipartisan opposition to this Proposed Rule and the means by which it is being adopted, CMS should withdraw its proposal immediately.

After a brief summary in the first section, the second section of these comments raises significant legal and policy concerns about three major aspects of the Proposed Rule:

- The limit on payments to governmental providers to the cost of Medicaid services;
- The definition of a unit of government; and
- The restriction on sources of non-federal share funding;

Thereafter, we raise several technical concerns, comments and questions about various aspects of the Proposed Rule, and comment on CMS' Regulatory Flexibility Act analysis.

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[21] Budget of the United States Government, Fiscal Year 2005, pages 149-150; Budget of the United States Government, Fiscal Year 2006, page 143; Letter from Michael O. Leavitt, Secretary of Health and Human Services, to the Honorable Richard B. Cheney, President, United States Senate, August 5, 2005 (transmitting legislative language to Senate implementing the fiscal year 2006 proposals); Letter from Michael O. Leavitt, Secretary of Health and Human Services, to the Honorable J. Dennis Hastert, Speaker of the House of Representatives, August 5, 2005 (transmitting legislative language to House of Representatives implementing the fiscal year 2006 proposals). Congress has rejected each of these proposals.

[22] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), H.R. 5661, 106th Cong., (enacted into law by reference in Pub. L. No. 106-554, § 1(a)(6)), Section 705(a).

[23] Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173.

I. SUMMARY OF COMMENTS

NAPH's major concerns about the Proposed Rule center around (1) the cost limit on Medicaid payments to governmental providers, (2) the new and restrictive definition of a "unit of government" and (3) the restrictions on sources of non-federal share funding.

The cost limit would impose deep cuts in funding for the health care safety net, with serious repercussions on access and quality for low-income Medicaid and uninsured patients. The cuts would not result in any measurable improvement in the fiscal integrity of the Medicaid program. Cost-based payments and limits are inherently inefficient, rewarding providers with high costs. The current upper payment limits, based on what Medicare would pay for the same services and calculated in the aggregate for each category of hospital, are reasonable (Medicare does not pay excessive rates) and allows states appropriate flexibility to target support to communities and providers where it is most needed.

Moreover, governmental providers, who disproportionately serve the uninsured, should not be subject to a more restrictive limit than private providers. Imposing a cost limit would undermine important policy goals shared by the Administration and providers alike – such as quality, patient safety, emergency preparedness, enhancing access to primary and preventative care, reducing costly and inappropriate use of hospital emergency departments, adoption of electronic medical records and other health information technology and reducing disparities. Finally, the cost limit would violate federal law in at least four respects. First, it will prevent states from adopting payment methodologies that are economic and efficient and that promote quality and access in contravention of Section 1902(a)(30)(A) of the Social Security Act (SSA); second, it defies simplicity of administration and ignores the best interests of Medicaid recipients that states are required to safeguard pursuant to Section 1902(a)(19); third, it would violate Section 705(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 by adopting upper payment limits that are not based on the proposed rule announced on October 5, 2000; and fourth, it would prohibit states from adopting prospective payment systems for their governmentally-operated federally qualified health centers and rural health clinics as required by Section 1902(bb) of the SSA. CMS should not modify the current upper payment limits.

We also believe that CMS does not have the authority to redefine a "unit of government." The statutory definition contained in Section 1903(w)(7)(G) of the SSA does not limit the term to entities that have taxing authority. CMS is far exceeding its authority in placing such a significant restriction on the much broader definition adopted by Congress. Congress' definition afforded due deference to states' determination of which of its instrumentalities are governmental, as required by Constitutional principles of federalism. CMS' proposed definition is an unprecedented intrusion into the core of states' rights to organize themselves as they deem necessary. The definition also undermines the efforts

of states and localities to carry out a core governmental function (ensuring access to health care) through the most efficient and effective means. Countless governments have organized or reorganized public hospitals into separate governmental entities in order to provide them with the autonomy and flexibility to deliver high quality, efficient health care services in an extremely competitive market, yet the Proposed Rule would not recognize such structures as governmental. CMS should defer to state designations of governmental entities.

In asserting that intergovernmental transfers (IGTs) can only be derived from tax revenues, the preamble to the Proposed Rule ignores the much broader nature of public funding. States, local governments and governmental providers derive their funding from a variety of sources, not just tax proceeds, and such funds are no less public due to their source. Limiting IGTs to tax revenues will deprive states of long-standing funding sources for the non-federal share of their programs, leaving them with significant budget gaps that can only be filled by diverting taxpayer funds from other important priorities or cutting their Medicaid programs. Moreover, CMS does not have authority to restrict local sources of funding under Section 1902(a)(2) of the SSA without explicit congressional authorization to do so. CMS should allow all public funding, regardless of its source, to be used as the non-federal share of Medicaid expenditures.

NAPH also raises several more technical issues and concerns about the regulation. Our recommendations in this regard include:

Cost Limit

- CMS should clarify that the limit based on the "cost of providing covered Medicaid services to eligible Medicaid recipients" does not exclude costs for disproportionate share hospital payments or payments authorized under Section 1115 demonstration programs.
- The definition of allowable costs should not be restrictive and should include all costs necessary to operate a governmental provider.
- CMS should confirm that graduate medical education costs would be allowable.
- CMS should clarify that the cost limit applies only to institutional governmental providers and not professional providers that may be employed by or affiliated with governmental entities.
- CMS should allow states to calculate the cost limit on a prospective basis.
- CMS should allow states to make direct payments to governmental providers for unreimbursed costs of serving Medicaid managed care enrollees.

Unit of Government Definition

- CMS should eliminate the requirement that units of government have taxing authority and should defer to state law determinations of public status.
- CMS should clarify that it is not altering federal or state law interpretations of public status outside of the provisions of the Proposed Rule.

Certification of Public Expenditures

- CMS should allow the use of certified public expenditures (CPEs) to finance payments not based on costs.
- CMS should confirm the mandatory and permissive nature of various steps in the reconciliation process.

Retention of Payments

- CMS should clarify whether the retention provision applies to CPEs.
- CMS should eliminate the provision providing authority for the Secretary to review "associated transactions."

Section 1115 Waivers

- CMS should clarify that states may maintain current levels of funding for the safety net care pools, low income pools and expanded coverage established through Section 1115 demonstration projects notwithstanding the new cost limit.
- CMS should clarify that other states may use waivers to adopt similar pools or coverage based on savings incurred by reducing governmental payments to cost.

Upper Payment Limit (UPL) Transition

- CMS should revise the regulation to ensure that it has no impact on transition payments made pursuant to upper payment limit regulations revised in 2001 and 2002.

Provider Donations

- CMS should clarify that it will not view transfers of taxpayer funding as provider donations.

Effective Date

- CMS should extend the effective date of the regulation and provide at least a ten-year transition period.
- CMS should clarify that all parts of the regulation will be imposed prospectively only.

Consultation with Governors

- CMS should immediately consult with states on the Proposed Rule and modify or withdraw it based on state concerns.

Finally, NAPH believes that in its Regulatory Flexibility Act analysis, CMS has seriously underestimated the impact that the Proposed Rule will have. The Proposed Rule will impose significant costs on states and providers in connection with new administrative burdens it establishes. The cost to states of developing new payment systems, adopting new financing mechanisms to pay for the non-federal share, developing new cost reporting systems and administering and auditing them will be significant. The cost to providers of complying with these new requirements is also substantial. More importantly, however, CMS vastly understates the direct and significant impact that the Proposed Rule will have on patient care, as providers and states struggle to cope with multi-million dollar funding cuts. In addition, the Proposed Rule will negatively impact local economies that are built around providers affected by this regulation. CMS should reevaluate its estimate of the impact of the Proposed Rule and the need for regulatory relief under the Regulatory Flexibility Act.

II. MAJOR LEGAL AND POLICY CONCERNS

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

NAPH objects to the new cost limit on Medicaid payments to government providers under the Proposed Rule on a number of grounds.

1. *The cost limit under the Proposed Rule imposes deep cuts in safety net support without addressing financing abuses.*

Rather than adopting a narrowly tailored solution to identified concerns with inappropriate Medicaid financing practices, CMS proposes to impose a cost limit on governmental providers that is simply a straightforward funding cut. According to CMS' own data, it has largely eliminated the "recycling" that the cost limit purports to address. Even if recycling were occurring, however, a cost limit would not eliminate it; it would simply limit the net funding for governmental providers. Yet the regulation grossly overreaches by imposing the restrictive limit for governmental providers in states that

have removed or never relied on inappropriate financing arrangements. In these cases, the new limit imposes a deep cut to rectify a non-existent problem.

2. The cost limit imposes inappropriate and antiquated incentives and unnecessary new administrative burdens.

A payment limit based on costs represents a sharp departure from CMS' efforts to bring cost-effective market principles into federal health programs. Prospective payment systems are structured to encourage health care providers to eliminate excess costs by allowing them to keep payments above costs as a reward for efficiency. Increasingly, CMS is considering new payment models, which would include incentives for providing high quality care as a means to better align payment and desired outcomes. The Proposed Rule would require a return to cost-based reporting and reimbursement that is inconsistent with the efforts of Congress and CMS over the past twenty years to move away from cost-based methodologies and the inefficient incentives these methodologies entail. It would incentivize providers to increase costs and eschew efficiencies in order to preserve revenues. It would also impose enormous new administrative burdens on states and providers, as they engage in cost reconciliation processes that could last for years beyond when services are provided. The massive diversion of scarce resources into such unnecessary bureaucracy is ill-advised at a time when the demands on the health care safety net are greater than ever.

3. The Medicare upper payment limit is not excessive.

In proposing the new cost limit, and asserting that it is necessary to ensure economy and efficiency in the program, CMS is effectively stating that 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.

For many providers, Medicare reimbursement, while not excessive, is higher than the direct costs of services for Medicare patients. The prospective payment system is deliberately delinked from costs and is intended to establish incentives for providers to hold down costs by allowing them to retain the difference between prospectively set rates and their costs. Moreover, Medicare reimbursement explicitly recognizes additional costs that are incurred by some providers for public goods from which the entire community benefits, such as operating a teaching program or providing access to a disproportionate share of low income patients. The Medicare reimbursement system is not unreasonable.

Moreover, the adoption of aggregate limits within specified groups of governmental and private providers allows states sufficient flexibility to target additional Medicaid reimbursement to individual providers to achieve specified policy objectives. In the preamble to the Proposed Rule, CMS raises concerns about some governmental providers receiving payments that are higher than those for other governmental providers. But variation in payment rates across providers has been a hallmark of Medicaid payment policy since the early 1980s when Congress eliminated the requirement that providers be reimbursed based on reasonable costs and allowed states flexibility to tailor reimbursement to localized needs. Today, state Medicaid programs feature a variety of targeted supplemental payments: for rural providers, children's hospitals, teaching hospitals, public hospitals, financially distressed providers, trauma centers, sole community providers and the like. Eliminating the aggregate nature of the payment limit restricts states' flexibility to address local needs through reimbursement policies. Such action runs counter to the Administration's commitment, and Congress' efforts, to enhance state flexibility in managing their Medicaid programs.

4. Hospitals cannot long survive without positive margins.

In any competitive marketplace, no business can survive simply by breaking even, earning revenues only sufficient to cover the direct and immediate costs of the services it provides. Any well-run business needs to achieve some margin in order to invest in the future, establish a prudent reserve fund, and achieve the stability which will allow it access to needed capital. Organizations that lose money on one line of business need to make up those losses on other lines in order to survive. These fundamental business concepts are equally applicable to the hospital industry. Margins are essential to survival; they are even more essential to a community-oriented mission.

The proposed cost limit would prohibit governmental hospitals from earning any margin on their largest line of business. Moreover, governmental hospitals, as compared to the hospital industry as a whole, are much more likely to have a line of business – care for the uninsured – in which they must absorb significant losses. For example, in 2004, NAPH members provided, on average, over $76 million in uncompensated care per hospital. Their average margin that same year was a mere 1.2 percent (the industry average was 5.2 percent). Under the Proposed Rule, public hospitals still may be able to achieve a small margin on Medicare and perhaps a slightly larger margin on commercially insured patients, but these two revenue sources constitute less than 45 percent of average NAPH net revenues. With self-pay patients comprising 24 percent of NAPH members' patient populations, margins on Medicare and commercial insurance alone are not sufficient to keep these hospitals afloat if CMS denies any margin on Medicaid patients. CMS would not expect a private business to operate with revenues no greater than direct costs. It should not expect public hospitals, with their disproportionate share of uninsured patient populations, to survive and thrive under this limit.

5. *It is unreasonable to impose a lower limit on governmental providers than private providers.*

It is unclear why CMS believes that rates that the agency would continue to allow states to pay private providers under the Proposed Rule are excessive with respect to government providers. The needs of governmental providers are often significantly greater than those of private providers as they typically provide a disproportionate share of care to the uninsured and offer critical yet under-reimbursed community-wide services (such as trauma care, burn care, neonatal intensive care, first response services, standby readiness capabilities, etc.). For example, the members of NAPH represent 2 percent of the nation's hospitals but provide a full 25 percent of uncompensated hospital care. A report issued in December by the Congressional Budget Office confirmed that governmental hospitals provide significantly more Medicaid and uncompensated care and other community benefits than private hospitals.[24] Moreover, governmental providers' payer mix is markedly different from that of private providers, with greater reliance on Medicaid revenues to fund operations and a lower share of commercially insured patients on which uncompensated costs can be shifted. By cutting Medicaid reimbursement for governmental providers, the Proposed Rule would slash their primary funding source.

6. *The cost limit would have a particularly devastating effect on hospitals in low DSH states.*

Medicaid disproportionate share hospital payments help to offset some of the unreimbursed costs that hospitals incur in caring for uninsured patients, but the adequacy of DSH allotments is declining as costs climb and insurance coverage drops. As a percentage of Medicaid expenditures, DSH has fallen dramatically in the last decade, declining from 14 percent of overall Medicaid expenditures in 1993 to approximately 6 percent in 2004. As DSH falls further and further behind growing uncompensated costs, other types of supplemental payments become an even more important source of support for safety net hospitals. This is especially true for hospitals in "low DSH states," where the statewide DSH allotment is significantly lower than the hospitals' need. Yet it is these non-DSH supplemental Medicaid payments that the proposed cost limit would impact most significantly, undermining the ability of governmental hospitals to continue to provide high volumes of care to the uninsured.

7. *The cost limit undermines important public policy goals.*

At a time when the federal government is calling on providers to improve quality and access, and to invest in important new technology, now is not the time to impose unnecessary funding cuts on governmental providers. Although disproportionately reliant on governmental funding sources, NAPH members have, in recent years, made

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

significant investments in new (and often unfunded) initiatives that are in line with HHS' policy agenda.

For example, NAPH members have invested millions of dollars in adopting electronic medical records and other new information systems that have a direct impact on quality of care, patient safety and long-term efficiency, all goals promoted by HHS. Similarly, in the heightened security-conscious post-9/11 world, public hospitals have played a critical role in local emergency preparedness efforts, enhancing their readiness to combat both manmade and natural disasters and epidemics. 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. NAPH members have been at the forefront of this effort, establishing elaborate 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. (In 2004 alone, 89 NAPH member hospitals provided 29 million non-emergency outpatient visits.) HHS is striving to reduce the disparities in care provided to minority populations. With an extremely diverse patient population, NAPH members have been leaders in providing culturally sensitive and welcoming care, in providing access to translation and interpretation services, and in adopting innovative approaches to treating the specific needs of different minority groups. All of 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.

8. The proposed cost limit violates federal law.

The proposed cost limit violates section 1902(a)(30)(A) and 1902(bb) of the Social Security Act (SSA) and section 705(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).[25] CMS is therefore without legal authority to impose the limit by regulation.

Under section 1902(a)(30)(A), state Medicaid programs are required:

> to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.[26]

Many states will be unable to meet the requirements of this provision given the restrictive limits imposed by CMS. By incentivizing providers to maximize costs in order to secure a higher reimbursement limit, the proposal clearly does not promote efficiency or

[25] H.R. 5661, 106th Cong., enacted into law by reference in Pub. L. No. 106-554, § 1(a)(6) ("BIPA").
[26] 42 U.S.C. § 1396a(a)(30)(A).

economy. By removing tools to promote efficiency (such as through prospective payments systems that encourage providers to reduce costs), CMS has hampered states' ability to provide the assurances required by the statute. Similarly, the cost limit thwarts states' efforts to ensure quality of care by eliminating flexibility to provide targeted above-cost incentives to promote and reward high quality care, particularly for providers identified by the state as having particular needs or faced with unique challenges. Finally, to the extent that the cost regulation prohibits states from paying rates that they have determined are necessary to ensure access for Medicaid recipients, CMS's proposed regulation undermines the statutory requirement that states assure access to care and services at least equal to that available to the general population.

Similarly, Section 1902(a)(19) requires states to provide safeguards to assure that "care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients."[27] The Proposed Rule hinders states' ability to make both assurances. Far from streamlining administration, the regulation would require states and providers to engage in elaborate cost reporting and reconciliation processes regardless of the volume of services provided. More importantly, however, CMS' single-minded focus on limiting states' use of local dollars to fund Medicaid and in cutting payments to the largest providers (governmental providers) of Medicaid services, the Proposed Rule patently ignores the best interests of recipients. In fact, it is Medicaid recipients who will be most directly and most severely harmed by this regulation.

The proposed cost limit also ignores Congress's explicit instructions to CMS in Section 705(a) of BIPA to adopt an aggregate Medicare-related upper payment limit (UPL). Adopted shortly after CMS proposed a regulation establishing aggregate UPLs within three categories of providers – state owned or operated, non-state owned or operated and private -- BIPA required that HHS "issue ... a final regulation based on the proposed rule announced on October 5, 2000 that ... modifies the upper payment limit test ... by applying an aggregate upper payment limit to payments made to governmental facilities that are not State-owned or operated facilities." The proposed cost limit for government providers deviates significantly from Congress's clear mandate in BIPA that the upper payment limits: (1) be aggregate limits and (2) include a category of facilities that are "not State-owned or operated." The proposed regulation is provider-specific, not aggregate, and eliminates ownership as a factor in determining whether a facility is a government facility. Moreover, in requiring that the final regulation be based on the proposed rule issued on October 5, 2000, Congress explicitly endorsed the establishment of a UPL based on Medicare payment principles, not costs.

Finally, Section 1902(bb) requires states to pay for services provided by federally qualified health centers (FQHCs) and rural health clinics (RHCs) through rates that are prospectively determined (based on historical costs). FQHCs and RHCs had previously been guaranteed cost-based reimbursement under Title XIX, but through the Balanced

[27] 42 U.S.C. § 1396a(a)(19).

Budget Act of 1997, Congress began phasing out this guarantee.[28] Before the phase-out was complete, Congress stepped in again in 2000 to require a new payment methodology for FQHCs that was specifically *not* cost reimbursement.[29] This evolution of FQHC and RHC payment policy – away from cost reimbursement and towards a prospective payment system that encourages efficiency – is the most recent articulation of Congress' intent with regards to Medicaid reimbursement. The Proposed Rule would require states to reconcile prospectively made payments to public FQHCs and RHCs and to require the clinics to return any "overpayment" (payments that in retrospect turn out to be in excess of cost). This required reconciliation process is in direct conflict with Section 1902(bb).

Recommendation: CMS should retain the aggregate upper payment limits based on Medicare payment principles for all categories of providers.

B. Defining a Unit of Government (§ 433.50)

NAPH urges CMS to reconsider its proposed new definition of a "unit of government." This proposal would usurp the traditional authority of states to identify their own political subdivisions and exceed the authority provided in the Medicaid statute. The new definition would undermine efforts to date by states to make units of government more efficient and less reliant on public tax dollars.

1. CMS' restrictive definition of units of government undermines marketplace incentives to operate public providers through independent governmental entities.

More than a century ago, state and local governments began establishing public hospitals to provide health care services in their communities, including services for their most needy residents. As the health care system matured, commercial insurance evolved and the Medicare and Medicaid programs were established, public hospitals filled a unique role in serving the poor and uninsured -- patients who were often shunned by other providers. The public hospitals were typically operated as a department of the state or local government, with control over hospital operations in the hands of an elected legislative body, funding appropriated to plug deficits, surpluses reverting into the general fund of the government, and subject to sunshine laws, public agency procurement requirements, civil service systems and other local laws designed with the operations of traditional monopolistic governmental agencies such as libraries, police and fire departments and public schools in mind.

Over time, some states began authorizing local governments to establish public hospitals as separate governmental entities in recognition of the competitive market in which hospitals operate. Generic state laws authorizing local governments to create hospital

[28] *See* Balanced Budget Act of 1997, § 4712.
[29] BIPA, § 702,

authorities, public hospital districts and similar independent governmental structures began to proliferate.

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

These restructurings have taken a wide variety of forms. Many governments have created hospital authorities, with a separate governing board, appointed by elected officials and dedicated solely to governing the hospital. Other states created hospital districts, public benefit corporations or non-profit corporations engaged in a public-private partnership with the local government to operate the hospital to fulfill the governmental function of serving the health care needs of the local population. Many state university medical schools have spun off their clinical operations into a separate governmental entity for similar reasons.

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

The Proposed Rule's definition of a unit of government runs exactly counter to this decades-long trend in the provision of governmental health care. Under the Proposed Rule, only the most traditional of public hospitals would qualify as a governmental entity capable of contributing to the non-federal share of Medicaid funding. Others simply would not be deemed an "integral part" of a unit of government with taxing authority under the strict criteria set forth in the Proposed Rule.

For example, one very common feature of the restructurings is the establishment of a separate and independent budget and accounting system for the hospital, in which revenues earned by the hospital are retained by the hospital and controlled by the governing board dedicated solely to the hospital rather than automatically reverting to the government's general fund. Such fiscal independence has been viewed as critical to

establishing the necessary incentives and accountability for hospital administrators to operate efficiently, to maximize patient care revenues and to invest in new initiatives widely. Similarly, many restructured hospitals are not granted unlimited access to taxpayer support but are forced to manage to a fixed budget, which again has been viewed as furthering the goals of economy and efficiency. In short, the governmental entities that previously owned and operated these hospitals have restructured them deliberately to be both governmental and autonomous. They are governmental under state law and they remain fully accountable to the public. But they are autonomous governmental entities in that the local or state government with taxing authority is no longer legally responsible for their liabilities, expenses and deficits. For this reason, they likely would not meet CMS' new unit of government definition, even though they have retained several governmental attributes and are considered governmental under the laws of the state.

The rule would undermine the efforts of state and local governments to deliver public health care services more efficiently and effectively, and penalize those that have reduced their reliance on taxpayer support. Governments that had restructured their public hospitals deliberately to retain their nature as a governmental entity under state law, in part so that they could continue contributing to funding the non-federal share of Medicaid expenditures, will find the rules suddenly switched on them as the federal government substitutes its judgment for state law regarding whether they remain public or not. Future restructurings will likely reflect CMS' narrow definition, undermining the important public policy goals achieved through the more flexible array of structures available under state law. CMS does not appear to have contemplated the perverse incentives its restrictive definition of units of government would provide.

2. *CMS does not have statutory authority to restrict the definition of a "unit of government."*

CMS has exceeded its statutory authority in adopting a definition of a "unit of government" more restrictive than that established in Title XIX of the SSA. Section 1903(w)(7)(G)[30] defines a "unit of local government," in the context of contributing to the non-federal share of Medicaid expenditures, as "a city, county, special purpose district, or other governmental unit in the State." The Proposed Rule narrows the definition of "a unit of government" to include, in addition to a state, "a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) *that has generally applicable taxing authority.*"[31] Congress never premised qualification as a unit of government on an entity's access to public tax dollars. Rather, Congress' formulation, which includes an "other governmental unit in the State," provides appropriate deference to the variety of governmental structures into which a state may

[30] 42 U.S.C. § 1396b(w)(7)(G).
[31] Proposed 42 C.F.R. § 433.50(a)(1)(i) (emphasis added).

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

Section 1903(w)(7)(G) is not the only section of Title XIX which evidences a Congressional intent to allow states to determine which entities are political subdivisions capable of participating in Medicaid financing. The absence of any requirement that units of government have taxing authority in order to contribute to the non-federal share of Medicaid expenditures is supported by the language elsewhere in the Medicaid statute. Section 1903(d)(1) requires states to submit quarterly reports for purposes of drawing down the federal share in which they must identify "the amount appropriated or made available by the State and its political subdivisions." The reference to the participation of political subdivisions in Medicaid funding nowhere includes a requirement that the subdivisions have taxing authority.[32]

In limiting the definition of unit of government, the Proposed Rule also overlooks Congress' specific concern about funds derived from State university teaching hospitals. In 1991, in the course of adopting affirmative limits on states' authority to rely on local funding derived from provider taxes or donations, Congress explicitly stated that the Secretary of HHS "may not restrict States' use of funds where such funds are . . . appropriated to State university teaching hospitals."[33] Clearly, Congress did not want to disrupt longstanding funding arrangements involving these important teaching institutions. In adopting a narrow definition of unit of government, which will have the effect of excluding many of our nation's premier public teaching hospitals, CMS has violated the spirit, and in some cases the letter, of this law.

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

In creating a new federal regulatory standard to determine which public entities within a state are considered to be "units of government" and which are not, CMS is encroaching on a fundamental reserved right of states to organize their governmental structures as they see fit. This is an extraordinary step for the federal government to take, as the internal organization of a state into units of government has historically been an area in which, out of respect for federalism, the federal government has been loath to regulate. This federal intrusion into the operation and administration of state government violates the very basis of the Medicaid program -- the federal-state partnership and the federalism principles on which it rests.

Recommendation: CMS should defer to states regarding the definition of a unit of government.

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[32] 42 U.S.C. § 1396b(d)(1).
[33] 42 U.S.C. § 1396b(w)(6)(A).

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

Traditionally, states have been able to rely on public funds contributed by governmental entities, regardless of the source of the public funds. As long as funds were contributed by a governmental entity, they were considered to be public and a legitimate source of Medicaid funding.

The Proposed Rule rejects the idea that all funds held by a public entity are public (or, in the language of the regulation, all funds held by a unit of government are governmental), notwithstanding a large body of state law to the contrary.[34] Rather, the regulation (or at least its preamble) would establish a hierarchy of public funds, and only funding derived from taxes would be allowed to fund Medicaid expenditures while those derived from other governmental functions (such as providing patient care services through a public hospital) would be rejected.

The preamble to the Proposed Rule states explicitly that, with respect to intergovernmental transfers, "the source of the transferred funds [must be] State or local tax revenue (which must be supported by consistent treatment on the provider's financial records)."[35] While the proposed regulatory language itself refers only to "*funds* from units of government"[36] without specifying the source of those funds, the preamble language clearly indicates CMS' intent to further restrict funding for state Medicaid programs by imposing the additional requirement that local funds be derived from tax revenues. The preamble does not specify the reason for this restriction, nor whether it would serve to bar federal Medicaid match for support provided by a local government to a hospital derived from such routine governmental funding sources such as the proceeds from bond issuances, revenue anticipation notes, tobacco settlement funds and the like. Moreover, if the regulation does indeed bar the use of such funding sources, how does CMS expect to be able to track the precise source of local support funding, given the fungibility of governmental funding?

The combination of adopting a restrictive definition of a unit of government and then further restricting the source of funds that can be transferred by entities that meet the strict unit of government test will leave state Medicaid programs, including important supplemental payment programs that support the health care safety net, starved for

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[34] *See, e.g. Adams County Record v. Greater North Dakota Association*, 529 N.W.2d 830, 834 (N.D. 1995) ("public funds" include "all funds derived from taxation, fees, penalties, sale of bonds, or from any other source, which belong to and are the property of a public corporation or of the state ...."); *Kneeland v. National Collegiate Athletic Association*, 850 F.2d 224, 227 (1988) (all revenues, except for trust funds, received by public colleges and universities, as well as various types of property of public colleges and universities are public funds).

[35] 72 Fed. Reg. at 2238

[36] Proposed 42 C.F.R. § 433.51(b).

resources. These funding shortfalls will need to be filled either by new broad-based uniform provider taxes (which would ultimately divert Medicaid reimbursement from patient care costs to covering the cost of new taxes), by new general revenue funding (shifting new costs onto state taxpayers) or by a reduction in Medicaid coverage or reimbursement. All of these solutions will ultimately impact the care that Medicaid beneficiaries receive.

In imposing this new restriction on the source of IGTs, CMS is again exceeding its Congressionally delegated authority. Section 1902(a)(2) of the SSA allows states to rely on "local sources" for up to 60 percent of the non-federal share of program expenditures. This provision does not limit the types of local sources that may be used. When Congress has intended to restrict such local sources, it has rejected CMS' attempts to impose limits by regulation and has insisted on legislating the limits itself. For example, in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991,[37] Congress adopted significant restrictions on sources of local funding, but did so by statute after imposing a series of moratoria on HHS' attempts to restrict local sources of funding administratively.[38] CMS is without legal authority to insist that local funding from units of government be limited to tax dollars only.

Recommendation: CMS should allow all public funding regardless of its source to be used as the non-federal share of Medicaid expenditures.

III. THE PROPOSED RULE INCLUDES TECHNICAL ERRORS, AMBIGUITIES AND MISGUIDED POLICY CHOICES

The best course, from a legal and policy perspective, would be for CMS to withdraw the Proposed Rule altogether. To the extent that the agency goes forward with the rule, there are several technical issues that need to be clarified, modified or otherwise addressed in the final rule. NAPH raises the following concerns:

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

1. *The Proposed Rule inappropriately limits reimbursable costs to the "cost of providing covered Medicaid services to eligible Medicaid recipients." (§ 447.206(c)(1))*

Proposed 42 C.F.R. § 447.206(c)(1) provides that "[a]ll health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider's cost of providing ***covered Medicaid services to eligible Medicaid recipients***." By its terms, this provision would prohibit *any* Medicaid reimbursement to

[37] Pub. L. No. 102-234, 105 Stat. 1793.
[38] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 1989 U.S.C.C.A.N. (103 Stat.) 2106; Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 1990 U.S.C.C.A.N. (104 Stat.) 1388.

governmental providers for costs of care for patients who are *not* eligible Medicaid recipients, or for services that are not covered under the state Medicaid plan. Taken literally, states could no longer pay public hospitals for unreimbursed costs for uninsured patients or for non-covered services to Medicaid patients through the disproportionate share hospital program. Similarly, the authority of several states to make payments to public providers pursuant to expenditure authority received through section 1115 demonstration projects to pay for otherwise unreimbursable costs to the uninsured, for infrastructure investments and for other purposes not covered under the state plan would be called into question (including Safety Net Care Pool payments authorized in California and Massachusetts, and Low Income Pool payments authorized in Florida). The cost limit could also extend to Medicaid reimbursement received by governmental providers from managed care organizations (despite CMS' disavowal of any such intent in the preamble). The problem is exacerbated because the regulation defines its scope as applying broadly to all "payments made to health care providers that are operated by units of government ...."[39] By contrast, the UPL regulations are carefully drafted to limit their scope to "rates set by the agency,"[40] and they include an explicit exemption for DSH payments.[41]

We assume that it is CMS' intention either (1) to apply the cost limit only to fee-for-service payments by the state agency for services provided to Medicaid recipients while relying on separate statutory or waiver-based authority to impose cost limits on DSH or demonstration program expenditures, or (2) to apply the cost limit at 42 C.F.R. §447.206 more broadly than the language of the Proposed Rule would suggest. In either case, modifications to the language of the regulation are needed to clarify its scope and the corresponding allowable costs. If the limit is to apply only to fee-for-service rates for Medicaid patients, DSH should be explicitly exempted. If the limit is to be more broadly applied, the language must be expanded to allow costs for the uninsured or non-covered Medicaid services for purposes of DSH payments. In addition, preamble guidance regarding the ongoing validity of expenditure authority granted through existing demonstration projects would help reduce confusion about the intended scope.

Recommendation: CMS should clarify that the limitation to cost of Medicaid services for Medicaid recipients is not intended to limit Medicaid DSH payments or CMS-approved payments under demonstration programs that expressly allow payment for individuals or services not covered under the state Medicaid plan.

[39] Proposed 42 C.F.R. § 447.206(a)
[40] 42 C.F.R. § 447.272(a), § 447.321(a).
[41] 42 C.F.R. § 447.272(c)(2).

2. *CMS should clarify that allowable costs will include all necessary and proper costs associated with providing health care services. (§ 447.206)*

The calculation of cost for purposes of applying the cost limit is not well-defined under the Proposed Rule. Since the magnitude of the cut imposed by the cost limit will depend on which costs CMS will and will not allow states to reimburse, NAPH requests that CMS provide further guidance on how Medicaid costs would be determined and in particular clarify that any determination of Medicaid "costs" will include all costs necessary to operate a governmental facility. For governmental hospitals, these costs must, at a minimum, include:

- costs incurred by the hospital for physician and other professional services (e.g. salaries for employed professionals, contractual payments to physician groups for services provided to hospitals, physician on-call and standby costs);
- capital costs necessary to maintain an adequate physical infrastructure;
- medical education costs incurred by teaching hospitals;
- investments in information technology systems critical to providing high quality, safe and efficient hospital care;
- investments in community-based clinics and other critical access points to ensure that Medicaid and uninsured patients have adequate access to primary care;
- costs of a basic reserve fund critical to any prudently-operated business enterprise; and

In addition, some costs on a hospital's cost report are allocated to cost centers judged to be unreimbursable for purposes of Medicare reimbursement, but are appropriately reimbursed under Medicaid or DSH. For example, a hospital may have a clinic that exclusively serves Medicaid and uninsured patients that may have been excluded for Medicare purposes, but are appropriately reimbursed under Medicaid. Similarly, some costs that may not be included in a particular reimbursable cost center for purposes of the Medicare cost report should be included under a cost-based Medicaid reimbursement system (including but not limited to interns and residents, organ acquisition costs, etc.). CMS must ensure that states may make appropriate adjustments to the Medicare cost report to accurately capture all costs reasonably allocated to Medicaid – whether or not Medicare fiscal intermediaries have allowed them.

In addition, NAPH strongly believes that allowable costs should also include costs for the uninsured (beyond costs directly reimbursable through the limited available DSH funding). Absent universal coverage or full reimbursement of uninsured costs, hospitals

must continue to rely on cross-subsidization from other payers, including commercial payers, Medicare and Medicaid, to pay for this care. CMS should allow state Medicaid programs to shoulder such costs rather than placing the full burden on Medicare and commercial payers. We therefore urge CMS to include uninsured costs among reimbursable Medicaid costs.

Recommendation: CMS should specify that any determination of Medicaid costs will include all costs necessary to operate a governmental facility including costs for the uninsured.

3. The costs of graduate medical education must be allowable costs.

The President's FY 2008 budget request includes an administrative proposal to eliminate Medicaid reimbursement for graduate medical education (GME) costs. Given the long-standing policy to permit GME payments (as of 2005, 47 states and the District of Columbia provided explicit GME payments to teaching hospitals, according to the Association of American Medical Colleges[42]) and the dozens of approved state plan provisions authorizing such payments, NAPH was surprised to see this proposal described as an administrative rather than legislative initiative. We question CMS' authority to adopt such a policy change without statutory authorization. To the extent that CMS intends to change the policy administratively, however, we assume that the agency would undertake a full notice and comment rulemaking process. In particular, we assume that CMS will allow governmental providers to include all of the costs of their teaching programs in the cost limits under the Proposed Rule unless and until the law is changed to prohibit Medicaid payments for GME. Please confirm our understanding that full GME costs will be includable as reimbursable costs.

Recommendation: CMS should clarify that graduate medical education costs will be includable in the cost limit under the Proposed Rule.

4. The Proposed Rule does not specify whether and under what circumstances professional providers 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."[43] 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."[44] 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 professionals employed by governmental entities. CMS should clarify that it does not

[42] Tim M. Henderson, *Direct and Indirect Graduate Medical Education Payments By State Medicaid Programs* (Association of American Medical Colleges), Nov. 2006, at 2.
[43] Proposed 42 C.F.R. § 447.206(a).
[44] Proposed 42 C.F.R. § 447.206(c)(4).

intend the regulation's reach to extend this far. Cost-based methodologies are particularly inappropriate for professional services.

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.

5. *A less costly, equally effective alternative to multiple cost reconciliations is available that would reduce the administrative burden on providers.*

It appears that the cost limits under the regulation must be enforced by reconciling final cost reports (often not final until years after the payment year) to actual payments made to ensure that no "overpayments" have occurred.[45] In addition, in order for states using cost-based payment methodologies funded by CPEs to provide payments to providers prior to the finalization of the payment year cost reports, the state must undertake not one, but two reconciliations after the payment year to ensure payments did not exceed costs.[46] It appears, therefore, that under this Proposed Rule, states and providers are going to be reconciling cost reports and payments for years after the actual payments are received.

The time and resources invested in this process will ultimately have no impact whatsoever on the quality or effectiveness of care provided to patients; in fact, these burdensome requirements divert scarce resources that would be much better spent on patient care. Moreover, the precision gained by reconciling payments to actual costs for the payment year as determined by a finalized cost report simply is not worth the massive diversion of such resources.

Instead, CMS should allow states to calculate cost limits prospectively, based on the most recent cost reports trended forward. While such a prospective methodology may result in a limit that is slightly higher or lower than actual costs incurred in the payment year, over time such fluctuations will even out. Moreover, calculations of cost limits to the dollar, as proposed by CMS, are not necessary to achieve the fiscal integrity objectives articulated by CMS. NAPH therefore urges CMS to reconsider the elaborate reconciliation processes it is requiring in this rule and instead allow providers to invest the savings from the use of a prospective process in services that will actually benefit patients.

Recommendation: CMS should allow states to calculate the cost limit on a prospective basis.

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[45] Proposed 42 C.F.R. § 447.206(e).
[46] Proposed 42 C.F.R. § 447.206(d)

6. 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.[47] There is an exception to this prohibition on direct provider payments for payments for graduate medical education, provided capitation rates have been adjusted accordingly. Given the extreme funding cuts that will be imposed on many governmental providers by the imposition of the cost limit, NAPH urges CMS to reconsider the scope of the exception to the direct payment provision. NAPH recommends that states be allowed to make direct Medicaid fee-for-service payments to governmental providers for all unreimbursed costs of care for Medicaid managed care patients (not just 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 account for the supplemental cost-based payments. If reimbursement to governmental providers is going to be restricted to cost, it should include costs for all Medicaid patients, not just those in the declining fee-for-service population.

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

B. Defining a Unit of Government (§ 433.50)

As stated above, we believe CMS's restrictive definition of unit of government is fatally flawed and should be abandoned in favor of permitting state discretion. However, to the extent this element is included in a final regulation, CMS must clarify certain aspects. In particular:

1. CMS should leave the statutory definition of "unit of government" in place.

The Proposed Rule would permit only units of government to participate in financing the non-federal share of Medicaid expenditures. The regulatory text then goes on to define a unit of government as "a State, a city, a county, a special purpose district or other governmental unit in the State (including Indian tribes) ***that has generally applicable taxing authority***."[48] A provider can only be considered to be a "unit of government" if it has taxing authority or it is an "***integral part of a unit of government with taxing***

[47] 42 C.F.R. §438.60.
[48] Proposed 42 C.F.R. § 433.50(a)(1)(i).

authority."[49] It is clear from this proposed definition that unless a provider has direct taxing authority, CMS will only consider it a "unit of government" if it is an integral part of a unit of government with taxing authority. As explained in Part II of these comments, states and local governments have restructured public hospitals so that they are deliberately autonomous from the state, county or city while retaining their public status under state law. State law, including state law as defined by the state courts, typically looks beyond the presence of taxing authority to other indicia of public status to determine whether an entity is governmental.[50] For example, courts may look to whether an entity enjoys sovereign immunity, to whether its employees are public employees, to whether it is governed by a publicly appointed board, to whether it receives public funding, to whether its enabling statute declares it to be a political subdivision or a public entity. There are a wide variety of factors that go into determining public status beyond whether the provider or the unit of government of which it is an integral part has taxing authority. NAPH urges CMS to eliminate the caveat that units of government must have taxing authority and allow any governmental entity so designated under state law to be treated as public and capable of participating in Medicaid financing.

Recommendation: CMS should eliminate the requirement that units of government have taxing authority and defer to state law interpretations of public status.

2. *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 use of the term "public" appears in several different contexts throughout the Medicaid statute, and many states employ their own definitions of public status within their Medicaid state plans. For example, federal financial participation is available at the rate of 75 percent of the costs of skilled professional medical personnel of the state agency or "any other public agency."[51] A Medicaid managed care organization that is a "public entity" is exempt from certain otherwise applicable solvency standards.[52] "Public institutions" that provide inpatient hospital services for free or at nominal charges are not subject to the charge limit otherwise applicable to inpatient services.[53] Moreover, many states adopt special reimbursement provisions in their state plans for "public hospitals," "governmental hospitals" or other types of public providers. The use of terms such as

[49] Proposed 42 C.F.R. §433.50(a)(1)(ii).
[50] *See e.g.,* Colorado Associate of Public Employees v. Board of Regents, 804 P. 2d 138 (1990) (the court based its determination that the hospital was a public entity on the State's role in establishing the hospital and its continued involvement in the control of the hospital's internal operations). Woodward v. Porter Hospital, Inc. 217 A.2d 37, 39 (1966)("a public hospital is an instrumentality of the state, founded and owned in the public interest, supported by public funds, and governed by those deriving their authority from the state.").
[51] 42 U.S.C. § 1396b(a)(2)(A).
[52] 42 U.S.C. §1396b(m)(1)(C)(ii)(II).
[53] 42 U.S.C. §1396b(i)(3).

"public," "unit of government" and "governmental" in other areas of state and federal Medicaid law does not incorporate the restrictions CMS is seeking to impose through the Proposed Rule. CMS should clarify that these restrictive definitions are for purposes outlined in the Proposed Rule only.

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.

C. Certified Public Expenditures (§ 447.206(d)-(e))

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

In the preamble to the Proposed Rule, CMS 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. Providers will incur costs associated with providing care to Medicaid patients whether they are paid on a cost basis or not. Their costs are no less real or certifiable based on the payment methodology. For example, if a provider incurs $100 in cost in providing care to a Medicaid patient, but the payment methodology is a prospective one that results in a $90 payment, the provider could still certify that it incurred $100 in costs in connection with care for that patient. Because the payment is limited to $90, however, only $90 of the certification would be eligible for federal match. When payment is not based on a cost methodology, CMS should allow providers to certify costs associated with care to Medicaid patients not to exceed the amount of payments provided under the state plan methodology.

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

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

In the regulatory language in Proposed 42 C.F.R. § 447.206(d)-(e), CMS alternates between mandatory and permissive language as to state obligations during CPE reconciliations. It appears that it is CMS' intent to *require* the submission of cost reports whenever providers are paid using a cost reimbursement methodology 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 finalized 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 reconciliation of costs.

D. Retention of Payments

NAPH supports CMS' attempts to ensure that health care providers retain the full amount of federal payments for Medicaid services. We do not believe, however, that the requirement in the Proposed Rule that providers receive and retain all Medicaid payments to them is enforceable. Nor do we believe that this provision will have a major impact on the funding of safety net providers. Although CMS asserts that governmental providers will benefit from the Proposed Rule in part because of the retention provision, this new requirement does not come close to undoing the significant damage caused by the cuts to payments and changes in financing required by other provisions of the Proposed Rule.

1. *CMS should clarify whether states will be required to pay all federal funding associated with provider-generated CPEs to the provider.*

The retention provision requires providers to "receive and retain the full amount of the total computable payment provided to them."[54] It is unclear whether this requirement applies to *all* payments, whether financed through IGTs, CPEs, general state revenues or otherwise. Currently, some states claim certified public expenditures based on costs incurred by public providers, but do not pass the federal matching payments to the provider. Would this practice be prohibited under the retention provision and would states be required to pay any match received on public provider CPEs to the provider?

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

[54] Proposed 42 C.F.R. § 447.207(a).

2. 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. NAPH members typically have a wide array of financial arrangements with state and local governments, with money flowing in both directions for a variety of reasons. We are 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 under the Medicaid program. It does not have authority over providers' use of Medicaid payments received.[55]

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

E. Applicability to Section 1115 Waivers

Currently, a number of states have implemented demonstration programs under Section 1115 waiver authority. Medicaid demonstrations typically must comply with a budget-neutrality expenditure cap calculated based on the Medicaid expenditures that would have been made in the absence of the waiver. Many recent demonstrations have relied heavily on money made available by eliminating certain above-cost payments to public providers. For example, California and Massachusetts established Safety Net Care Pools funded by agreements to eliminate certain supplemental payments. Florida likewise established a Low Income Pool on the same basis. Iowa similarly expanded coverage through Iowa Cares. These demonstrations have been the result of significant and extended discussions between states and CMS.

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[55] *See Englund v. Los Angeles County*, 2006 U.S. Dist. LEXIS 82034, at *26 (E.D. Cal. 2006). When analyzing supplemental Medicaid funding paid to Los Angeles County, the Court noted that "once the County received the [Medicaid] payment it was not limited to how it used the money" (*citing* testimony of Bruce Vladeck, Administrator of Health Care Financing Administration, 1993-1997). The Court also cited Mr. Vladeck's statement that, "money is fungible. Once it was paid to the hospitals, if it was paid for services that were actually being provided, at that point our [HCFA's] sort of formal jurisdiction over it and interest of what became of the funds ended." *Id.* at 27.

All of the demonstrations contain language in the Special Terms and Conditions requiring budget neutrality to be recalculated in the event that a change in Federal law, regulation, or policy impacts state Medicaid spending on program components included in the Demonstration. Throughout the Proposed Rule, CMS confirms that the proposed changes would apply to states that operate Section 1115 waiver programs, but fails to discuss the extent to which the Proposed Rule would affect budget neutrality calculations under Medicaid waivers. Will CMS recalculate budget neutrality applicable to these waivers based on the new regulation? If not, will these states be able to continue their new initiatives beyond the term of the current demonstration project? It will be difficult for these states to establish new programs under their waivers if they are going to be terminated within a few years. Moreover, will CMS allow other states to adopt waivers establishing similar pools or expanded coverage based on the termination of above-cost supplemental payment programs?

Recommendation: CMS must clarify (i) whether current waiver states will be permitted to preserve their waivers, including safety net care pools and expanded coverage currently funded by the states' agreements to limit existing provider payments to cost; (ii) whether CMS plans to enforce requirements under waiver special terms and conditions (STCs) that budget neutrality agreements be renegotiated upon changes in federal law; (iii) whether CMS will allow other states to adopt similar waivers, which may incorporate savings realized from the Proposed Rule's cost limit into their own safety net care pools or coverage expansion initiatives; and (iv) if CMS does not plan to allow other states to make use of cost limit savings, the legal basis for this decision.

F. UPL Transition

The Proposed Rule preamble states that "transitional UPL payments ... are unchanged under this policy."[56] However, the Proposed Rule does implement changes to the UPL endpoint -- reducing it for governmental hospitals from the aggregate estimate of what would be paid under Medicare payment principles to the individual provider's cost of providing Medicaid services to eligible Medicaid recipients. Therefore, transition period payments would appear to be significantly impacted, since the transitional UPLs are largely based on the UPL endpoint. If CMS truly intends that transition period UPL payments be unchanged, CMS must revise the regulatory language to make that clear.

Recommendation: CMS should revise the regulatory language to ensure no diminution of transitional UPL payments.

G. Provider Donations

If the Proposed Rule is finalized in its current form, a number of providers that were previously considered public and that provided IGTs or CPEs to help finance the non-

[56] 72 Fed. Reg. at 2245.

federal share of Medicaid expenditures will no longer be able to do so. Some of these providers receive appropriations from a unit of government that does have taxing authority, but the provider cannot be considered to be an integral part of such governmental unit under the terms of the Proposed Rule. CMS should make clear that those appropriations will continue to be fully matchable under the new regulation and that it will not disallow such taxpayer funding as an indirect provider donation. We are particularly concerned in this respect about a passage in the preamble stating that "[h]ealth care providers that forego generally applicable tax revenue that has been contractually obligated for the provision of health care services to the indigent ... are making provider-related donations."[57] A local government must have full authority to redirect taxpayer dollars to the state Medicaid agency for use as the non-federal share.

For example, a county which provides $20 million to support the provision of indigent care at a hospital deemed to be private under the Proposed Rule should be permitted instead to transfer that funding to the State Medicaid agency for use as the non-federal share of a $40 million DSH payment to the hospital. The preamble language appears to indicate that CMS could view such a transfer as a provider donation even though it is transferred from an entity that is clearly governmental and even though the funds transferred are derived from tax revenues. When taxpayer funding is transferred by a unit of government to the Medicaid agency for use as the non-federal share, CMS should provide federal financial participation without question.

Recommendation: CMS should clarify that it will not view the transfer of taxpayer funding as an indirect provider donation.

H. Effective Date

1. The September 1, 2007 effective date is not achievable.

The stated effective date of the new cost limit is September 1, 2007.[58] An effective date for other portions of the regulation is not provided. Given that many states will need to overhaul their provider payment systems and plug large budgetary gaps resulting from the required changes in non-federal share financing, the proposed effective date is not feasible. State plans amendments will need to be developed, vetted with the public, submitted to CMS and approved, a process which recently has routinely lasted 180 days or significantly longer. By the time a final rule is published, States will have long finalized budgets for fiscal years that include time periods after September 1, 2007 (SFY 2008 or, in some cases, SFY 2009 budgets). For many states, funding levels have already been set. Many state legislatures are in session for a limited period of time, and some meet every other year. Elimination of federal funding of the magnitude proposed in this regulation cannot possibly be incorporated and absorbed at this late date. Moreover, to

[57] *Id.*
[58] Proposed 42 C.F.R. § 447.206(g); § 447.272(d)(1); § 447.321(d).

the extent that states have had advance warning of at least some of the policies contained in the final rule by virtue of this Proposed Rule and other agency activities, states are under no obligation to modify their programs based on the provisions of a proposed regulation without the force and effect of law, nor would it be wise to undertake such restructuring given that the regulation may undergo significant change.

Moreover, given the widespread impact of the Proposed Rule as discussed elsewhere in these comments, and the longstanding reliance of states on payment and financing arrangements allowable under current law, CMS should adopt generous transition provisions to allow states time to come into compliance and allow providers time to adjust to significantly lower reimbursement rates. Any such transition periods should be at least ten years.

Recommendation: CMS should revise the effective date of the Proposed Rule and establish a ten-year transition period so that states, health care providers, and other affected entities are provided adequate time to come into compliance.

2. The effective date of portions of the Proposed Rule is ambiguous.

NAPH seeks confirmation that the effective date of the entire regulation is, in fact, proposed to be September 1, 2007. While this date is specifically established as the date by which states must come into compliance with cost limits, effective dates are not provided in connection with other revised sections of the regulations. Moreover, throughout the preamble, CMS characterizes its actions as "clarifying" policies with respect to the definition of units of government, intergovernmental transfers, certified public expenditures and the retention requirement. We are therefore concerned that CMS may view these regulatory changes as being effective immediately and retroactively, as a simple clarification of current policy and not the sweeping regulatory overhaul that it clearly is. Please confirm that these regulations are prospective in their entirety.

Any attempt to impose these policies without going through notice and comment rulemaking would violate the Administrative Procedures Act (APA), which requires legislative rules such as the policy changes articulated in the Proposed Rule to be adopted through a formal rulemaking process.[59] Moreover, in addition to the requirements of the APA, Congress has very explicitly instructed CMS not to adopt policy changes without undertaking notice and comment rulemaking. The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (the 1991 Amendments) contains an uncodified provision stating that:

> the Secretary may not issue any interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public

[59] 5 U.S.C. § 553.

funds as a source of State share of financial participation under title XIX of the Social Security Act.[60]

The regulation referred to in this provision (which was subsequently moved without substantive change to 42 C.F.R. § 433.51) is the current regulatory authority for the use of "public funds" from "public agencies" as the non-federal share of Medicaid expenditures, including IGTs and CPEs. The Proposed Rule adopts significant modifications to this provision, including a narrowing of the source and types of funds eligible for federal match, requiring "funds from units of governments" rather than "public funds" from "public agencies." Congress' prohibition of changes to this regulation through an interim final regulation was intended to require HHS to undertake notice and comment rulemaking. To the extent that CMS contends that the current regulatory change is effective at any time prior to the finalization of the formal rulemaking process, it is in violation of both the APA and the 1991 Amendments.

Recommendation: CMS should clarify that all parts of the regulation are effective on a prospective basis.

I. Consultation with Governors

Section 5(c) of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991[61] requires the Secretary to "consult with the States before issuing any regulations under this Act." The preamble of the Proposed Rule does not mention any such consultation with states. Did the agency comply with this statutory mandate, and if so, how and when? Given that the National Governors Association sent a letter on February 23, 2007 to Congressional leadership strongly opposing the Proposed Rule, we also request information on whether the states' concerns have been taken into consideration at all in the formulation of this policy.

Recommendation: CMS should immediately consult with states on the Proposed Rule and modify or withdraw it based on state concerns.

IV. CMS' Regulatory Impact Analysis is Deeply Flawed

1. CMS underestimates the administrative burden imposed on states and providers.

The Proposed Rule imposes significant new burdens on health care providers that CMS fails to acknowledge or severely underestimates. In addition to the significant cut in federal funding that many providers face under the Rule, compliance with new requirements proposed by CMS, including the reporting requirements, will place

[60] Pub. L. No. 102-234, §5(b), 105 Stat. 1793, 1804.
[61] Pub. L. No. 102-234.

substantial additional costs on states and providers. These costs have not been incorporated into CMS' impact analysis; NAPH requests that CMS correct this oversight. As acknowledged in the Proposed Rule, Executive Order 12866 requires agencies to assess both the costs and the benefits of the proposed rule.

For example, costs that are unrecognized in the Proposed Rule include the cost to States that have already formulated complex provider reimbursement methodologies and payment processes based upon existing rules that now must be overhauled to come into compliance with the new rules. As CMS well knows from its role in administering the Medicare program, developing new payment systems for providers is a considerable and costly undertaking. Similarly, many states are going to have to find alternative sources of funding to finance the non-federal share of Medicaid expenditures. To the extent that these sources will involve a redirection of current general revenue funds to plug Medicaid budget holes, other state programs will suffer. To the extent that new taxpayer funding will need to be raised, that is a significant cost to the state. Some states may turn to provider taxes to finance the shortfall, which would not only impose additional costs on providers (including small entities and rural hospitals protected by the Regulatory Flexibility Act) but would involve a substantial commitment of administrative resources to develop and obtain CMS approval for a tax that is compliant under the complex federal provider tax regulations.

The Proposed Rule mandates the creation of additional cost reporting systems to ensure compliance with the cost limit imposed on governmental providers. Even apart from the potential need to create cost reporting systems for provider types that may never have had to deal with cost reporting systems, such as public school districts, states with existing cost reporting systems for hospital providers that do not comply with the Proposed Rule's requirements will be required either to modify their current Medicaid cost report system or to create new ones specifically for this purpose. For example, some states have Medicaid hospital cost report systems that echo the Medicare cost finding system, but may vary in significant ways. The Proposed Rule may require states to adopt cost reports more closely tied to the Medicare cost report to ensure compliance. Furthermore, even in those states that have existing Medicaid cost reporting systems that would pass CMS muster, these systems may not be equipped to capture measurement of costs for the uninsured population or for Medicaid managed care recipients, both of which are potentially relevant in the context of Medicaid DSH payments (or demonstration program payments) to governmental hospital providers.

In addition to the creation and/or modification of these cost reporting systems, states will need to construct new structures for auditing the new cost reports. In the context of CPEs, "periodic State audit and review"[62] is required explicitly, but it is unclear the extent to which CMS expects states to audit and review all cost report submissions.

[62] Proposed 42 C.F.R. § 433.52(b)(4).

Reviewing these cost reports would require additional staffing by state Medicaid agencies and additional expenditures by providers in order to complete the required submissions.

All of these costs -- costs related to creation of the new report system, costs related to auditing the reports, and provider costs of compliance– should be included in the cost/benefit analysis.

2. *The Proposed Rule will have a direct and very significant impact on patient care.*

In addition, we vehemently disagree with the assertion in the Regulatory Impact Analysis that the impact on patient care services will be minimal.[63] As noted above, NAPH members have estimated state-level impacts that anticipate cuts of tens and hundreds of millions of dollars annually per state. With this amount of money drained from the program, significant impacts on patient care services cannot be avoided. These potential impacts include closed community clinics, reduced hours in the remaining clinics, increased reliance on emergency departments for routine care, a reduction in emergency preparedness, less outreach and patient education efforts, little or no investment in expanded access, delayed or canceled plans to upgrade information systems and adopt electronic medical records, less ability to provide translation services to non-English speakers, reduced capacity to maintain or launch intensive disease management programs, etc. The choices available to providers to cope with multimillion dollar funding cuts are not plentiful and are always painful. There is no "fat" left in the system after years of public and private funding cuts; there are no "easy" cuts to make. Virtually any decision made by a hospital system to adjust their budgets to cuts of this magnitude will certainly have a direct impact on patient care, no matter how much the hospital may try to avoid it. CMS ignores the impact this regulation will have, particularly on the poorest and most vulnerable patients.

3. *CMS fails to acknowledge the widespread economic impact on local communities.*

In addition, the Proposed Rule will have a significant economic impact on local communities, as public providers reliant on supplemental Medicaid funding eliminated by this regulation take steps to cut their budgets. Public hospitals typically are a significant economic force in their communities, and their financial health (or lack thereof) has far-reaching ripple effects. Many of these budget cuts will necessarily entail layoffs. The inability to invest in infrastructure will be felt by vendors and contractors in the community. The impact of reduced access will have effects on the health of the community, including the health of the community's workforce, thereby impacting employers throughout the hospital's service area. The community's preparedness for emergencies may suffer because of lack of funding, impacting the ability of the

[63] 72 Fed. Reg. at 2245.

community to attract and retain new businesses and employers crucial to economic vitality. Existing businesses that cater to hospital employees will feel the effects of a shrinking workforce. To the extent that local governments need to step in to fill the gaps caused by the withdrawal of federal funds, every single local taxpayer is affected. A vibrant, dynamic and comprehensive health care safety net is a crucial ingredient in the success of local economies. CMS fails to acknowledge the impact of this Medicaid funding cuts on the economic health of local communities.

Recommendation: CMS should reevaluate its estimate of the impact of the Proposed Rule and the need for regulatory relief under the Regulatory Flexibility Act. Upon reevaluation of the impact, CMS should either withdraw the proposal or modify as recommended in Part II of these comments.

Submitter : Mr. David Hughes **Date:** 07/13/2007

Organization : Pitt County Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2258-FC-19-Attach-1.PDF

#19

PITT COUNTY MEMORIAL HOSPITAL
University Health Systems of Eastern Carolina℠

July 13, 2007

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

Re: (CMS-2258-FC) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (Vo. 72, N0. 102), May 29, 2007

Dear Ms. Norwalk:

This letter is the response from Pitt County Memorial Hospital related to the proposed Unit of Government that was published in the Federal Register on May 29, 2007. Pitt County Memorial Hospital, one of four academic medical centers in North Carolina, is the flagship hospital for University Health Systems of Eastern Carolina and serves as the teaching hospital for the Brody School of Medicine at East Carolina University. Pitt Memorial is a regional resource for all levels of health services and information. The hospital is a tertiary referral center and provides acute, intermediate, rehabilitation and outpatient health services to more than 1.2 million people in 29 counties. In an average year, about 33,000 inpatients and more than 266,000 outpatients are treated in our facilities. More than 3,000 babies are born here in a typical year. Our clinical staff includes more than 500 physicians and 1,200 nurses.

The proposed definition of Unit of Government 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 the application of this definition 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.

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

2100 Stantonsburg Road P.O. Box 6028 Greenville, North Carolina 27835-6028

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

Under the proposed new definition North Carolina's public hospitals will have to meet the new definition Unit of Government in order to continue to certify their public expenditures to draw down matching federal funds. Because the new definition imposes the requirement that a Unit of Government 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 which has the effect of wiping out entire valuable programs that are otherwise fully consistent with all of the Medicaid statutes is unreasonable and objectionable. Pitt County Memorial Hospital 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 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 implementing new regulations before October 1, 2009 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. A date no earlier than October 1, 2009 is necessary for the affected stakeholders to try to mitigate the detrimental impact of the changes.

Pitt County Memorial Hospital urges CMS to withdraw its proposed definition of Unit of Government, 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, Pitt County Memorial Hospital urges CMS to adopt a more reasonable implementation schedule that allows until October 1, 2009 before the new definition takes effect. Thank you for your consideration.

Respectfully Submitted,

David S. Hughes

David S. Hughes
Vice President of Financial Services

Submitter : Mr. Leonard Marquez **Date:** 07/13/2007

Organization : The MetroHealth System

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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

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

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

Submitter : Mr. James Nathan **Date:** 07/13/2007

Organization : Lee Memorial Health System (LMHS)

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Unit of Government Definition

Unit of Government Definition

See Attachment

CMS-2258-FC-21-Attach-1.DOC

#21

LEE MEMORIAL
HEALTH SYSTEM

P.O. BOX 2218

FORT MYERS, FLORIDA 33902

239-332-1111

CAPE CORAL HOSPITAL

GULF COAST HOSPITAL

HEALTHPARK CARE CENTER

HEALTHPARK MEDICAL CENTER

HEALTHPARK OF THE ISLANDS

LEE CONVENIENT CARE

LEE MEMORIAL HOSPITAL

LEE PHYSICIAN GROUP

SOUTHWEST FLORIDA
REGIONAL MEDICAL CENTER

THE CHILDREN'S HOSPITAL

THE REHABILITATION HOSPITAL

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July 18, 2007

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

Ref: Comments on Unit of Government Definition (§ 433.50) contained in CMS–2258–FC: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748 (May 29, 2007).

Dear Ms. Norwalk:

On behalf of Lee Memorial Health System (LMHS), I am submitting comments to reiterate our opposition to the proposed definition of a unit of government contained in 42 C.F.R. § 433.50, which was published by the Centers for Medicare and Medicaid Services (CMS) in CMS-2258-FC (the Final Rule).[1] The Final Rule does not fundamentally change the most damaging provisions of CMS-2258-P (the Proposed Rule) for LMHS and the Florida Medicaid program. ***On behalf of LMHS, I urge you to defer to state law in the determination of "unit of government" and to withdraw the Final Rule.***

LMHS is aware that recently-passed legislation prohibits CMS from taking any steps to implement this proposal until May 25, 2008.[2] By submitting these comments, LMHS does not concede that CMS has the authority to receive or review comments during the period of the moratorium. If the moratorium expires without further action from Congress, commenters should be permitted a fresh opportunity to provide input on the definition of a unit of government at that time.

LMHS has served a critical public health role 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's 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.

LMHS again urges CMS to reconsider its new definition of a unit of government. Despite the significant concerns raised in our comments on CMS-2258-P (the Proposed Rule) as well as the hundreds of other comment letters submitted, CMS has not fundamentally altered this new definition.

CMS' modifications of the unit of government definition (§ 433.50) are insufficient, as LMHS and similar public hospitals still will not qualify as a unit of government.

[1] 72 Fed. Reg. 29748 (July 6, 2007).
[2] Pub. L. No. 110-28, § 7002.

The Final Rule imposes on states a restrictive new definition of a "unit of government" for purposes of Medicaid financing, requiring that an entity must have "taxing authority, ha[ve] direct access to tax revenues, [be] a State university teaching hospital with direct appropriations from the State treasury, or [be] an Indian tribe..." in order to be considered a unit of government.[3] Providers that are not determined to be units of government under this new definition are prohibited from contributing funding to the non-federal share of Medicaid expenditures. While the Final Regulation appears to expand the number of entities considered governmental compared with the Proposed Rule, the definition would still illogically exclude hospitals, such as LMHS, that are clearly governmental under state law but without tax revenues.

It is unreasonable and unnecessary for CMS to impose such a restrictive definition of a unit of government that it would exclude an institution that is clearly considered governmental under its enabling legislation as well as state and federal case law. 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 purposes."[4] In subsequent legislation that officially changed the hospital's name, the Legislature confirmed that LMHS is indeed a "public body."[5] 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. 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 legislation, and to receive appropriations, which it does on a sporadic basis. Clearly, pursuant to both the explicit terms of LMHS's creation and based on the level of state oversight to which LMHS is subject, the state of Florida considers LMHS to be a unit of government.

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

The governmental status of LMHS has been conclusively and comprehensively established. LMHS's funds are governmental funds. It confounds common sense to treat LMHS as a nongovernmental entity simply because tax revenues are not a source of revenues.

This 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 CMS to show deference to state law in the determination of a unit of government for purposes of Medicaid financing. This requires more than the nominal deference incorporated into the Final Rule by allowing states to make an initial determination subject to being overturned by CMS.

CMS should provide a generous transition period for states and providers to implement the changes of the Final Rule and should not require states and providers to prepare during the one-year moratorium.

Although CMS has not specifically solicited comments on the effective dates of the various provisions of the regulation, LMHS reiterates that CMS should provide adequate time for states and providers to adopt the changes necessary to come into compliance with this regulation. The Florida Legislature must be given an opportunity 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, the state Medicaid agency requires time to develop and obtain approval for any state plan amendments that may be required to adopt changes to states rules and provider manuals.

---

[3] 42 C.F.R. §433.50(a)(1)(i) (as adopted in the Final Rule).
[4] 1963 Fla. Laws ch. 1552, §§ 1, 7.
[5] 2000 Fla. Laws ch. 439.

Given the existence of the legislative moratorium and the expressed intent of Congress to review the issues addressed the rule, CMS cannot reasonably expect states to take any actions towards implementing a regulation that is unlikely to go into effect in its current form. To the extent CMS intends to provide further clarification (e.g., in the context of determining governmental provider status[6]), such guidance cannot be made available until after the end of the moratorium. Basic principles of fairness require CMS to provide a time period after the end of the moratorium before this Final Rule would take effect.

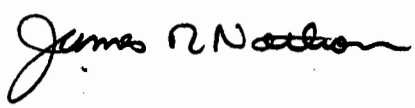
Finally, CMS must provide adequate time for states to come into compliance with the cost limit regulation. The Final Rule indicates that institutional governmentally-operated health care providers must comply with the Medicaid cost limit beginning with the Medicaid state plan rate year 2008. For most states, this rate year begins on July 1, 2007.[7] As a practical matter, given all of the steps that states need to take to prepare for the implementation of a cost limit (including developing new or modifying existing cost reports, adopting state plan amendments, making changes to their state budgets, etc.) it would be inappropriate to implement the cost limit for institutional providers prior to rate year 2010 (i.e., the first rate year that begins no less than sixty days after the expiration of the legislative moratorium). Again, basic principles of fairness require that CMS provide states with the time necessary to come into compliance.

* * *

LMHS appreciates the opportunity to submit these additional comments and to reiterate its strong opposition to the provisions of this Final Rule, in particular the definition of a unit of government. 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.

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

[6] 72 Fed Reg. at 29764-65.
[7] This oddly predates and thus conflicts with the Effective Date listed in the Final Rule, July 30, 2007.

Submitter : **Date: 07/13/2007**

Organization : **University of Colorado Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-FC-22-Attach-1.DOC

#22

UNIVERSITY OF COLORADO HOSPITAL

July 13, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201
Attn: CMS-2258-FC (VIA Electronic Submission)

Re: Proposed Rule CMS-2258-FC – "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" (Fed. Regis. Vol. 72, No. 102), May 29, 2007 ("Rule")

Dear Ms. Norwalk:

Thank you for the opportunity to provide comment regarding the above cited Rule as proposed by the Centers for Medicare and Medicaid Services. The University of Colorado Hospital (UCH) remains opposed to the portion of the Rule that proposes to change the definition of "unit of government." Even though modified from the initial proposed Rule (January 18, 2007), we fear that its implementation would still leave our hospital outside proposed (re)definition of "governmental unit" and thus would have a devastating impact on our 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.

While we appreciate CMS's modification of the initial Rule recognizing the unique roles and missions of teaching/academic hospitals, the Rule, still requiring "direct appropriation" from the State or other governmental entity would still exclude our hospital from the definition as UCH, *the* major teaching hospital in Colorado *does not* receive direct appropriation from the State.

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

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

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.

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 maintaining our opposition to the change to the definition of "unit of government" proposed by the Rule 42 CFR – CMS-2258-FC.

Proposed Rule 42 CFR – CMS-2258-FC:

University of Colorado Hospital expresses its strong objection to this proposed CMS Rule and its scheduled implementation on May 25, 2008. Should this proposed Rule take effect our hospital stands to lose $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", "public", or "*state university teaching*" hospitals to be only those directly supported by "units of government having taxing authority", or hospitals that "*have access to tax revenues*", and such taxing authority is "responsible for the expenses, liabilities and deficits" of such hospitals, it still 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. Even with the one-year moratorium Congress placed on the implementation of this Rule, the timing of the May 25, 2008 effective date would make it very difficult for UCH and the State of Colorado to react, develop, and implement appropriate alternatives.

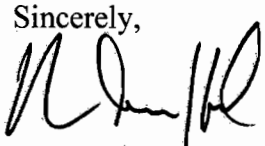
CMS notes that title XIX of the Social Security Act (the "Act") requires that states share in the cost of Medicaid expenditures but permits the states to delegate some responsibility for the non-Federal share of the Medicaid expenditures to units of local governments under some circumstances. The Rule's 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) has "direct access to tax revenues" as an integral part of a unit of government which is legally obligated to fund the hospital's expenses, liabilities and deficits; or (3) is a (government fiscally supported) "state university teaching" hospital. 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 three (revised) criteria and, significantly, would no longer be able to certify public expenditures.

UCH would not be able to totally satisfy any of these three 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 once again reevaluate the proposed Rule taking into consideration the 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 State and throughout the country. Accordingly we continue to urge CMS to withdraw this Rule or, at the very least, further amend the Rule to broaden the definition of "government", "public" or "teaching" 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 these much needed medical services.

Sincerely,



Bruce Schroffel
President & CEO

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

Submitter : Mr. Tom Galligan **Date:** 07/13/2007

Organization : North Carolina Division of Medical Assistance

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

North Carolina submits the attached comments.

CMS-2258-FC-23-Attach-1.PDF

#23

North Carolina Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center • Raleigh, N. C. 27699-2501
Tel 919-855-4100 • Fax 919-733-6608

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Mark T. Benton, Director
William W. Lawrence, Jr., M.D., Senior Deputy Director

July 12, 2007

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

File Code: CMS – 2258 – FC; 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. 102, May 29, 2007)

Via: Electronic web submission:

Dear Ms. Norwalk:

These comments are submitted by North Carolina in response to the invitation for further comment on the issue of the definition of units of government set forth in the Final Rules published in the Federal Register on May 29, 2007 by the Department of Health and Human Services (the Department or DHHS).

We acknowledge that the final rules issued on May 29, 2007 have no force and effect by reason of the Congressional action, signed into law by the President on May 25, 2007, imposing a one-year prohibition on any action by the Secretary to finalize or otherwise implement provisions of the proposed rule that was the subject of the final rules published on May 29, 2007. Nonetheless, the Department having called for additional comment on the issue of the definition of units of government, North Carolina is availing itself of the opportunity to demonstrate the errors in the rationale offered by the Department to justify the unwarranted definition contained in its May 29 issuance, in the hope that the Department will abandon its efforts to narrowly define providers who may participate in financing Medicaid expenditures and return to the approach that has guided the Medicaid program for the past 40 years.

Department's Newly-Issued Definition is Problematic and Unreasonable

The Department's May 29 issuance would permit a health care provider to qualify as a "unit of government" only if (1) the provider itself possesses "generally applicable taxing authority"; (2) has "direct access to generally applicable tax revenues," meaning that it is an "integral part" of a unit of government with taxing authority which is legally obligated to fund the provider's expenses, liabilities an deficits; (3) receives appropriated funding as a State university teaching hospital (with certain qualifications); or (4) is an Indian Tribe or Tribal Organization and meets specified criteria.

Very few public health care providers possess "generally applicable taxing authority." Some are supported by governmental bodies sufficiently to qualify under the second category set forth above. But many others, that are public in nature and have traditionally been so treated for Medicaid reimbursement purposes, would not so qualify. This includes those entities (special districts, authorities, non-profit corporations) that have been established under North Carolina state law to pursue innovative ways of maintaining public health services while incorporating business efficiencies that are best pursued outside traditional governmental bureaucracies.

The Department's approach would undermine these worthwhile advances in public administration. It would withhold federal Medicaid funds validly earned by entities that cannot point to general taxes as their sole source (other than FFP) of the cost of their operations. It ignores all the gains achieved by public entities that have learned how to support their public missions by means other than increasing general taxes, and actually penalizes the entities for achieving a higher degree of operating efficiency and relying on other revenue sources.

If implemented, these providers would be faced with the choice of foregoing Medicaid reimbursement or seeking tax increases to fund what they are now funding through their own operations. The likelihood of obtaining increased taxes, particularly to fund services for the poorest segments of society, can hardly be said to be great. The more likely alternative will be major reductions in the service capabilities of these public entities. How will the Administration, which claims to be constantly on the lookout to protect citizens against increasing tax burdens, respond to increased taxes or a reduction in the access to health care for our state's most health fragile adults, children, and newborn babies?

Department's Newly-Issued Definition is Not Consistent With the Law

The Department cites section 1903(w)(6) of the Social Security Act as its authority to implement this definition. North Carolina disagrees. This section is not a limit on which providers can participate in financing Medicaid. Rather, the section restricts the Department's ability to limit states' use of funds made available by health care providers. The provision insures that the Department has no authority to limit provider participation that is derived from state or local taxes (other than impermissible provider taxes or donations). It neither says nor means that provider participation derived from other revenues sources is not permitted, and it does not address, nor was it meant to address, which providers can participate in the funding of Medicaid services.

Another provision of the same statute that enacted section 1903(w)(6) does address the latter subject. Section 5(b) of Public Law 102-234 (not codified), which limits the Department's ability to change the treatment of "public funds" as a source of State share of financial

participation under title XIX" was reflected in the then-current regulations, and now is contained in 42 CFR 433.51. That regulation, and its predecessors have directly authorized the use of any "public funds" (not just tax-generated funds), including those transferred or certified by "public agencies" as the non-federal share of Medicaid expenditures. It is disappointing that the Department cited section 1903(w)(6), which does not support its restrictive definition, over 20 times in the Federal Register in its response to comments. The Department failed even once during the discussion to cite the regulation that directly authorizes participation in a manner not consistent with the Department's proposal (42 CFR 433.519(b)), even though that regulation was validated by specific identification in the very legislation from which section 1903(w)(6) was derived.

The Department claims support for its restrictive position on participation in the financing of Medicaid expenditures from the definition of "provider-related donation" in section 1903(w)(2)(A) of the same statue. That provision does not justify the Department's position. When it was enacted as part of the 1991 legislation adopting the Provider Tax Amendments, the House conference Report emphasized 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. (Emphasis in the original)

And in connection with the adoption of implementing regulations, the Department's preamble explained

> Prior to the enactment of Public Law 102-234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a State's share of financial participation in the entire Medicaid program. As mentioned previously, the statutory provisions of Public Law 102-234 do not include restriction on the use of public funds as the State share of financial participation. Therefore, the provisions of § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.

The law has not change since the enactment of the 1991 statue and the implementing regulations, and the Department's May 29 issuance does not cite or rely on any change that would warrant the Department now in determining that public funds may not be the basis for certification or transfer, or that such a transfer would be seen as a prohibited provider donation.

Conclusion

On the issue of the definition of a 'unit of government" the issue comes down to this: (1) those providers that are themselves "units of government" under the CMS definition may participate in the funding of Medicaid expenditures (through certification or transfer) without regard to the source of the certified or transferred fund; (2) those public providers not themselves "units of government" but which receive funding from government sources derived from tax revenue may participate in the funding of Medicaid expenditures (by certifying their expenditures and by having the governmental unit certify the source of funds used); (3) the Department's current position is that public providers not themselves "units of government" may not participate in funding Medicaid expenditures from sources other than appropriated amounts derived from tax collections.

As shown by the arguments above, the third element is an unwarranted limitation, and there is a high probability that it will lead to substantial problems for providers that fall within the third category. A degradation is service capability undoubtedly will occur, and that would be disastrous for North Carolina's Medicaid program and the citizens it serves. The Department should abandon this third element, and return to its traditional position on participation by public providers in the funding of Medicaid.

Sincerely,

T. H. Galligan
Deputy Director – Budget and Finance

Cc: Carmen Hooker Odom
L. Allen Dobson, MD
Dan Stewart
Mark T. Benton
Roger Barnes

Submitter : Mr. Santiago Munoz **Date:** 07/13/2007

Organization : University of California

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Unit of Government Definition

Unit of Government Definition

See Attachment

CMS-2258-FC-24-Attach-1.PDF

#24

UNIVERSITY OF CALIFORNIA

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July 13, 2007

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

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

Dear Administrator Norwalk:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Proposed Rule **CMS-2258-FC** related to Medicaid payments.[1] These comments are submitted on behalf of the University of California (UC) Health System and its academic medical centers (AMCs) located at Davis, Los Angeles, Irvine, San Diego, and San Francisco. We appreciate the opportunity to comment on the revised definition of "unit of government" in Section 433.50. While some of the clarifications and changes to this section were appropriate, even as revised, the definition of unit of government improperly limits states' ability to fund the nonfederal share of Medicaid expenditures. The rule unnecessarily restricts (i) the types of public entities that can participate in Medicaid funding and (ii) states' ability to use local public funding for the Medicaid program. These restrictions are not authorized by statute and are inconsistent with Congressional intent. We respectfully urge CMS to withdraw the entire final rule, including the provision addressing units of government in Section 433.50.

[1] 72 Fed. Reg. 27949 (May 29, 2007).

The University of California

The UC clinical enterprise is the fifth largest healthcare delivery system in California and provides patient care services valued at over $4 billion. Additionally, the UC AMCs play a critical role in educating health professionals and advancing cutting-edge health-sciences research. Moreover, the UC AMCs offer services that are essential to the health and well being of Medicaid beneficiaries and all Californians including a broad array of highly specialized services such as trauma, neo-natal intensive care, cancer centers, geriatric and orthopedic centers of excellence, organ transplant programs, world class primary and preventive care, and extensive sub-specialties often available only in an academic setting.

Medicaid and uninsured patients represent nearly 30% of the patient population at the UC AMCs. We rely heavily on Medicaid payments to help ensure access to this patient population. This is especially important considering that we attract the highest resource intensive patients requiring specialty, tertiary and quaternary care. Quite simply, a significant number of our Medicaid patients have medical conditions that can only be managed in tertiary referral hospitals such as an academic medical center. The complexity of our patient population is reflected in the specialty and regional nature of the care we provide.

"Unit of Government" Definition

Although UC and its providers appear to fall within the definition of "unit of government" under revised Section 433.50, there is some ambiguity remaining in the language. If CMS intends to implement this final regulation, UC is seeking a clarification of its status as a unit of government, either in the regulation itself, or through another binding CMS policy statement.

Unlike most state universities, the University of California was not created by a state statute. The Regents of the University of California, created by Article IX, Section 9 of the California Constitution, is charged with the management of the UC health system. The UC AMCs are licensed to the Regents, not to the State of California, and the services to be provided are determined by the Regents. The Regents have no power to levy taxes. Financial support for the AMCs is derived from day-to-day operations, as well as through State appropriations for capital improvements and clinical teaching programs. Unlike other State agencies, financial responsibility for the operational and capital budgets of UC AMCs lies with the Regents, as do any profits or losses from operations. The Regents do not have independent taxing authority and the UC AMCs are not an integral part of those units of state government that do have such authority, as contemplated by the rule.

In comments to the proposed rule, UC expressed concern that the rule would restrict the use of "funds appropriated to State university teaching hospitals" in direct violation of the plain language of Section 1903(w)(6) of the Act. Such a restriction would preclude UC and its AMCs from funding the non-federal share of Medi-Cal services through intergovernmental transfers ("IGT") and certified public expenditures ("CPE"). CMS addressed this concern through two significant changes to Section 433.50.

Section 433.50 (a)(1)(i) has been revised to recognize as a unit of government, "a State university teaching hospital with direct appropriations from the State treasury..." Because the Regents and the UC AMCs are a single legal entity, the State appropriations for the UC teaching programs generally go to the Regents. The appropriations are then allocated by the Regents among its educational functions, including the medical education teaching programs. Thus, while the Regents clearly receive "direct" state appropriations, the UC teaching AMCs do not receive separate, individual appropriations. Nonetheless, UC should be considered a unit of government under Section 433.50(a)(1)(i) because, as the legal entity that owns and operates the UC health care providers, the Regents receive the "direct" State appropriations required under the revised rule. CMS should clarify that UC and its AMCs can provide the non-federal share of Medi-Cal expenditures though IGTs or CPEs under this reading of Section 433.50.

We also note that the statute does not limit its protection for "funds appropriated to State university teaching hospitals" under Section 1903(w)(6) of the Act to only those funds "directly" appropriated. Thus, if the inclusion of this "direct" appropriation requirement limits the State's use of UC funds for CPEs or IGTs, the regulation is inconsistent with the statute and should be deleted.

The UC AMCs may also be considered units of government under Section 433.50(a)(1)(ii). As revised, that section includes a provider that receive "appropriated funding as a State university teaching hospital providing supervised teaching experiences to graduate medical school interns and residents enrolled in a State university in the State." Clearly, the UC AMCs fall within this aspect of the unit of government definition.

If the statutorily-imposed moratorium expires and CMS implements the rule, it should clarify the ambiguities in the regulation so that it is clear that the State can rely on IGTs and CPEs from the University of California and its AMCs in support of the Medi-Cal program.

Although it appears that CMS has addressed the concerns with the definition of unit of government that are specific to the University of California, the final regulations issued

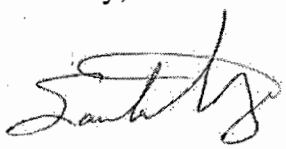
on May 29, 2007 are, taken as a whole, inconsistent with Congressional intent and should be withdrawn. In particular, Section 433.50, even as amended, inappropriately limits states' ability to fund Medicaid expenditures in violation of the Medicaid statute. While the revised definition of unit of government may recognize the UC providers as governmentally operated providers, the cost limit regulation would inappropriately limit payments to those same providers. As such, we believe CMS should withdraw the final rule in its entirety.

Finally, there are a number of other legal and technical issues raised in the comment letter submitted by the coalition of California's public hospitals paid under the California's Hospital/Uninsured Care Demonstration Project, approved under Section 1115 of the Social Security Act. The UC AMCs supports those comments and incorporate them by reference in this comment letter.

We believe the final regulations issued on May 29, 2007 are inconsistent with statutory language and should be withdrawn.

Thank you for the opportunity to comment on this proposal. If there are questions or if I can provide any additional information or input, please contact me at 510-987-9062 or santiago.munoz@ucop.edu.

Sincerely,



Santiago Muñoz, Associate Vice President
Clinical Services Development

cc: Medical Center CFOs

Submitter : Mr. Wright Lassiter III **Date:** 07/13/2007

Organization : Alameda County Medical Center

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment.

Unit of Government Definition

Unit of Government Definition

See attachment.

CMS-2258-FC-25-Attach-1.DOC

#25

ALAMEDA COUNTY MEDICAL CENTER

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

July 13, 2007

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

Re: Comments on Provisions of Final Regulations (CMS-2258-FC)
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 continued opposition to the Medicaid rule regarding providers operated by units of government. (CMS-2258-FC) [1] In particular, we appreciate the opportunity to comment on the revised definition of "unit of government" in Section 433.50. Even as revised, however, the definition improperly fails to recognize ACMC as a unit of government for Medicaid purposes. ACMC 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 implemented and ACMC can no longer participate in Medi-Cal funding, 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 clinic services. Therefore, ACMC urges you to withdraw the final rule.

In addition to the adverse impact on ACMC, the definition of unit of government improperly limits states' ability to fund the nonfederal share of Medicaid expenditures. The rule narrows the types of public entities that can participate in Medicaid funding and restricts the states' ability to use local public funding for the Medicaid program.

[1] 72 Fed. Reg. 29749 (May 29, 2007).

These restrictions are not authorized by statute and are inconsistent with Congressional intent. As a member of the California Association of Public Hospitals and Health Systems ("CAPH"), ACMC joins in the comments submitted by CAPH in response to the final regulation. Along with CAPH, ACMC urges you to withdraw the entire final rule, including the provision addressing units of government in Section 433.50.

The Alameda County 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.

Since its creation as a public hospital authority, ACMC has participated in Medi-Cal funding through intergovernmental transfers ("IGT") or certified public expenditures ("CPE") of its public funds. ACMC's contribution of the non-federal share of Medi-Cal expenditures is consistent with the Medicaid statute. Moreover, ACMC is expressly authorized to contribute to the funding of Medicaid expenditures under California's Hospital/Uninsured Care Demonstration Project ("Hospital Waiver') pursuant to the Special Terms and Conditions for that program.

Under Section 433.50, the Centers for Medicare and Medicaid Services ("CMS") will preclude ACMC from using its public funds to support the Medi-Cal program. CMS has provided no rationale that justifies this restriction. As discussed in ACMC's comments in response to the proposed regulations, the legal analysis relied upon by CMS to support the rule is seriously flawed. (Please see the attached copy of those comments for a full discussion of ACMC's concerns.) Notwithstanding the changes in the final rule, nothing in Section 1902(a) (2) or Section 1903(w) of the Social Security Act, or the legislative history of those provisions, supports Section 433.50.

The regulatory definition continues to be inconsistent with the plain language of the statutory definition of unit of government. The rule simply adds requirements to the statutory definition in Section 1903(w) (7) (G) of the Act. If Congress had intended to impose these additional requirements, 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.

CMS did not adequately respond to these concerns in the May 29, 2007 publication of the final rule.[2] For example CMS comments that "States have been ignoring the statutory limitation" by allowing entities like ACMC to participate in Medicaid funding through IGTs and CPEs in the past. This statement is entirely inconsistent with CMS' express recognition of ACMC as a governmentally operated hospital in California's Hospital

[2] 72 Fed. Reg. 29754-55.

Waiver. CMS' suggestion that no loss of federal funds will occur as a result of the rule is similarly without merit. The assumption that states will appropriate other funds to replace the public funds that can no longer be used to fund Medicaid services simply disregards the political reality in California and throughout the county. Contrary to CMS' assertion that the rule is designed to protect ACMC and similar entities, as numerous commenters noted, Section 433.50 and the related cost limit on governmentally operated providers will adversely affect overall Medicaid funding for safety net providers in California and nationally.

In conclusion, there is no legitimate federal interest in imposing these restrictions on California's ability to fund its Medi-Cal program and the rule should be withdrawn. Even if the congressionally imposed moratorium is permitted to expire in May 2008, CMS should reconsider the rule. In the event that CMS goes forward with implementing this rule, however, it should modify the definition of unit of government to make the definition consistent with the statute.

Sincerely,

Wright Lassiter III
Chief Executive Officer

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 supplemental Medi-Cal funding primarily related to subsidizing costs associated with our uninsured patient population. Since the majority of Medi-Cal supplemental funding is related to inpatient services, we would expect to see the following potential impacts:

1) Longer waits in the emergency room for inpatient beds, aggravating an already significant problem for ACMC
2) Forced ration based healthcare, longer wait times in the clinics for specialists and primary care, delayed surgeries. Some outpatient primary and specialty clinics may close entirely.
3) Closure of inpatient units
4) Focus on acute services rather than preventative services, will be seeing sicker patients.

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

It will limit our Medi-Cal reimbursements to the costs of providing Medi-Cal 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, Endsocopy 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 **$21 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 Lassiter III, CEO

Submitter : Ms. Paula Sanders

Date: 07/13/2007

Organization : CCAP/PACAH by Post & Schell P.C.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

Unit of Government Definition

Unit of Government Definition

See Below.

CMS-2258-FC-26-Attach-1.DOC

Re: CMS-2258-FC: Comments on Final Rule *Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Endure the Integrity of Federal-State Financial Partnership,* 72 Federal Register 29748 (May 29, 2007)

We are counsel to The County Commissioners Association of Pennsylvania (CCAP) and the Pennsylvania Association of County Affiliated Homes (PACAH). We appreciate the opportunity to comment on the final rule *Medicaid Program: Cost Limit for Providers Operated by Units of Government and Provisions to Endure the Integrity of Federal-State Financial Partnership,* CMS-2258-FC, 72 Fed. Reg. 29748 (May 29, 2007).

CCAP is a statewide, nonprofit, bipartisan association representing the commissioners, chief clerks, and solicitors of Pennsylvania's sixty-seven (67) counties. The Association serves to strengthen Pennsylvania counties' ability to govern their own affairs and improve the well-being and quality of life of their constituents. The Association strives to educate and inform the public, administrative, legislative and regulatory bodies, decision makers, and the media about county government. CCAP also has contractual agreements with a number of independent associations and organizations having ties to county government. PACAH is an affiliate of CCAP and represents the interests of county and county-affiliated nursing homes as well as private nursing homes in Pennsylvania. The overall intent of this affiliation process is to have mechanisms whereby these groups and CCAP can arrive at common policy positions.

Since 1995, qualified local government units, through CCAP, have participated in intergovernmental transfers (IGTs) with the Commonwealth of Pennsylvania. Additionally, many of CCAP's constituent county members have made certified public expenditures (CPEs) on behalf of their county nursing facilities. The Final Rule contains numerous provisions that would enact significant modifications to the Medicaid program, many of which would require fundamental changes in the way county governments and their constituent health and social service organizations operate. Most importantly, the Final Rule has the potential to disrupt totally the Medicaid payment system for Pennsylvania's county nursing homes.

CCAP respectfully requests that the Centers for Medicare and Medicaid Services (CMS) withdraw the revised definition, or in the alternative, delay the implementation date and revise the definition to recognize the flexibility and self-determination that states and local governments have traditionally exercised to define units of government and to establish appropriate funding mechanisms for the Medicaid program. CCAP urges CMS to remove barriers created in the rule that would significantly burden local government in the delivery of health care services to our country's most vulnerable citizens.

CCAP respectfully suggests that CMS has overstated its case and that there is no need for the Final Rule or revised definition, CMS already has sufficient safeguards under the existing review system and State plan approval process, as evidenced by the 10 percent rejection rate, to protect the integrity and accountability of the Medicaid program without overreaching and disturbing the delicate balance between federal, state, local governments public and private (non-governmental) health care providers.

Regulation Section 433.50(a)(1): Redefining "Unit of Government"

The Final Rule is inconsistent with the definition of a "unit of local government" as set forth in Title XIX of the Social Security Act:

> A unit of local government is a city, a county, a special purpose district, or other governmental unit in the State.

42 U.S.C. § 1396b(w)(7)(g). CMS's final rule restricts this definition to require, that for purposes of determining eligibility to contribute to Medicaid financing through intergovernmental transfers or certified public expenditures, a "unit of government" must be:

> [A] State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) *that has taxing authority [or] has direct access to tax revenues.*

Proposed 42 C.F.R. § 433.50(a)(1)(i) (emphasis added). This definition is inconsistent with the reality of many providers operated by units of local government who have access to tax revenues guaranteed by contract, statute, ordinance or other "non-direct" arrangements. The revised definition fails to recognize the practical implications of contractual arrangements, for example, between some Pennsylvania counties and their nursing homes which may be established as independent but county-controlled and financed not-for-profit organizations.

Even more troubling is CMS's attempt to further limit the number of eligible contributors by the imposition of the following restrictive requirement:

> A health care provider may be considered a unit of government only when it is *operated by a unit of government* as demonstrated by a showing of the following:
>
> (A) The health care provider has generally applicable taxing authority; or
>
> (B) The health care provider has direct access to generally applicable tax revenues. This means the health care provider is able to directly acces 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.*

Proposed 42 C.F.R. § 433.50(a)(1)(ii)(A)(B) (emphasis added). CCAP respectfully suggests that these criteria are too narrow and fail to recognize other *bona fide* and legitimate indicia of county operation. CCAP respectfully disagrees with CMS's position that taxing authority or *direct access* to tax revenues is the only allowable criterion to prove operation by a local unit of

government. CCAP further submits that CMS's position is inconsistent with the express language of the Social Security Act and with congressional intent.

The revised regulatory definition ignores the realities facing many public health care providers, who, for a variety of reasons, have chosen to restructure their organizational and legal compositions. Some may have undergone restructuring to protect the public fisc from the vagaries and threats from plaintiff negligence suits, which are being brought against long term care providers with increasing frequency, while others may have restructured to assure increased efficiencies and economies. Such restructurings should not, however, disqualify such public providers and units of government from being allowed to participate in Medicaid funding arrangements through IGTs and CPEs.

Pennsylvania has always recognizes that local governments have many reasons for structuring their health care providers in different ways depending upon the needs of the specific localities. Toward that end, the Pennsylvania Medicaid program identifies a county nursing facility as a licensed long term care nursing facility that is enrolled in the Medicaid program as a provider of nursing facility services and is "*controlled by the county* institution district or by county government if no county institution district exists." 55 Pa. Code § 1187.2 (emphasis added). The fact that the public health care provider is an independent entity does not negate its existence as a unit of government that fulfills the legal obligations of the local government to meet the health care needs of Pennsylvania citizens. Pennsylvania looks beyond form to substance and intent.

By ignoring the characteristic of public control of county nursing facilities that forms the hallmark of Pennsylvania's definition of a county nursing home, the Final Rule would severely restrict the number of entities in Pennsylvania which would qualify as units of government for purposes of the Pennsylvania Medicaid program. By adopting such a narrow definition of "unit of government," CMS has exceeded its regulatory authority and ignored both the language of Title XIX of the Social Security Act as well as long-established principles of comity between the federal government on the one hand, and state and local governments on the other.

Submitter : Ms. Keri Disney **Date:** 07/13/2007

Organization : Parkland Health & Hospital Sytem

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2258-FC-27-Attach-1.DOC

#27

Parkland Health & Hospital System

July 13, 2007

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

Parkland Memorial Hospital

Community Oriented Primary Care

Parkland Community Health Plan Inc.

Parkland Foundation

Re: Comments on Unit of Government Definition (§ 433.50) contained in CMS–2258–FC: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748 (May 29, 2007).

Dear Ms. Norwalk:

Parkland Health & Hospital System (Parkland) writes to convey its continued serious concerns regarding the Centers for Medicare and Medicaid Services' (CMS) proposed definition of a unit of government under 42 C.F.R. § 433.50 as published in CMS-2258-FC (the Final Rule). The Final Rule does not fundamentally change the most damaging provisions of CMS-2258-P (the Proposed Rule) to which Parkland and a diverse group of other commenters expressed considerable opposition. ***Parkland reiterates its strong request that CMS withdraw the entire Final Rule, including the definition of a unit of government.***

Parkland fills a unique place in the Dallas / Fort Worth Metroplex and has since our inception in 1894. We are mandated to furnish medical aid and hospital care to indigent and needy persons residing in Dallas County. However, our services go far beyond the Dallas County lines as we are a regional referral center. We provide $409 million in uncompensated care annually. This is due to the fact that we were the first Level I trauma center in the state and are only one of two in Dallas County. Additionally, we operate a Level III Neonatal Intensive Care Unit and the second largest civilian burn center in the United States. On an annual basis, we will admit 42,682 patients and deliver 16,489 babies. Through our outpatient clinics and our system of community health centers, we will have 876,555 visits annually. In short, we are the provider of last resort. Dallas County has few other options should Parkland go away.

5201 Harry Hines Boulevard, Dallas, Texas 75235 214/590-8006 Fax 214/590-8096
http://www.pmh.org

As you know, Congress has prohibited CMS from taking any steps to implement this rule until May 25, 2008.[1] Parkland does not believe that CMS has the authority to receive or review comments during the period of the legislative moratorium, and therefore submits this letter under protest. If the moratorium does expire without further action from Congress, we believe that the public should be permitted a fresh opportunity to comment on the definition of a unit of government based on circumstances in effect at that future time. CMS should not rely on stale comments prepared and received while the agency is under a moratorium.

Furthermore, if the moratorium expires without further Congressional action, CMS must take into consideration Congress' intent in enacting the moratorium when implementing the effective dates outlined in this Final Rule. The moratorium provides a clear indication that Congress views the issues raised by the rule as being within the legislative domain and intends to address these issues itself. Congress was clearly concerned about CMS implementation of the regulation. An overwhelming bipartisan majority of Congress (65 Senators and 263 members of the House) has gone on record in opposition to the regulation since its release in proposed form in January 2007. The legislative moratorium passed Congress with significant bipartisan support.

In rushing to submit the Final Rule to the Office of the Federal Register *after* Congress had already approved a legislative moratorium and just hours before the President signed it into law, CMS deliberately defied clear Congressional intent to prevent implementation from moving forward and allow Congress to consider the issues raised. When Congress passed the moratorium, the regulation was in proposed form; before it could become effective, the regulation would have needed to be finalized and sixty days would have had to elapse after publication.[2] CMS' clever administrative timing should not undo what Congress thought it had accomplished– providing a year for it to consider alternatives to the regulation, followed (if necessary) by an additional sixty days for Congress to consider whether to reject a final regulation through the procedures outlined in the Congressional Review Act (CRA).[3] Following Congressional intent, no provision of the regulation should become effective prior to sixty days after the moratorium expires. Moreover, states cannot be expected to take any steps before May 25, 2008 towards implementing a regulation that is unlikely to go into effect in its current form.

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[1] Pub. L. No. 110-28, § 7002.
[2] Congressional Review Act § 801(a)(3), 5 U.S.C. § 801(a)(3)(2006).
[3] *Id.* §§ 801-808.

As solicited in the Final Rule, Parkland and other members of the National Association of Public provide the following comments to continue to urge CMS to reconsider its new definition of a unit of government. Despite the significant concerns raised in the hundreds of comment letters submitted in response to the Proposed Rule, CMS has not fundamentally altered this new definition. Previous comment letters have laid out in extensive detail the flawed legal and policy assumptions underlying the proposed definition, and our concerns continue to apply in large part to the revised definition. This narrow definition of a unit of government would usurp the traditional authority of States to identify their own political subdivisions, exceed the authority provided in the Medicaid statute, and undermine past and future efforts to date by States to make units of government more efficient and less reliant on public tax dollars.

The comments in this letter focus on the modifications to the unit of government definition between the Proposed and Final Rules. Our comments center around five themes:

1. The modifications of the unit of government definition are insufficient to address the legal and policy concerns underlying the original proposal.

2. Allowing States only initial determination of the governmental status of their providers based on the CMS form does not show adequate deference to State law interpretations of governmental status.

3. CMS does not adequately acknowledge the burden of identifying all governmental providers within 90 days.

4. CMS's clarification regarding the scope and prospective application of the unit of government definition is appropriate.

5. CMS should acknowledge the impact of the one-year moratorium on the effective dates of the provisions of the Final Rule and ensure adequate time for Congressional review and State and provider compliance.

We elaborate on each of these points below.

1. The modifications of the unit of government definition are insufficient to address the legal and policy concerns underlying the original proposal.

In the Final Rule, CMS modified the definition of a "unit of government" included in the proposed regulation in a manner that will allow an undetermined number of additional entities to qualify as governmental, including certain teaching hospitals and Indian tribes. While in general, Parkland supports a more expansive definition, the modifications adopted by CMS merely tinker around the edges of the definition and do not address the underlying fundamental flaws of CMS' attempt to impose a uniform and restrictive Federal definition on States.

a. CMS has impermissibly narrowed the statutory definition

Notwithstanding the changes made in the final regulation, CMS has still impermissibly narrowed the definition of a unit of government adopted by Congress. Congress defined the term "unit of local government" to mean "with respect to a State, a city, county, special purpose district, or other governmental unit in the State." The Final Regulation defines it as these same types of entities but narrows the universe of units of government by requiring the entity to meet further criteria in order to qualify – the entity must also have "direct access to tax revenues, [be] a State university teaching hospital with direct appropriations from the State treasury, or [be] an Indian tribe...."[4] While the Final Rule expands the definition to include entities with direct access to tax revenues, State university teaching hospitals and Indian tribes, the definition is still significantly more narrow than that adopted by Congress, and would still impermissibly exclude a wide range of entities that are clearly governmental under State law but that do not have direct access to tax revenues or otherwise meet CMS' additional criteria. The statutory definition includes an undefined catchall category of "other governmental unit[s] in the State," indicating Congress' recognition of the wide variety of structures into which a State may subdivide itself. The Final Rule continues to override the statutory deference granted to various forms of units of government and imposes a single, narrow Federal standard.

b. State University Teaching Hospitals May Be Units of Government without Direct Appropriations

Parkland supports CMS' inclusion of State university teaching hospitals in the definition of a unit of government, but believes that CMS has not gone far enough. As with other governmental hospitals, State university teaching hospitals have been established

[4] 42 C.F.R. §433.50(a)(1)(i) (as included in the Final Rule).

through a wide variety of organizational structures, many of which would not meet CMS' narrow definition of a unit of government. Some of these governmental teaching hospitals receive direct appropriations, some do not. There is no statutory basis for requiring the receipt of appropriations as a prerequisite to being governmental. The reference to "funds appropriated to State university teaching hospitals" in the statute does not appear in the section defining a unit of government; it is included as an example of the types of protected funds that the Secretary may not restrict from use as the non-Federal share.

c. The addition of "direct access to tax revenues" to the proposed definition is one of form, not substance.

CMS has proposed to include in the "unit of government" definition at 42 C.F.R. § 433.50(a)(1)(i) entities that do not have taxing authority but do have "direct access to tax revenues" of a related unit of government. This change does not, however, substantively expand the universe of health care providers that would be considered governmental, as the definition in the Proposed Rule had already regarded providers with such direct access to tax revenues as "operated by" units of government and therefore considered units of government under § 433.50(a)(1)(ii). This modified regulation in the Final Rule therefore does not provide any additional flexibility to include a broader group of public providers, and Parkland continues to object to CMS' proposed definition as impermissibly narrowing the statutory limitation on units of government.

d. CMS' deviation from a narrow unit of government definition with respect to Indian tribes should be extended to all entities

Parkland supports the inclusion of all Indian tribes regardless of taxing authority in the definition of a unit of government. We note, however, that there is no statutory basis for treating Indian tribes any differently from other entities that are units of government under state law, and CMS does not attempt to base its exception on any statutory language. Rather, CMS appears to have adopted an expansive and deferential unit of government definition for Indian tribes based solely on its policy preferences. We agree with the policy choices adopted by CMS for Indian tribes. We submit, however, that CMS' recognition that its proposed definition was too narrow an interpretation of the statute with respect to Indian tribes is simply more evidence that Congress did not intend such a narrow definition in the first place.

2. Allowing States only initial determination of the governmental status of their providers based on the CMS form does not show adequate deference to State law interpretations of governmental status.

CMS acknowledged receiving many comments that the creation of a new Federal regulatory standard to determine which public entities within a State are considered to be "units of government" violates the Federal-State partnership of the Medicaid program and the principles of federalism on which it rests. CMS' response, however, was not to defer to State interpretations, but instead to require that States make the initial determination of the governmental status of their providers subject to the proposed narrow definition and final agency review. If CMS disagrees with the State's determination, the State will be considered out of compliance with Federal statutory and regulatory criteria and may be subject to denial of Medicaid reimbursement, State plan amendments, and/or disallowances of claims for Federal financial participation.

Congress' statutory definition of a unit of government affords due deference to States' determinations of which of their instrumentalities are governmental, as required by Constitutional principles of federalism. CMS shows no such deference by nominally allowing States to make the initial determination but requiring them to do so according to restrictive Federal criteria and with the possibility of their determination being overturned by CMS. The proposed definition continues to be an unprecedented intrusion into the core of States' rights to organize themselves as they deem necessary.

3. CMS does not adequately acknowledge the burden of identifying all governmental providers within 90 days.

In the preamble to the Final Rule, CMS newly requires each State to report its universe of governmentally-operated health care providers with the first quarterly expenditure report due ninety (90) days after the effective date of the regulation. Multiple commenters noted in response to the Proposed Rule that for some health care providers, completion of the form may require extensive legal research and analysis. Parkland underscores this point given the proposed deadline for States to submit the list. Whether an entity has "direct access to generally applicable tax revenues," whether it is an "integral part" of a "unit of government with taxing authority," whether the unit of government is "legally obligated" to fund the provider's "expenses, liabilities, and deficits," and whether a "contractual arrangement with the State or local government" is the "primary or sole basis for the health care provider to receive tax revenues" are often extremely complex questions under State law, requiring constitutional, statutory, regulatory, administrative and caselaw research. In many cases the answers are not clearcut, and they are sometimes contradictory. States and their lawyers will be required

to make judgment calls, balancing factors that do not all point in the same direction. To the extent that there are many governmental providers (or potential governmental providers) in a State, the burden of making these determinations could be substantial. Considering the potential complexity of this determination, and that CMS may be issuing additional guidance on use of the "Tool to Evaluate the Governmental Status of Heath Care Providers" form as warranted, States may have difficulty in completing these determinations within the required timeframe.[5]

Parkland believes that ninety days (90) is entirely insufficient to accurately identify all governmental providers. Furthermore, as explained in more detail in Comment 5, CMS should not require or expect States to expend the time and resources necessary to do so during the period of the legislative moratorium. Given the expressed intent of Congress to override at least portions of the regulation, States cannot be expected to take any steps before May 25, 2008 towards implementing a regulation that is unlikely to go into effect in its current form.

4. CMS' clarification regarding the scope and prospective application of the unit of government definition is appropriate.

Parkland supports CMS' clarification in the Final Rule that the new definition of unit of government will be applied prospectively only.

Parkland further appreciates CMS' clarification that the proposed definition of a unit of government is limited to the purposes of financing the non-Federal share of Medicaid payments and application of a Medicaid upper payment limit on such governmental health care providers, and is not intended to otherwise alter Federal or State law interpretations of public status.

5. CMS should acknowledge the impact of the one-year moratorium on the effective dates of the provisions of the Final Rule and ensure adequate time for Congressional review and State and provider compliance.

Although CMS has not specifically solicited comments on the effective dates of the various provisions of the regulation, given the enactment of a Congressional moratorium on implementation of the regulation within hours of the issuance of the

[5] Of course, given the Congressional moratorium on implementation of the regulation, CMS should not expect states to begin to undertake this analysis during the period in which the moratorium is in effect.

Final Rule, Parkland believes it important to address the impact of the moratorium on the effective dates outlined in the rule. The moratorium prohibits the Secretary of Health and Human Services from taking "*any action* (through promulgation of regulation, issuance of regulatory guidance, *or other administrative action)*" to finalize or "otherwise implement" the Proposed Rule or any "rule or provisions" similar to those in the Proposed Rule.[6]

Congress' concern about implementation of the regulation could not be clearer. Since the proposed Medicaid rule was released in January 2007, an overwhelming bipartisan majority of Congress (65 Senators and 263 members of the House) has gone on record in opposition to it. The moratorium passed Congress with significant bipartisan support. Furthermore, the legislative history of the moratorium provides clear indication that Congress views the issues raised by the rule as legislative domain and intends to address these issues itself during the period of the moratorium. For example, Senator Richard Durbin, Assistant Majority Leader of the Senate and one of the prime sponsors of the moratorium, stated that "the purpose of this amendment is simply to declare a moratorium on this new rule until we can put together this new approach through the Finance Committee."[7] Senator Max Baucus, Chair of the Senate Finance Committee, also suggested that "[i]t is Congress's job to make major changes to the law. A 1-year moratorium will give the Finance Committee enough time to study this issue and determine the right approach."[8] Senator Charles Grassley, Ranking Member of the Finance Committee, stated "If some people think CMS has gone too far, then we should review their actions in the Finance Committee. . . If we think there are things we should have done differently, then we should legislate."[9] Indeed, Sen. Grassley voiced specific concern about the definition of governmental provider and suggested that these concerns should be dealt with in the Finance Committee.[10] In rushing to submit the Final Rule to the Federal Register office *after* Congress had already approved the moratorium and just hours before the President signed it into law, CMS deliberately defied clear Congressional intent to slow down the implementation of the regulation and allow Congress to consider the issues raised.

Notwithstanding CMS' rush toward implementation, Congress' intent in enacting the moratorium must be taken into consideration in implementing the effective dates

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[6] Pub. L. No. 110-28, § 7002 *(emphasis added)*.
[7] 153 Cong. Rec. S4026 (Mar. 28, 2007).
[8] 153 Cong. Rec. S5138 (Apr. 26, 2007).
[9] 153 Cong. Rec. S4020 (Mar. 28, 2007).
[10] *Id.*

outlined in the Final Rule. Congress has clearly stated that it does not want implementation of the regulation to move forward in any way during the period of the moratorium. That intent must be respected if the moratorium should expire without further Congressional action.

a. If Congress takes no further action, CMS should provide at least 60 days after the moratorium expires before the provisions of the Final Rule take effect.

When Congress passed the moratorium, the regulation was in proposed form; it would have needed to be finalized and sixty days would have had to elapse before any portion of it could become effective.[11] CMS waited until after final Congressional action on the moratorium but before the President signed the legislation to issue the Final Rule. CMS' clever administrative timing, however, should not undo what Congress thought it had accomplished through the moratorium – providing a year for it to consider alternatives to the regulation, followed (if necessary) by an additional sixty days for Congress to consider whether to reject any final regulation through the procedures outlined in the CRA.[12] At a minimum, no provision of the regulation should become effective prior to sixty days after the moratorium expires.

It is worth noting that the language in the Final Rule that would require compliance with the cost limit for institutional providers as of State plan rate year 2008 likely violates of the CRA. Section 801(a)(3) of the CRA states that the earliest that a rule may be effective is sixty (60) days from publication.[13] In this case, sixty days from publication is July 27, 2007. Thus, in the majority of States where State plan rate year 2008 begins July 1, 2007 (i.e., prior to July 27, 2007), the cost limit provision of the Final Rule would violate CRA requirements intended to ensure adequate Congressional review.

A sixty day period is the minimum that should be afforded to States to come into compliance as well.[14] Given the existence of the moratorium and the expressed intent of Congress to override at least portions of the regulation, States cannot be expected to take any steps before May 25, 2008 towards implementing a regulation that is unlikely to go into effect in its current form. Furthermore, to the extent that States or providers may require further clarifications from CMS in order to do so (as CMS acknowledges

[11] Congressional Review Act § 801(a)(3), 5 U.S.C. § 801(a)(3)(2006).
[12] *Id.* §§ 801-808.
[13] 5 U.S.C. § 801(a)(3) (2006).
[14] Parkland believes that sixty days is far too short of a time for states to come into compliance with many of the provisions of the regulation, as discussed in our comments to the Proposed Rule.

may be necessary related to the form for determining governmental provider status[15]), such guidance cannot be made available until after the end of the moratorium. Basic principles of fairness require CMS to provide a time period after the end of the moratorium before this Final Rule would take effect.

b. The comment period related to the new definition of a unit of government should not begin until after the moratorium expires.

The language of the moratorium clearly prohibits CMS from taking "any action (through promulgation of regulation, issuance of regulatory guidance, or *other administrative action*)" to implement any provisions of this rule.[16] Parkland believes that accepting comments on the definition of unit of government is an "administrative action" prohibited by this language. If the moratorium were to expire without further legislation by Congress, the 45-day comment period should begin on May 25, 2008. Furthermore, it is consistent with the underlying principles of notice and comment rulemaking that the public should be permitted a contemporaneous opportunity to comment based on circumstances in effect at that future time. CMS should not rely on stale comments prepared and received while the agency is under a moratorium. CMS should initiate a new comment period for the unit of government definition upon expiration of the moratorium.

c. If the moratorium expires without Congressional action, CMS should provide adequate time for States to come into compliance with the cost limit regulation.

The Final Rule indicates that institutional governmentally-operated health care providers must comply with the Medicaid cost limit beginning with the Medicaid State plan rate year 2008. As explained above, we believe that this compliance date violates the CRA, notwithstanding the legislative moratorium. Furthermore, if the legislative moratorium expires on May 25, 2008 without further Congressional action, we believe that the regulation could not become effective until 60 days thereafter (or July 24, 2008), which will be after the beginning of rate year 2009 for most States. As a practical matter, therefore, given all of the steps that States need to take to prepare for the implementation of a cost limit (including developing new or modifying existing cost reports, adopting State plan amendments, making changes to their State budgets, etc.) it would be inappropriate to implement the cost limit for institutional providers prior to rate year 2010 (or the first rate year that begins after sixty days after the expiration of the moratorium). With respect to non-institutional providers, the cost limit should be

[15] 72 Fed. Reg. 29748, 29764-65 (May 29, 2007).
[16] Pub. L. No. 110-28, § 7002 (*emphasis added*).

Submitter : Mr. Patrick Wardell **Date:** 07/13/2007

Organization : Hurley Medical Center

Category : Hospital

Issue Areas/Comments

Unit of Government Definition

Unit of Government Definition

See Attachment.

CMS-2258-FC-28-Attach-1.DOC

#28

July 13, 2007

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

RE: Hurley Medical Center's Comments to the Provisions Regarding Cost Limits For Public Providers and "Unit of Government" Definition in the Final CMS Rule 2253-FC Published May 25, 2007

Hurley Medical Center appreciates the opportunity to offer additional comments on the specific provisions of the CMS *Final Rule* which redefine "Units of Government". I would first like to present you an overview of who we are to put the impact of these provisions in proper context.

WHO WE ARE – An Overview of Hurley Medical Center:

Hurley Medical Center was established by the City of Flint as a part of the city government in 1905. It is a city-chartered hospital with a governing Board of Hospital Managers appointed by the Mayor of the City of Flint, with approval of the Flint City Council. Hurley has enjoyed governmental status for more than 100 years. In 1985, the United States Department of Treasury documented in a letter to Hurley, its status as a governmental entity, declaring it to be an instrumentality of a political subdivision of the state of Michigan, and thus, exempt from Federal income tax as provided under Section 115 (a)(2) of the Code. The federal government's affirmation of Hurley's governmental status is consistent with the City of Flint's designation of Hurley as a governmental entity in its City Charter. However, if CMS takes the position that HMC is not a unit of government, there is a contradiction involving two (2) federal agencies, as discussed fully herein.

Hurley is the largest hospital in Genesee County with 461 beds. Hurley is this region's premier public medical center and teaching hospital, providing safe, reliable, high-quality care for thousands of Genesee County residents each year. Hurley is one of the largest employers in Genesee County and provides about 2,200 jobs to local residents. Nine (9) unions represent Hurley's employees. Hurley enjoys a positive and productive relationship with all its workers.

Hurley Medical Center is the only medical center in the region that provides specialty care in: Trauma, emergency and critical care services, advanced burn center, kidney transplantation, neonatal intensive care, pediatric intensive care, high risk pregnancy care, and psychiatric services. The volume of patients seeking care and treatment at Hurley is tremendous. In 2005, Hurley served 23,211 inpatients. The number of outpatient visits

totaled 472,208. The number of babies born at Hurley was 2,824 and more than 78,084 patients visited Hurley's Emergency Department. Almost 20 percent of Genesee County residents rely on Medicaid. One in five children in Genesee County lives in poverty. 27 percent of the people of Flint live in poverty, significantly more than the national average of 11.7 percent. The Flint and Genesee County community, particularly the poor, has depended on Hurley Medical Center for the past 100 years.

It is Hurley's mission to provide care to everyone, without regard to ability pay. As the primary Medicaid health care provider in the region, Hurley provides more than $20 million a year in uncompensated care to the community. Without sufficient governmental assistance, Hurley's ability to continue to provide medical services critical to our community will be jeopardized, and maybe lost.

Comments on the Final Rule definition of "Unit of Government": It is our view that in the Proposed Rule, CMS had proposed a restrictive new definition of "unit of government" which would substantially limit the types of entities authorized to provide non-federal share funding and determine which healthcare providers would be subject to the new cost limit. These comments address the following specific points discussed in this Final CMS Rule.

Providers with Direct Access to Tax Revenues: CMS has proposed to include in the "unit of government" definition governmental entities that do not have taxing authority but do have "direct access to tax revenues" of a related unit of government. We understand this to mean that with respect to providers, direct access to tax revenues means that the provider can directly access funding as an integral part of a unit of government with taxing authority that is legally obligated to fund the provider's expenses, liabilities and deficits. We note that this change is apparently not intended to be substantive, as the Proposed Rule had already considered providers with such direct access to tax revenues to be "operated by" units of government - the Final Rule would consider them to be units of government. Despite now defining such providers directly as units of government, this revised definition, nevertheless, impermissibly narrows the statutory definition of a unit of government and usurps the sovereign, constitutionally guaranteed power of the states, to define its own units of government.

Prospective Application of Unit of Government Definition. We understand that the Final Rule intends to clarify that the new definition will be applied prospectively only, effective 60 days after publication of the Final Rule (subject to the moratorium. Prospective application of the Final Rule does not lessen the infringement on states' rights.

The provisions of the Final Rule, granting CMS the ultimate determination as to who is a "unit of government", create a conflict among the various branches of government. We understand that the agency will now allow states to make the initial determination of a health care provider's governmental status using a slightly revised Tool to Evaluate the Governmental Status of Health Care Provider. The revised Tool, originally issued with the Proposed Rule, now includes a question asking for the state's

initial determination. CMS reserves the right, however, to disagree with the State's determination. CMS will require that States maintain copies of the Tool on file for CMS examination upon request. In addition, each State must report to CMS on its universe of governmentally-operated health care providers within ninety (90) days of the effective date of the regulation (subject to the moratorium). Despite these changes and consideration of state input, Hurley submits that CMS wrongfully rejected commenter proposals to defer to States on the definition of governmental providers and that the ultimate determination of who is a unit of government should remain entirely with the states. ***The provisions of the Final Rule, as it applies to Hurley Medical Center, create a conflict among the various branches of government, including the federal government; the state; and, the local city government. The federal government, specifically, the Internal Revenue Service, has already defined Hurley Medical Center, as a political subdivision of the state, and thus, a "unit of government" with tax-exempt status. The State of Michigan has already defined a "Home Rule City" (The Home Rule City Act - M.C.L. 117.1 et. seq.), which the city of Flint qualifies, and mandates and delegates to such cities full executive and legislative authority in accordance with the terms of their duly enacted city charters. The City of Flint, as a Home Rule City, has defined Hurley Medical Center to be a multiple member body of the City, and thus, a unit of government. This authority, to define governmental units, which CMS now attempts to assume, therefore clearly lies with the state, and for purposes of tax-exempt status, the Internal Revenue Service.***

It is hoped and expected that CMS will give serious consideration to the comments of public providers on this *Final Rule,* and will not hastily implement these new provisions upon expiration of the President's moratorium. Thank you.

Sincerely,

Patrick Wardell
President & Chief Executive Officer

Submitter : Mr. John Bluford **Date:** 07/13/2007

Organization : Truman Medical Center

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-2258-FC-29-Attach-1.PDF

#29

TMC
TRUMAN MEDICAL CENTERS
Better. For Everyone.

Executive Office

July 13, 2007

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

Re: Comments on Unit of Government Definition (§ 433.50) contained in CMS–2258–FC: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748 (May 29, 2007).

Dear Ms. Norwalk:

Truman Medical Centers (TMC) writes to convey its continued serious concerns regarding the Centers for Medicare and Medicaid Services' (CMS) proposed definition of a unit of government under 42 C.F.R. § 433.50 as published in CMS-2258-FC (the Final Rule). The Final Rule does not fundamentally change the most damaging provisions of CMS-2258-P (the Proposed Rule) to which TMC and a diverse group of others expressed considerable opposition. Truman Medical Centers *reiterates its strong request that CMS withdraw the entire Final Rule, including the definition of a unit of government.*

TMC's comments on Defining a Unit of Government were conveyed on March 19, 2007. Those comments are attached. TMC, along with many others, does not believe that CMS has the authority to receive or review comments during the period of the legislative moratorium, and therefore submits this letter in protest.

Again, Truman Medical Centers reiterates its strong request that CMS withdraw the entire Final Rule, including the delimitation of a unit of government.

Sincerely,

John W. Bluford
President/CEO

Submitter : Mr. Cary Adams **Date:** 07/13/2007

Organization : Murphy Austin Adams Schoenfeld LLP

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Unit of Government Definition

Unit of Government Definition

See Attachment

CMS-2258-FC-30-Attach-1.PDF

CMS-2258-FC-30-Attach-2.PDF

#30

CARY M. ADAMS
(916) 446-2300, EXT. 3001
cadams@murphyaustin.com

July 13, 2007

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-FC
P.O. Box 8014
Baltimore, MD 21244-8014

Re: Comment on Unit of Government Definition

Dear CMS:

We represent a number of disproportionate share hospitals in the State of California. These providers are located in counties that are part of the County Medical Services Program ("CMSP"). We urge CMS to clarify that CMSP is a "unit of government" eligible to IGT funds for Federal matching. CMSP was created by state statute to assist in administration of indigent healthcare programs on behalf of California counties with a population under 300,000. (WIC, §16809.) Counties eligible to participate in CMSP are identified by name in the statute; 34 counties participate in the program. (WIC, §16809.3.) The CMSP Governing Board is also a creature of statute and is considered a "public entity" within the meaning of California state law. (*See* WIC, §16809.4.) Pursuant to Section 16809 et seq. approximately $220 million in tax revenue is appropriated annually directly to CMSP to pay for these programs. The bulk of this revenue comes from State Realignment funding and Realignment Growth funding, which are portions of vehicle licensing taxes and state sales taxes allocated for healthcare purposes, and a fraction is required by state law to be contributed by each county from their general funds, in proportions specified by State Statute. For each source of funding, specified amounts or percentages are noted as being associated with each of the thirty-four counties. None of CMSP's funding comes from provider donations or provider taxes.

With this funding the CMSP administers and pays for programs that provide health coverage for indigent residents of these thirty-four counties. CMSP operates no hospitals or other direct providers of care, but instead contracts with the providers to pay them, or contracts with a third party administrator that in turn contracts with providers, to pay them. In the event that there is a shortfall in funding, each county is required as a condition of its contract with CMSP to provide supplemental funding in proportions specified by State statute to fill the funding gap.

As we read the new section 433.50(a)(1)(i), we believe CMSP is and should be covered by the definition of "other governmental unit in the State that . . . has direct access to tax revenues . . . ." It is certainly a unit of government and by statute it has direct access to more than $220 million in state and county funding, plus the ability to obtain more to cover any shortfall. It operates no providers and receives no provider taxes or donations. We believe CMSP, like larger counties, should be eligible to IGT its funds to serve as the state portion of Medicaid funding to be matched by federal financial participation. It would be bad policy to penalize these smaller, rural, poorer counties just because they look to a state unit of government to provide administrative services and pay for their indigent care programs. It would bar a source of revenues available to larger counties and therefore inappropriately discriminate against smaller counties

We urge CMS to make explicit that a state unit of government like CMSP qualifies as a source of IGTs to fund the state portion of Medicaid, eligible for federal match, either by stating as much in the regulation, or agreeing with the interpretation stated above in published responses to comments.

Very truly yours,

MURPHY AUSTIN ADAMS SCHOENFELD LLP

CARY M. ADAMS

CMA/td

Submitter : Dr. Robert Robinson **Date:** 07/13/2007

Organization : Division of Medicaid - State of Mississippi

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Unit of Government Definition

Unit of Government Definition

Docket Number: CMS-2258-FC - Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership

CMS-2258-FC-31-Attach-1.PDF

#31

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

July 13, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P. O. Box 8014
Baltimore, Maryland 21244-8014

Attention: **CMS-2258-FC**

RE: Unit of Government Definition (SEC 433.50)
Final Rule: 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:

The State of Mississippi respectfully submits its comments to the final rule published June 22, 2007. This final rule would serve to disallow practices in Mississippi that the State has openly conveyed to CMS and its agents (including the Office of Inspector General).

With this final rule, the Administration would reverse the precedents that have been established through decades of CMS actions. It would be assumed that heretofore all of the providers participating in approved Intergovernmental Transfers (IGT) and Certified Public Expenditures (CPE) activities within all states were meeting the new found definition of "local government" and not the definition of "non-state, public" that has, in fact, been used as a standard by countless states and CMS for decades. CMS need only look at the Medicare cost reports submitted by the providers that have been audited related to Medicare, Upper Payment Limit (UPL), Disproportionate Share Hospital (DSH), and Medicaid payments in the State of Mississippi to see that most of the public hospitals that voluntarily assisted the State to meet Federal matching requirements defined themselves as "private, nonprofit."

The State of Mississippi Division of Medicaid reimburses costs for hospital treatment for needy persons annually in the amount of approximately $234,000,000 for DSH. Of this amount, the State pays between approximately $45,000,000 and $60,000,000, and receives Federal financial participation (FFP) in the approximate amount of $189,000,000. The State has shared in the cost as required, reducing the Federal medical assistance percentage (FMAP) of 100 per centum to 75 per centum, which includes delegation of some responsibility to local sources.

There are various appropriate methods of financing that are necessary to establish the foundation for funding local health care facilities using state, county, and municipal funds. The fact that states and units of local government have seen fit to build upon public, nonprofit entity investments and to leverage their resources in caring for the poor and underserved would seem to be a model for the very public/private partnerships that the Administration has sought to foster.

The final rule does not represent an effort to clarify; rather, it represents a reversal of clearly demonstrated CMS policy and practice that has been in place for decades. CMS's requirement that an entity must have a "general applicable taxing authority" would restrict the use of funds at the local levels within states beyond the intent of Congress. Although the time frame has been extended to June 25, 2008, there has been a complex financing system designed and implemented under scrutiny from CMS and utilized only to benefit the most vulnerable residents of the State, which would be equally as complex to redesign.

Sincerely,

Robert Robinson
Executive Director

Cc: Andrea Maresca, MPH
American Public Human Services Association

Submitter : Mr. Charles Miller **Date:** 07/13/2007

Organization : Covington & Burling LLP

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attached.

Unit of Government Definition

Unit of Government Definition

See attached.

CMS-2258-FC-32-Attach-1.DOC

#32

BEFORE THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

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

SUPPLEMENTARY JOINT COMMENTS RELATING TO
THE DEFINITION OF UNITS OF GOVERNMENT ON
BEHALF OF THE STATES OF ALASKA, CONNECTICUT, IDAHO, LOUISIANA, MARYLAND, MICHIGAN, MISSOURI, NEW HAMPSHIRE, NEW JERSEY, NORTH CAROLINA, OKLAHOMA, PENNSYLVANIA, TENNESSEE, UTAH, VERMONT, WASHINGTON, AND WISCONSIN

These Supplementary Comments are submitted on behalf of the agencies and officials responsible for administering the Medicaid program in the States of Alaska, Connecticut, Idaho, Louisiana, Maryland, Michigan, Missouri, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, Tennessee, Utah, Vermont, Washington, and Wisconsin ("Commenting States") and are in response to the invitation for further comment on the issue of the definition of units of government set forth in the Final Rule with Comment Period published by the Department of Health and Human Services ("the Department") in the Federal Register on May 29, 2007, at 72 Fed. Reg. 29748.

The Commenting States acknowledge that the final rules issued on May 29, 2007 have no force and effect by reason of the Congressional action, signed into law by the President

on May 25, 2007, imposing a one-year prohibition on any action by the Secretary to finalize or otherwise implement provisions of the proposed rule that was the subject of the final rules published on May 29, 2007. Nonetheless, the Department having called for additional comment on the issue of the definition of units of government, the Commenting States are availing themselves of the opportunity to demonstrate the errors in the rationale offered by the Department to justify the unwarranted definition contained in its May 29 issuance, in the hope that the Department will, during the one-year period provided by the Congressional moratorium, abandon its efforts to narrow the definition of providers that may participate in the financing of Medicaid expenditures and return to the approach that has guided the Medicaid program throughout its 40-plus-year history.

Much of what is set forth in the Joint Comments filed on March 19, 2007, on behalf of 17 of states in response to the initial rulemaking proposal remains applicable to the subject of these supplementary comments. Rather than repeat what was said in those Joint Comments, we incorporate them herein and urge the Department to review them in connection with its further consideration of the unit-of-government-definition issue.

Why the Newly-Issued Definition Is So Bad

The Department's May 29 issuance would permit a health care provider to qualify as a "unit of government" only if (1) the provider itself possesses "generally applicable taxing authority"; (2) has "direct access to generally applicable tax revenues," meaning that it is an "integral part" of a unit of government with taxing authority which is legally obligated to fund the provider's expenses, liabilities and deficits; (3) receives appropriated funding as a State university teaching hospital (with certain qualifications); or (4) is an Indian Tribe or Tribal Organization and meets specified criteria. 72 Fed. Reg. at 29832.

Very few public health care providers possess "generally applicable taxing authority." Some are supported by governmental bodies sufficiently to qualify under the second category set forth above. But many others, that are public in nature and have traditionally been so treated for Medicaid reimbursement purposes, would not so qualify. This includes the hundreds of entities (special districts, authorities, non-profit corporations and the like) that have been established under state law to pursue innovative ways of maintaining public health services while incorporating business efficiencies that are best pursued outside of traditional governmental bureaucracies.

Public entities of this kind have been created precisely to avoid the very thing that the Department now wants to make a prerequisite--that a governmental body be fully responsible for their expenses, liabilities and deficits. Yet, the very absence of assured governmental backing is what forces these entities to operate more efficiently, to live within their means, and to manage their resources so as to carry out their public mission without excessive drain on the public fisc.

These public entities are now able to participate in the financing of their Medicaid business through combinations of earnings from other lines of business, contributions from individuals and foundations, and, in some cases, limited public subsidy. They stand as proof that public services can be maintained by incorporation of sound business principles into the operation of public entities, and that general taxes need not be the only source of funding of public functions.

The Department's approach would undermine these worthwhile advances in public administration. It would withhold federal Medicaid funds validly earned by entities that cannot point to general taxes or appropriated funds as their sole source (other than federal

financial participation) of the cost of their operations. It ignores all the gains achieved by public entities that have learned how to support their public missions by means other than increasing general taxes, and actually penalizes the entities for relying on other revenue sources.

That is simply awful public policy, as well as a disaster for the health care system that the Department has a responsibility to foster. Nor can it be squared with the fundamental philosophy of an Administration that claims to be constantly on the lookout to protect citizens against ever-increasing tax burdens.

If this terrible policy were ever implemented, the primary brunt would be felt by safety-net hospitals, but there are also other providers of health care (for example, clinics affiliated with local governments; some nursing homes) that would be impacted by the unduly narrow definition of providers that may participate in the funding of Medicaid services. These providers would be faced with the Hobson's choice of forgoing Medicaid reimbursement or seeking tax increases to fund what they are now funding through their own operations. The likelihood of obtaining increased taxes, particularly to fund services for the poorest segments of society, can hardly be said to be great. The more likely alternative will be major reductions in the service capabilities of these public entities.

These consequences are not in keeping with the goals of the Medicaid program, nor with the stated policy objectives of the current Administration. They are results that sound public policy would seek at all costs to avoid. Only the most compelling legal inhibitions could warrant responsible officials in even considering actions that would produce these outcomes. Yet, as we now show, the governing legal framework does not support the position advanced by the Department.

Why the Department's Newly-Issued Definition Is Not Consistent With the Law

The effect of the Department's final rule defining "units of government," were it ever to be placed in operation, is to bar from participation in the financing of Medicaid services a large group of public providers that have been so participating from the earliest days of the Medicaid program, some 40 years ago. One might have thought that a rule change with that effect would necessarily have been based upon some recent statutory enactment compelling the reversal of four decades of practice. But there is no such enactment in this case. To the contrary, the Department has justified its unduly narrow definition of "units of government" on a provision added to the Medicaid statute in 1991, over 15 years ago.

That provision--section 1903(w)(6) of the Social Security Act--does not impose the limit that the Department now says it requires. Nor was it intended to do anything of the kind. And nothing in the intervening 15 years, either in Congressional enactment or agency rulemaking, supports the interpretation that the Department now gives to that provision. Yet in its extended response in the May 29 issuance to the many objections voiced by commenters to the proposed definition of unit of government, the Department continually falls back on section 1903(w)(6). It is essentially the entire basis for the Department's legal conclusion that the definition it has propounded is supported by law.

Section 1903(w)(6) is not a limit on which providers can participate in financing Medicaid. Rather, that section restricts the Department's ability to limit states' use of funds made available by health care providers. The provision insures that the Department has no authority to limit provider participation that is derived from state or local taxes (other than impermissible provider taxes or donations). It neither says nor means that provider participation

derived from other revenue sources is not permitted, and it does not address, nor was it meant to address, which providers can participate in the funding of Medicaid services.

But another provision of the same statute that enacted section 1903(w)(6) does address the latter subject. That is section 5(b) of Public Law 102-234 (not codified), which limits the Department's ability to change the treatment of "public funds as a source of State share of financial participation under title XIX" as reflected in the then-current regulations, now contained in 42 C.F.R. § 433.51. That regulation, and its predecessors, have directly authorized the use of any "public funds" (not just tax-generated funds), including those transferred or certified by "public agencies," as the non-federal share of Medicaid expenditures. It is disappointing that while the Department cited section 1903(w)(6), which does not support its restrictive definition, over 20 times in 14 pages of the Federal Register discussing comments on its proposed definition, it failed even once during that entire discussion to cite the regulation that directly authorizes participation in a manner not consistent with the Department's proposal (42 C.F.R. § 433.51(b)), even though that regulation was particularly validated by specific identification in the very legislation from which section 1903(w)(6) was derived.

The Department claims support for its restrictive position on participation in the financing of Medicaid expenditures from the definition of "provider-related donation" in section 1903(w)(2)(A) of the statute--"any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government" by, *inter alia*, a health care provider. That provision does not justify the Department's position. When it was enacted, as part of the 1991 legislation adopting the Provider Tax Amendments, the House Conference Report emphasized 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." H.R. Conf. Rep. 102-409, at 18 (1991), *reprinted in* 1991 U.S.C.C.A.N. 1441, 1444 (emphasis added).

And in connection with the adoption of implementing regulations, the Department's preamble explained,

> Prior to the enactment of Public Law 102-234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a State's share of financial participation in the entire Medicaid program. As mentioned previously, the statutory provisions of Public Law 102-234 do not include restrictions on the use of public funds as the State share of financial participation. Therefore, the provisions of § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.

HCFA, Interim Final Rule, Limitations on Provider-Related Donations and Health Care-Related Taxes, 57 Fed. Reg. 55118, 55119 (Nov. 24, 1992).

Nothing has changed in the law since the enactment of the 1991 statute and the implementing regulations (and the Department's May 29 issuance does not cite or rely on any such change) that would warrant the Department now in determining that public funds may not be the basis for certification or transfer, or that such a transfer would be seen as a prohibited provider donation.

Conclusion

On the issue of the definition of a "unit of government" the issue comes down to this: (1) those providers that are themselves "units of government" under the CMS definition may participate in the funding of Medicaid expenditures (through certification or transfer) without regard to the source of the certified or transferred fund; (2) those public providers not themselves "units of government" but which receive funding from government sources derived

from tax revenue may participate in the funding of Medicaid expenditures (by certifying their expenditures and by having the governmental unit certify the source of funds used); (3) the Department's current position is that public providers not themselves "units of government" may not participate in funding Medicaid expenditures from sources other than appropriated amounts derived from tax collections.

As shown above the third element is an unwarranted limitation, and will likely lead to substantial problems for providers that fall within the third category. That would be bad for the Medicaid program and for the needy people it serves. The Department should abandon that element, and return to its traditional position on participation by public providers in the funding of Medicaid.

Respectfully Submitted,

/s/

Charles A. Miller
Caroline M. Brown
Susannah Vance
Covington & Burling LLP
1201 Pennsylvania Ave. NW
Washington, DC 20004
(202) 662-5410

On behalf of the States of:

Alaska
Connecticut
Idaho
Louisiana
Maryland
Michigan
New Hampshire
New Jersey
Oklahoma
Tennessee
Utah
Vermont
Washington
Wisconsin

and

Missouri Department of Social Services,
Division of Medical Services
North Carolina Department of Health &
Human Services
Pennsylvania Department of Public Welfare

July 13, 2007

Submitter : Christine Neuhoff **Date:** 07/13/2007

Organization : Shands HealthCare

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attached letter

CMS-2258-FC-33-Attach-1.DOC

#33

Shands HealthCare

Legal Services

720 SW 2nd Avenue, Suite 360A Gainesville, FL 32601
352.733.0030 352.733.0052 fax

July 13, 2007

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

Re: Comments on Unit of Government Definition (§ 433.50) contained in CMS–2258–FC: Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748 (May 29, 2007).

Dear Ms. Norwalk:

Shands HealthCare writes to convey its continued serious concerns regarding the Centers for Medicare and Medicaid Services' (CMS) proposed definition of a unit of government under 42 C.F.R. § 433.50 as published in CMS-2258-FC (the Final Rule). The Final Rule does not fundamentally change the most damaging provisions of CMS-2258-P (the Proposed Rule) to which Shands and a diverse group of other commenters expressed considerable opposition.

Shands reiterates its request that CMS withdraw the entire Final Rule, including the definition of a unit of government. Moreover, we endorse the Comments on Unit of Government Definition submitted by the National Association of Public Hospitals and Health Systems, to the Centers for Medicare and Medicaid Services (CMS).

As you know, Congress has prohibited CMS from taking any steps to implement this rule until May 25, 2008.[1] Shands does not believe that CMS has the authority to receive or review comments during the period of the legislative moratorium, and therefore submits this letter under protest. If the moratorium does expire without further action from Congress, we believe that the public should be permitted a fresh opportunity to comment on the definition of a unit of government based on circumstances in effect at that future time. CMS should not rely on stale comments prepared and received while the agency is under a moratorium.

[1] Pub. L. No. 110-28, § 7002.

Furthermore, when Congress passed the moratorium, the regulation was in proposed form; before it could become effective, the regulation would have needed to be finalized and sixty days would have had to elapse after publication.[2] CMS' act of submitting the Final Rule to the Office of the Federal Register *after* Congress had already approved a legislative moratorium and just hours before the President signed it into law, should not undo what Congress thought it had accomplished– providing a year for it to consider alternatives to the regulation, followed (if necessary) by an additional sixty days for Congress to consider whether to reject a final regulation through the procedures outlined in the Congressional Review Act (CRA).[3] Following Congressional intent, no provision of the regulation should become effective prior to sixty days after the moratorium expires. Moreover, States cannot be expected to take any steps before May 25, 2008 towards implementing a regulation that is unlikely to go into effect in its current form.

Despite the significant concerns raised in the hundreds of comment letters submitted in response to the Proposed Rule, CMS has not fundamentally altered this new definition of unit of government. Shands' previous comment letter laid out its concerns with respect to the proposed definition, and our concerns continue to apply to the revised definition. We therefore are attaching the relevant section of our previously-submitted comments to this letter in the hopes that CMS will reconsider this ill-advised approach. This narrow definition of a unit of government would usurp the traditional authority of States to identify their own political subdivisions, exceed the authority provided in the Medicaid statute, and undermine past and future efforts to date by States to make units of government more efficient and less reliant on public tax dollars.

Shands offers these supplemental comments concerning the revised definition:

1. The modifications of the unit of government definition are insufficient to address the legal and policy concerns underlying the original proposal.

2. Allowing States only initial determination of the governmental status of their providers based on the CMS form does not show adequate deference to State law interpretations of governmental status.

3. CMS does not adequately acknowledge the burden of identifying all governmental providers within 90 days.

4. CMS's clarification regarding the scope and prospective application of the unit of government definition is appropriate.

5. CMS should acknowledge the impact of the one-year moratorium on the effective dates of the provisions of the Final Rule and ensure adequate time for Congressional review and State and provider compliance.

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[2] Congressional Review Act § 801(a)(3), 5 U.S.C. § 801(a)(3)(2006).
[3] *Id.* §§ 801-808.

* * *

Shands appreciates the opportunity to submit these additional comments and to reiterate our strong opposition to the provisions of this Final Rule.

Yours truly,

/s/
Christine S. Neuhoff*
Associate General Counsel

* *Authorized House Counsel under Florida Bar Rule 17, not admitted in Florida. Member of the State Bar of California*

Excerpt from Shands HealthCare letter 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:

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"). Shands opposes this restrictive new definition and urges CMS to allow states to determine which entities are units of government pursuant to state law.

Shands operates three formerly public hospitals – Shands at the University of Florida (in Gainesville), Shands Jacksonville, and Shands Lake Shore (in Lake City). All of these facilities are owned by public entities and leased to Shands. The public owners of the facilities (the University of Florida Board of Governors, the Lake Shore Hospital Authority, and the city of Jacksonville) chose to enter these leases to ensure the efficient operation of the hospitals and to enable these hospitals to better compete with the private hospitals in the area. Each of these hospitals provides critically needed high cost services regardless of a patient's ability to pay. As a result, if the hospital is unable to attract paying patients, as well as indigent patients, the hospital will be unable to afford to keep up with technology and maintain or expand the services it provides. Each of the public lessors required that Shands through these hospitals continue to provide care to the indigent residents of the counties that they serve.

The Proposed Rule threatens to undermine all of the good that we have accomplished through the reorganization of these hospitals. Medicaid has always recognized our funding as public, and, in accordance with the statutory scheme established by Congress in Title XIX of the Social Security Act, has allowed our funds to be used as the non-federal share of Medicaid expenditures. The matching of our funds is a *critical* element of our operation, and the $107 million in supplemental payments that we receive in connection with this match is essential to our ability to carry out the safety net role described above. Moreover, CMS has recently reviewed the IGTs we provide and has determined them to be an appropriate source of non-federal share funding. Given that we, like many of our counterparts across the country, are contributing to Medicaid expenditures through mechanisms that are not in any way abusive, it is unclear why CMS feels the need to adopt a restrictive definition of a unit of government.

Indeed, CMS has scrutinized and approved all sources of the non-federal share of Medicaid funding in Florida in the course of approving Florida's recently adopted Section 1115 wavier, which resulted in the creation of Florida's Low Income Pool

program ("LIP") and significant Medicaid reform. The implementation of Medicaid reform in Florida is ongoing, and reliant upon the terms and conditions negotiated with CMS, which included the establishment of a CMS-approved alternative Upper Payment Limit ("UPL") program, the non-federal share of which is funded entirely by IGTs and CPEs that the Proposed Rule has placed in jeopardy.

If the funding contributed on behalf of Shands is deemed to no longer be public under this regulation, and if we are no longer able to support our Medicaid payments through our IGTs, we would stand to lose the very payments that have allowed us to so successfully serve as the backbone of the safety net in our community. Our Disproportionate Share Hospital ("DSH") payments and LIP payments provide crucial financial support for so many of the services we provide that are unreimbursed or under-reimbursed. For example, these supplemental payments enabled Shands to establish a Level I Trauma Center in north central Florida in 2005, a region of the state that had no trauma services at that time. Without these supplemental payments, Shands operating margin would not have permitted the establishment of such a costly new service.

The impact to our facility of the potential loss of these payments would be catastrophic. More importantly, however, our patients – especially those who are eligible for Medicaid or who are uninsured – are most likely to suffer from the loss of access to care that would result from this new policy. If our supplemental payments are reduced by more than $100 million annually, as they would be under the Proposed Rule, Shands will likely need to reduce or eliminate services in order to maintain the overall quality of the services it provides.

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 the Florida Medicaid Program 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."

Submitter : Tim Kennedy **Date:** 07/13/2007

Organization : Indiana Hospital and Health Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2258-FC-34-Attach-1.DOC

#34

Indiana Hospital&Health Association

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VIA ELECTRONIC TRANSMISSION

July 13, 2007

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

Re: CMS-2258-FC: Definition of "Unit of Government"

Dear Sir/Madam:

On May 29, 2007, CMS issued a Final Rule which amended 42 CFR § 433.50 to include a definition of "unit of government" that, with regard to health care providers, restricts the funding of intergovernmental transfers ("IGTs") and certified public expenditures ("CPEs") to providers that have taxing authority or direct access to tax revenues as an integral part of a governmental unit with taxing authority (hereinafter, this amendment to 42 CFR § 433.50 is referred to as the "Definition"). The Indiana Hospital and Health Association (hereinafter the "IHHA") appreciates this opportunity to submit comments regarding the Definition.

Combined, two of Indiana's key Medicaid reimbursement programs (the "municipal hospital disproportionate share program" and the "municipal hospital upper payment limit program") have historically relied upon IGTs from, among others, 37 Indiana acute care governmental hospitals. These hospitals, because of the Definition, will no longer be permitted to fund such IGTs.[1] Furthermore, there is reason to believe that neither the State of Indiana, nor any Indiana counties or cities, will make their own funds available to replace the IGTs that will be lost because of the Definition. In short, the Definition threatens to eviscerate the aforementioned reimbursement programs that are vital to the 37 hospitals.

With all due respect, the IHHA believes that the loss of these IGTs is not justified. As reflected by the comments below, the IHHA believes that Pub. L. 102-234 did not mandate the adoption of the Definition. The IHHA also believes that the proper interpretation and

[1] Please note that these comments do not take into consideration any Congressional action which may have suspended the operation of the Final Rule.

application of Pub. L. 102-234 did not depend upon "unit of government" being defined in the manner set forth in the Definition. In fact, in the IHHA's view, no amendment of 42 CFR § 433.50, of any kind, was required by Pub. L. 102-234.

The IHHA accepts the proposition that the funding of IGTs and CPEs by health care providers must be limited to governmental health care providers; but since nothing in Pub. L. 102-234 (or any other Medicaid-related federal law) requires that such governmental health care providers be limited to the types of providers described in the Definition, it is fair to question whether the Definition serves primarily to ensure the integrity of the Medicaid program's federal-state financial partnership (which is the stated purpose of the Final Rule), or whether it operates primarily to reduce the number of sources of IGTs and CPEs. Accordingly, the IHHA respectfully urges CMS to: (i) reconsider the legal basis (or lack thereof) for the Definition; (ii) recognize that the IGTs and CPEs that are lost because of the Definition will be very difficult, if not impossible, to replace; (iii) adopt appropriate amendments to 42 CFR § 433.50, and related regulations, that expressly authorize the funding of IGTs and CPEs by broadly defined governmental health care providers; and (iv) implement additional mechanisms that directly operate to help ensure the integrity of the Medicaid program's federal-state financial partnership.

COMMENTS

I. "Background"

In its "Background" section of the Final Rule and in its Responses to certain Comments, CMS, at first blush, appears to conclude that Pub. L. 102-234 prohibits governmental health care providers, other than the types described in the Definition, from funding IGTs and CPEs. However, a close review of the "Background" and the Responses reveals that CMS, while certainly implying such a prohibition, does not squarely address whether Pub. L. 102-234 outlaws the funding of IGTs and CPEs by governmental health care providers other than the types described in the Definition.

A complete and thoughtful analysis of the Definition requires, as a threshold matter, a clear understanding of whether CMS is taking the position that Pub. L. 102-234 forbids the funding of IGTs and CPEs by governmental health care providers other than the types described in the Definition. The IHHA respectfully requests that CMS precisely state its position on this issue. In doing so, it is important that CMS specifically address HCFA's statement, in the amendments made to the regulations at 42 CFR part 433, at 47 FR 5519 (November 24, 1992), that "the statutory provisions of Public Law 102-234 do not include restrictions on the use of public funds as the State share of financial participation."

Similarly, if it is CMS's position that, even prior to Pub. L. 102-234, applicable federal law limited the funding of IGTs and CPEs by governmental health care providers to the types of providers described in the Definition, an appropriate analysis of the Definition first requires an explanation from CMS regarding the legal and factual bases for its position.

II. "Analysis of and Responses to Public Comments"

1. In various Responses,[2] CMS confirms that section 1903(w)(6)(A) served as the basis for its decision to forego traditional indicia of a health care provider's governmental status (e.g., sovereign immunity, public employees, publicly approved governing board, public funding, classification under state statutes as a political subdivision or public entity, etc.) in favor of the indicia set forth in the Definition (i.e., a health care provider's taxing authority or direct access to tax revenues as an integral part of a governmental unit with taxing authority). In the IHHA's view, CMS's reliance on section 1903(w)(6)(A) was misplaced and, consequently, it was unreasonable for CMS not to use traditional indicia of governmental status when it defined "unit of government".

To be sure, section 1903(w)(6)(A) forbids the Secretary from restricting the use of State or local taxes to fund IGTs and CPEs. However, the fact that the Secretary may not restrict the use of State or local taxes does not mean that section 1903(w)(6)(A) operates to ban IGTs and CPEs that are funded by public funds other than State or local taxes. To the contrary, as noted above, CMS's predecessor, HCFA, previously confirmed that nothing about Pub. L. 102-234 (which, of course, includes section 1903(w)(6)(A)) restricts the use of public funds as the state share of financial participation.[3] It was therefore erroneous for CMS to use section 1903(w)(6)(A) as the basis for prohibiting the funding of IGTs and CPEs by governmental health care providers other than the types described in the Definition. Because the definition of "unit of government" is so vitally important to governmental health care providers and the communities they serve, and because CMS's adopted the Definition based upon a flawed reliance on section 1903(w)(6)(A), the IHHA respectfully requests that CMS repeal the Definition.

2. Assuming the purpose of the Final Rule is to ensure the integrity of the Medicaid program's federal-state financial partnership (and not the reduction of the number of sources available to make IGTs and CPEs), and in the event CMS is not willing to simply repeal the Definition, the IHHA respectfully requests that CMS consider revising the Definition to reflect the description of governmental units found in the initial version of the "Intergovernmental Cooperation Act of 1968"[4]. The purpose of the Act, which is set forth in its preface, touches upon many of the same issues generated by the Definition:

> "To achieve the fullest cooperation and coordination of activities among the levels of government in order to improve the operation of our federal system in an increasingly complex society, to improve the administration of grants-in-aid to the States, to permit the provision of reimbursable technical services to State and local government, to establish coordinated intergovernmental policy

[2] Responses 9R; 37R; 39R; 47R; 48R; 49R; and 68R
[3] 57 FR 55118, 55119 (November 24, 1992)
[4] Pub. L. 90-577

> and administration of development assistance programs, to provide for the acquisition, use, and disposition of land within urban areas by Federal agencies in conformity with local government programs, to provide for periodic Congressional review of Federal grants-in-aid, and for other purposes."

The IHHA believes that the following definitions set forth in the Act may properly serve as a solid basis for defining the types of governmental units, including governmental health care providers, that should be permitted to fund IGTs and CPEs.

> "Sec. 102. The term 'State' means any of the several States of the United States, the District of Columbia, Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State, but does not include the governments of the political subdivisions of the State.
>
> Sec. 103. The term 'political subdivision' or 'local government' means a local unit of government, including specifically a county, municipality, city, town, township, or a school or other special district created by or pursuant to State Law.
>
> Sec. 104. 'Unit of general local government' means any city, county, town, parish, village, or other general purpose political subdivision of a State.
>
> Sec. 105. 'Special-purpose unit of local government' means any special district, public-purpose corporation, or other strictly limited-purpose political subdivision of a State, that shall not include a school district."

Again, the IHHA not advocating that the above definitions be adopted verbatim, but they may serve as a genesis for an appropriate description of the types of governmental entities authorized to fund IGTs and CPEs.

3. CMS acknowledges that many commenters find it unreasonable that the Definition "would eliminate long-standing funding arrangements for Medicaid services...." In Response 23R, CMS appears to justify the elimination of these long-standing funding arrangements by asserting that "States have been ignoring the statutory limitation to 'units of government'...."

In order to fully analyze the Definition, it is appropriate to consider the extent to which the Definition would eliminate long-standing funding arrangements, and whether the scope and nature of the elimination of such funding arrangements is reasonable. Because CMS apparently justified the elimination of these funding arrangements on the States' "ignoring" the statutory limitations on "units of government", it is appropriate and necessary for CMS to specify any legal authorities that, in CMS's opinion, should have alerted the States to limiting the funding of IGTs and CPEs by governmental health care providers to those types of governmental health care providers described in the Definition.

4. The amended version of 42 CFR § 433.50(a)(ii) refers to a health care provider that is "operated" by a unit of government. The IHHA respectfully requests that CMS explain the extent to which, if at all, it is sufficient for a health care provider to be "owned," but not operated – or at least not completely operated, by a unit of government. This issue may arise with respect to health care providers whose license and infrastructure are "owned" by a unit of government, but whose day-to-day operations are managed by a private organization. [5]

Thank you for your time and consideration. Again, the IHHA appreciates this opportunity to submit it comments concerning the Definition. If you have any questions, please do not hesitate to contact the IHHA.

Sincerely,

Timothy W. Kennedy
Counsel

cc: Douglas J. Leonard, President
Indiana Hospital&Health Association
Allison D. Wharry, Director of Health Policy
Indiana Hospital&Health Association
John C. Render, Esq.

587109v1

[5] In its January 12, 2001 Final Rule establishing a 150% aggregate limit on Medicaid payments for non-State owned or operated public hospitals, HCFA acknowledged, with approval, situations where facilities that are owned by a unit of government, "but managed or operated by a . . . private company." See 66 F.R. 3148, 3154 (January 12, 2001).

Submitter : Mr. Santiago Munoz **Date:** 07/13/2007

Organization : University of California

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Unit of Government Definition

Unit of Government Definition

See Attachment

CMS-2258-FC-35-Attach-1.PDF

#35

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July 13, 2007

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

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

Dear Administrator Norwalk:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Proposed Rule **CMS-2258-FC** related to Medicaid payments.[1] These comments are submitted on behalf of the University of California (UC) Health System and its academic medical centers (AMCs) located at Davis, Los Angeles, Irvine, San Diego, and San Francisco. We appreciate the opportunity to comment on the revised definition of "unit of government" in Section 433.50. While some of the clarifications and changes to this section were appropriate, even as revised, the definition of unit of government improperly limits states' ability to fund the nonfederal share of Medicaid expenditures. The rule unnecessarily restricts (i) the types of public entities that can participate in Medicaid funding and (ii) states' ability to use local public funding for the Medicaid program. These restrictions are not authorized by statute and are inconsistent with Congressional intent. We respectfully urge CMS to withdraw the entire final rule, including the provision addressing units of government in Section 433.50.

[1] 72 Fed. Reg. 27949 (May 29, 2007).

The University of California

The UC clinical enterprise is the fifth largest healthcare delivery system in California and provides patient care services valued at over $4 billion. Additionally, the UC AMCs play a critical role in educating health professionals and advancing cutting-edge health-sciences research. Moreover, the UC AMCs offer services that are essential to the health and well being of Medicaid beneficiaries and all Californians including a broad array of highly specialized services such as trauma, neo-natal intensive care, cancer centers, geriatric and orthopedic centers of excellence, organ transplant programs, world class primary and preventive care, and extensive sub-specialties often available only in an academic setting.

Medicaid and uninsured patients represent nearly 30% of the patient population at the UC AMCs. We rely heavily on Medicaid payments to help ensure access to this patient population. This is especially important considering that we attract the highest resource intensive patients requiring specialty, tertiary and quaternary care. Quite simply, a significant number of our Medicaid patients have medical conditions that can only be managed in tertiary referral hospitals such as an academic medical center. The complexity of our patient population is reflected in the specialty and regional nature of the care we provide.

"Unit of Government" Definition

Although UC and its providers appear to fall within the definition of "unit of government" under revised Section 433.50, there is some ambiguity remaining in the language. If CMS intends to implement this final regulation, UC is seeking a clarification of its status as a unit of government, either in the regulation itself, or through another binding CMS policy statement.

Unlike most state universities, the University of California was not created by a state statute. The Regents of the University of California, created by Article IX, Section 9 of the California Constitution, is charged with the management of the UC health system. The UC AMCs are licensed to the Regents, not to the State of California, and the services to be provided are determined by the Regents. The Regents have no power to levy taxes. Financial support for the AMCs is derived from day-to-day operations, as well as through State appropriations for capital improvements and clinical teaching programs. Unlike other State agencies, financial responsibility for the operational and capital budgets of UC AMCs lies with the Regents, as do any profits or losses from operations. The Regents do not have independent taxing authority and the UC AMCs are not an integral part of those units of state government that do have such authority, as contemplated by the rule.

In comments to the proposed rule, UC expressed concern that the rule would restrict the use of "funds appropriated to State university teaching hospitals" in direct violation of the plain language of Section 1903(w)(6) of the Act. Such a restriction would preclude UC and its AMCs from funding the non-federal share of Medi-Cal services through intergovernmental transfers ("IGT") and certified public expenditures ("CPE"). CMS addressed this concern through two significant changes to Section 433.50.

Section 433.50 (a)(1)(i) has been revised to recognize as a unit of government, "a State university teaching hospital with direct appropriations from the State treasury..." Because the Regents and the UC AMCs are a single legal entity, the State appropriations for the UC teaching programs generally go to the Regents. The appropriations are then allocated by the Regents among its educational functions, including the medical education teaching programs. Thus, while the Regents clearly receive "direct" state appropriations, the UC teaching AMCs do not receive separate, individual appropriations. Nonetheless, UC should be considered a unit of government under Section 433.50(a)(1)(i) because, as the legal entity that owns and operates the UC health care providers, the Regents receive the "direct" State appropriations required under the revised rule. CMS should clarify that UC and its AMCs can provide the non-federal share of Medi-Cal expenditures though IGTs or CPEs under this reading of Section 433.50.

We also note that the statute does not limit its protection for "funds appropriated to State university teaching hospitals" under Section 1903(w)(6) of the Act to only those funds "directly" appropriated. Thus, if the inclusion of this "direct" appropriation requirement limits the State's use of UC funds for CPEs or IGTs, the regulation is inconsistent with the statute and should be deleted.

The UC AMCs may also be considered units of government under Section 433.50(a)(1)(ii). As revised, that section includes a provider that receive "appropriated funding as a State university teaching hospital providing supervised teaching experiences to graduate medical school interns and residents enrolled in a State university in the State." Clearly, the UC AMCs fall within this aspect of the unit of government definition.

If the statutorily-imposed moratorium expires and CMS implements the rule, it should clarify the ambiguities in the regulation so that it is clear that the State can rely on IGTs and CPEs from the University of California and its AMCs in support of the Medi-Cal program.

Although it appears that CMS has addressed the concerns with the definition of unit of government that are specific to the University of California, the final regulations issued

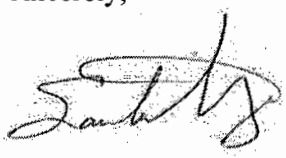
on May 29, 2007 are, taken as a whole, inconsistent with Congressional intent and should be withdrawn. In particular, Section 433.50, even as amended, inappropriately limits states' ability to fund Medicaid expenditures in violation of the Medicaid statute. While the revised definition of unit of government may recognize the UC providers as governmentally operated providers, the cost limit regulation would inappropriately limit payments to those same providers. As such, we believe CMS should withdraw the final rule in its entirety.

Finally, there are a number of other legal and technical issues raised in the comment letter submitted by the coalition of California's public hospitals paid under the California's Hospital/Uninsured Care Demonstration Project, approved under Section 1115 of the Social Security Act. The UC AMCs supports those comments and incorporate them by reference in this comment letter.

We believe the final regulations issued on May 29, 2007 are inconsistent with statutory language and should be withdrawn.

Thank you for the opportunity to comment on this proposal. If there are questions or if I can provide any additional information or input, please contact me at 510-987-9062 or santiago.munoz@ucop.edu.

Sincerely,



Santiago Muñoz, Associate Vice President
Clinical Services Development

cc: Medical Center CFOs

Submitter : Ms. Nancy Hutchison **Date:** 07/13/2007

Organization : Safety Net Financing Division, CDHS

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Unit of Government Definition

Unit of Government Definition

See Attachment

CMS-2258-FC-36-Attach-1.PDF

#36

DHCS

State of California—Health and Human Services Agency
Department of Health Care Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

JUL 13 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-FC
P.O. Box 8014
Baltimore, MD 21244-8014

Dear Sir or Madam:

The Department of Health Care Services (DHCS), on behalf of the State of California, appreciates this opportunity to comment on the proposed rule change, as set forth in 72 Fed. Reg. 29748, on the issue of the definition of "unit of government." The Final Rule with Comment Period proposes to add new language to § 433.50 to define a "unit of government" to conform to the provisions of section 1902(w)(7)(G) of the Social Security Act (Act).

The State of California acknowledges that the final rules issued on May 29, 2007, have no force and effect by reason of the Congressional action, signed into law by the President on May 25, 2007, imposing a one-year prohibition on any action by the Secretary to finalize or otherwise implement provisions of the proposed rule that was the subject of the final rule published on May 29, 2007. Nevertheless, the State of California reiterates its position that the final rules be withdrawn in their entirety.

Nonetheless, since the Centers for Medicare & Medicaid (CMS) has called for additional comment on the issue of the definition of "unit of government," we are availing ourselves of that opportunity in the hope that CMS will, during the one-year period provided by the Congressional moratorium, abandon its efforts to narrow the definition of providers that may participate in the financing of Medicaid expenditures and return to the approach that has guided the Medicaid program throughout its 40-plus-year history.

COMMENTS:

1. Impact of the definition of "unit of government" on California.

Proposed § 433.50(a)(1)(i) defines "unit of government" as a State, city, county, special purpose district, or other governmental unit in the State that has taxing authority, has direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury. . .. This definition is too narrow because, even though the Preamble appears to offer assurances that California's existing section 1115 *Medi-Cal Hospital/Uninsured Care*

Demonstration (Demonstration) is designed to meet federal regulatory requirements, the language of the regulation does not specifically support this.

Specifically, Alameda County Health Authority is an entity approved by CMS to certify its expenditures which subsequently will be used to claim federal funding under the Demonstration. Yet, this entity may not fully meet the definition of "unit of government," as proposed by CMS, because the Health Authority has limited "taxing authority."

Additionally, five University of California (UC) hospitals have been approved by CMS to certify their expenditures which subsequently will be used to claim federal funding under the Demonstration. The UC system is an "arm" of the State established under Article IX, Section 9 of the California Constitution. Although our concern with the UC hospitals may be alleviated by the addition of the language in section 433.50(a)(C), it is still unclear whether the UC hospitals would meet the definition of "unit of government," as proposed by CMS, because the UC system Schools of Medicine (health care provider) do not directly receive appropriated funding from the State.

California has additional concerns that involve public entities that are county educational agencies where the source of funding for Medicaid expenditures by those agencies is limited to tax revenue collected by a "unit of government."

The proposed regulations might exclude an unknown number of school districts or county offices of education (referred to as local educational agencies or "LEAs") from the definition of a "unit of government."

It is not clear from the definition of a special purpose district whether LEAs that provide School Based Medi-Cal Administrative Activities (SMAA) or LEAs that provide medical assistance through the LEA Billing Option program would be considered a "unit of government."

In addition, the degree to which each LEA, or Local Educational Consortium through which a LEA may certify its expenditures, meets the criteria in the same proposed regulations is unknown. Those county educational agencies that are fiscally independent from the county board of supervisors may not qualify. Because these issues remain unclear, the proposed regulations place the SMAA and LEA Billing Option programs at risk. The proposed regulations may result in unintended consequences, not only for the State's schools, but also for other public entities.

Finally, in California more than 70 public hospitals, which include 51 small public hospitals, receive supplemental Medicaid reimbursement under Assembly Bill 915 (Frommer, Chapter 747, Statutes of 2002). These providers, who certify their expenditures under this program, also could be negatively impacted by this proposed definition, as further explained below.

2. Very few public health care providers possess "generally applicable taxing authority."

CMS's May 29, 2007, issuance would permit a health care provider to qualify as a "unit of government" only if:

> (1) The provider has generally applicable taxing authority;
> (2) Has "direct access to generally applicable tax revenues," meaning that it is an "integral part" of a unit of government with taxing authority which is legally obligated to fund the provider's expenses, liabilities and deficits;
> (3) Receives appropriated funding as a State university teaching hospital (with certain qualifications); or . . .

Very few public health care providers have direct access to "generally applicable taxing authority." Some are supported by governmental bodies sufficiently to qualify under the second category set forth above. But many others, that are public in nature and have traditionally been treated as such for Medicaid reimbursement purposes, would not qualify. This includes the hundreds of entities (special districts, authorities, non-profit corporation and the like) that have been established under state law to pursue innovative ways of maintaining public health services while incorporating business efficiencies that are best pursued outside of traditional governmental bureaucracies.

Public entities of this kind have been created precisely to avoid the very thing that CMS now wants to make a prerequisite—that a governmental body be fully responsible for their expenses, liabilities and deficits. Yet, the very absence of assured governmental backing is what forces these entities to operate more efficiently, to live within their means, and to manage their resources so as to carry out their public mission without excessive drain on the public fisc.

These public entities are now able to participate in the financing of their Medicaid business through combinations of earnings from other lines of business, contributions from individuals and foundations, and, in some cases, limited public subsidy. They stand as proof that public services can be maintained by incorporation of sound business principles into the operation of public entities, and that general taxes need not be the only source of funding of public functions.

CMS's approach would undermine these worthwhile advances in public administration. It would withhold federal Medicaid funds validly earned by entities that cannot point to general taxes as their sole source (other than federal financial participation) of the cost of their operations. It ignores all the gains achieved by public entities that have learned how to support their public missions

by means other than increasing general taxes, and actually penalizes the entities for relying on other revenue sources.

That is not sound public policy, and will prove to be a disaster for the health care system that CMS has a responsibility to foster. Nor can it be squared with the fundamental philosophy of an Administration that claims to be constantly on the lookout to protect citizens against ever-increasing tax burdens.

If this onerous policy were ever implemented, the primary brunt would be felt by safety-net hospitals; but there are also other providers of health care (clinics, some nursing homes) that would be impacted by the unduly narrow definition of providers that may participate in the funding of Medicaid services. These providers would be faced with the Hobson's choice of either foregoing Medicaid reimbursement or seeking tax increases to fund what they are now funding though their own operations. The likelihood of obtaining increased taxes, particularly to fund services for the poorest segments of society, can hardly be said to be great. The more likely alternative will be major reductions in the service capabilities of these public entities.

These consequences are not in keeping with the goals of the Medicaid program, nor with the stated policy objectives of the current Administration. They are results that sound public policy would seek at all costs to avoid. Only the most compelling legal inhibitions could warrant responsible officials in even considering actions that would produce these outcomes. Yet, the governing legal framework does not support the position advanced by CMS.

3. CMS's definition of "unit of government" is not consistent with the law.

The effect of CMS's final rule defining "unit of government," were it ever to be placed in operation, would be to bar a large group of public providers from continuing participation in the financing of Medicaid services. A rule change with that effect should only be based upon some recent statutory enactment compelling the reversal of four decades of practice. But there is no such enactment in this case. To the contrary, CMS has justified its unduly narrow definition of "unit of government" on a provision added to the Medicaid statute in 1991, over 15 years ago.

That provision—section 1903(w)(6) of the Act—does not impose the limit that CMS now says it requires. Nor was it intended to do anything of the kind. And nothing in the intervening 15 years, either in Congressional enactment or agency rulemaking, supports the interpretation that CMS now gives to that provision. Yet in its extended response in the May 29 issuance to the many objections voiced by commenters on the proposed definition of "unit of government," CMS continually falls back on section 1903(w)(6) of the Act. It is essentially the entire basis for its legal conclusion that the definition it has propounded is supported by law.

Section 1903(w)(6) of the Act is not a limit on which providers can participate in financing Medicaid. Rather, that section restricts CMS's ability to limit states' use of funds made available by health care providers. The provision insures that CMS has no authority to limit provider participation that is derived from state or local taxes (other than impermissible provider taxes or donations). It neither says, nor means, that provider participation derived from other revenue sources is not permitted, and it does not address, nor was it meant to address, which providers can participate in the funding of Medicaid services.

But another provision of the same statute that enacted section 1903(w)(6) of the Act does address the latter subject. That is section 5(b) of Public Law 102-234 (not codified), which limits CMS's ability to change the treatment of "public funds as a source of State share of financial participation under title XIX" as reflected in the then-current regulations, now contained in 42 C.F.R. § 433.51. That regulation, and its predecessors, have directly authorized the use of any "public funds" (not just tax-generated funds), including those transferred or certified by "public agencies" as the non-federal share of Medicaid expenditures. It is disappointing that while CMS cited section 1903(w)(6) of the Act, which does not support its restrictive definition, over 20 times in 14 pages of the Federal Register discussing comments on its proposed definition, it failed even once during that entire discussion to cite the regulation that directly authorizes participation in a manner not consistent with CMS's proposal (42 C.F.R. § 433.519(b)), even though that regulation was particularly validated by specific identification in the very legislation from which section 1903(w)(6) of the Act was derived.

CMS claims support for its restrictive position on participation in the financing of Medicaid expenditures from the definition of "provider-related donation" in section 1903(w)(2)(A) of the Act—"any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government" by, inter alia, a health care provider. That provision does not justify CMS's position. When it was enacted, as part of the 1991 legislation adopting the Provider Tax Amendments, the House conference Report emphasized 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. (Emphasis in the original.)

And, in connection with the adoption of implementing regulations, CMS's preamble explained:

> Prior to the enactment of Public Law 102-234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a States' share of financial

participation in the entire Medicaid program. As mentioned previously, the statutory provisions of Public Law 102-234 do not include restrictions on the use of public funds as the State share of financial participation. Therefore, the provisions of § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.

Nothing has changed in the law since the enactment of the 1991 statute and the implementing regulations (and CMS's May 29 issuance does not cite or rely on any such change) that would warrant CMS to now determine that public funds may not be the basis for certification or transfer, or that such a transfer would be seen as a prohibited provider donation.

4. **CMS is exceeding its authority by intervening in the State's unique role in defining the criteria for a "unit of government."**

CMS exceeds it's authority by intervening in the State's unique role in defining the criteria for a "unit of government." Although CMS made some minor changes, the final rule may still limit the types of entities that could be considered a "unit of government" and may fail to accommodate the various recognized governmental entities established in California. Although CMS will now allow States to make the initial determination of a health care provider's governmental status, CMS reserves the right to reverse the State's determination.

5. **The applicability of the proposed rules to California's programs is unclear.**

Under the Demonstration and other programs, California has made major commitments of funding that rely on certification of expenditures by governmental entities that may not satisfy the extremely restrictive proposed definition in the final rule of those entities that may certify expenditures. Therefore, DHCS urges CMS to provide assurances that the definition of "unit of government" in § 433.50 will not impact California's existing hospital financing programs.

In conclusion, CMS's proposed definition of "unit of government" is an unwarranted limitation that could result in substantial problems for the viability of many of California's public providers that have historically been recognized by CMS as a "unit of government" eligible to receive federal reimbursement using certified public expenditures and intergovernmental transfers. The final rules would not be sound policy for the Medicaid program because of the detrimental impact to California's safety net providers. Therefore, DHCS urges CMS to withdraw the final rules and in particular, the proposed changes to the definition of "unit of government", and return to its traditional position on participation by California's existing public providers in the funding of Medicaid.

Sincerely,

Stan Rosenstein
Chief Deputy Director
Health Care Programs

cc: Mr. Toby Douglas
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Submitter : Ms. Nancy Hutchison **Date:** 07/13/2007

Organization : Safety Net Financing Division, DHCS

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Unit of Government Definition

Unit of Government Definition

See Attachment

CMS-2258-FC-37-Attach-1.PDF

#37

DHCS

State of California—Health and Human Services Agency
Department of Health Care Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

JUL 13 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-FC
P.O. Box 8014
Baltimore, MD 21244-8014

Dear Sir or Madam:

The Department of Health Care Services (DHCS), on behalf of the State of California, appreciates this opportunity to comment on the proposed rule change, as set forth in 72 Fed. Reg. 29748, on the issue of the definition of "unit of government." The Final Rule with Comment Period proposes to add new language to § 433.50 to define a "unit of government" to conform to the provisions of section 1902(w)(7)(G) of the Social Security Act (Act).

The State of California acknowledges that the final rules issued on May 29, 2007, have no force and effect by reason of the Congressional action, signed into law by the President on May 25, 2007, imposing a one-year prohibition on any action by the Secretary to finalize or otherwise implement provisions of the proposed rule that was the subject of the final rule published on May 29, 2007. Nevertheless, the State of California reiterates its position that the final rules be withdrawn in their entirety.

Nonetheless, since the Centers for Medicare & Medicaid (CMS) has called for additional comment on the issue of the definition of "unit of government," we are availing ourselves of that opportunity in the hope that CMS will, during the one-year period provided by the Congressional moratorium, abandon its efforts to narrow the definition of providers that may participate in the financing of Medicaid expenditures and return to the approach that has guided the Medicaid program throughout its 40-plus-year history.

COMMENTS:

1. Impact of the definition of "unit of government" on California.

Proposed § 433.50(a)(1)(i) defines "unit of government" as a State, city, county, special purpose district, or other governmental unit in the State that has taxing authority, has direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury. . .. This definition is too narrow because, even though the Preamble appears to offer assurances that California's existing section 1115 *Medi-Cal Hospital/Uninsured Care*

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Demonstration (Demonstration) is designed to meet federal regulatory requirements, the language of the regulation does not specifically support this.

Specifically, Alameda County Health Authority is an entity approved by CMS to certify its expenditures which subsequently will be used to claim federal funding under the Demonstration. Yet, this entity may not fully meet the definition of "unit of government," as proposed by CMS, because the Health Authority has limited "taxing authority."

Additionally, five University of California (UC) hospitals have been approved by CMS to certify their expenditures which subsequently will be used to claim federal funding under the Demonstration. The UC system is an "arm" of the State established under Article IX, Section 9 of the California Constitution. Although our concern with the UC hospitals may be alleviated by the addition of the language in section 433.50(a)(C), it is still unclear whether the UC hospitals would meet the definition of "unit of government," as proposed by CMS, because the UC system Schools of Medicine (health care provider) do not directly receive appropriated funding from the State.

California has additional concerns that involve public entities that are county educational agencies where the source of funding for Medicaid expenditures by those agencies is limited to tax revenue collected by a "unit of government."

The proposed regulations might exclude an unknown number of school districts or county offices of education (referred to as local educational agencies or "LEAs") from the definition of a "unit of government."

It is not clear from the definition of a special purpose district whether LEAs that provide School Based Medi-Cal Administrative Activities (SMAA) or LEAs that provide medical assistance through the LEA Billing Option program would be considered a "unit of government."

In addition, the degree to which each LEA, or Local Educational Consortium through which a LEA may certify its expenditures, meets the criteria in the same proposed regulations is unknown. Those county educational agencies that are fiscally independent from the county board of supervisors may not qualify. Because these issues remain unclear, the proposed regulations place the SMAA and LEA Billing Option programs at risk. The proposed regulations may result in unintended consequences, not only for the State's schools, but also for other public entities.

Finally, in California more than 70 public hospitals, which include 51 small public hospitals, receive supplemental Medicaid reimbursement under Assembly Bill 915 (Frommer, Chapter 747, Statutes of 2002). These providers, who certify their expenditures under this program, also could be negatively impacted by this proposed definition, as further explained below.

2. Very few public health care providers possess "generally applicable taxing authority."

CMS's May 29, 2007, issuance would permit a health care provider to qualify as a "unit of government" only if:

> (1) The provider has generally applicable taxing authority;
> (2) Has "direct access to generally applicable tax revenues," meaning that it is an "integral part" of a unit of government with taxing authority which is legally obligated to fund the provider's expenses, liabilities and deficits;
> (3) Receives appropriated funding as a State university teaching hospital (with certain qualifications); or . . .

Very few public health care providers have direct access to "generally applicable taxing authority." Some are supported by governmental bodies sufficiently to qualify under the second category set forth above. But many others, that are public in nature and have traditionally been treated as such for Medicaid reimbursement purposes, would not qualify. This includes the hundreds of entities (special districts, authorities, non-profit corporation and the like) that have been established under state law to pursue innovative ways of maintaining public health services while incorporating business efficiencies that are best pursued outside of traditional governmental bureaucracies.

Public entities of this kind have been created precisely to avoid the very thing that CMS now wants to make a prerequisite—that a governmental body be fully responsible for their expenses, liabilities and deficits. Yet, the very absence of assured governmental backing is what forces these entities to operate more efficiently, to live within their means, and to manage their resources so as to carry out their public mission without excessive drain on the public fisc.

These public entities are now able to participate in the financing of their Medicaid business through combinations of earnings from other lines of business, contributions from individuals and foundations, and, in some cases, limited public subsidy. They stand as proof that public services can be maintained by incorporation of sound business principles into the operation of public entities, and that general taxes need not be the only source of funding of public functions.

CMS's approach would undermine these worthwhile advances in public administration. It would withhold federal Medicaid funds validly earned by entities that cannot point to general taxes as their sole source (other than federal financial participation) of the cost of their operations. It ignores all the gains achieved by public entities that have learned how to support their public missions

by means other than increasing general taxes, and actually penalizes the entities for relying on other revenue sources.

That is not sound public policy, and will prove to be a disaster for the health care system that CMS has a responsibility to foster. Nor can it be squared with the fundamental philosophy of an Administration that claims to be constantly on the lookout to protect citizens against ever-increasing tax burdens.

If this onerous policy were ever implemented, the primary brunt would be felt by safety-net hospitals; but there are also other providers of health care (clinics, some nursing homes) that would be impacted by the unduly narrow definition of providers that may participate in the funding of Medicaid services. These providers would be faced with the Hobson's choice of either foregoing Medicaid reimbursement or seeking tax increases to fund what they are now funding though their own operations. The likelihood of obtaining increased taxes, particularly to fund services for the poorest segments of society, can hardly be said to be great. The more likely alternative will be major reductions in the service capabilities of these public entities.

These consequences are not in keeping with the goals of the Medicaid program, nor with the stated policy objectives of the current Administration. They are results that sound public policy would seek at all costs to avoid. Only the most compelling legal inhibitions could warrant responsible officials in even considering actions that would produce these outcomes. Yet, the governing legal framework does not support the position advanced by CMS.

3. CMS's definition of "unit of government" is not consistent with the law.

The effect of CMS's final rule defining "unit of government," were it ever to be placed in operation, would be to bar a large group of public providers from continuing participation in the financing of Medicaid services. A rule change with that effect should only be based upon some recent statutory enactment compelling the reversal of four decades of practice. But there is no such enactment in this case. To the contrary, CMS has justified its unduly narrow definition of "unit of government" on a provision added to the Medicaid statute in 1991, over 15 years ago.

That provision—section 1903(w)(6) of the Act—does not impose the limit that CMS now says it requires. Nor was it intended to do anything of the kind. And nothing in the intervening 15 years, either in Congressional enactment or agency rulemaking, supports the interpretation that CMS now gives to that provision. Yet in its extended response in the May 29 issuance to the many objections voiced by commenters on the proposed definition of "unit of government," CMS continually falls back on section 1903(w)(6) of the Act. It is essentially the entire basis for its legal conclusion that the definition it has propounded is supported by law.

Section 1903(w)(6) of the Act is not a limit on which providers can participate in financing Medicaid. Rather, that section restricts CMS's ability to limit states' use of funds made available by health care providers. The provision insures that CMS has no authority to limit provider participation that is derived from state or local taxes (other than impermissible provider taxes or donations). It neither says, nor means, that provider participation derived from other revenue sources is not permitted, and it does not address, nor was it meant to address, which providers can participate in the funding of Medicaid services.

But another provision of the same statute that enacted section 1903(w)(6) of the Act does address the latter subject. That is section 5(b) of Public Law 102-234 (not codified), which limits CMS's ability to change the treatment of "public funds as a source of State share of financial participation under title XIX" as reflected in the then-current regulations, now contained in 42 C.F.R. § 433.51. That regulation, and its predecessors, have directly authorized the use of any "public funds" (not just tax-generated funds), including those transferred or certified by "public agencies" as the non-federal share of Medicaid expenditures. It is disappointing that while CMS cited section 1903(w)(6) of the Act, which does not support its restrictive definition, over 20 times in 14 pages of the Federal Register discussing comments on its proposed definition, it failed even once during that entire discussion to cite the regulation that directly authorizes participation in a manner not consistent with CMS's proposal (42 C.F.R. § 433.519(b)), even though that regulation was particularly validated by specific identification in the very legislation from which section 1903(w)(6) of the Act was derived.

CMS claims support for its restrictive position on participation in the financing of Medicaid expenditures from the definition of "provider-related donation" in section 1903(w)(2)(A) of the Act—"any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government" by, inter alia, a health care provider. That provision does not justify CMS's position. When it was enacted, as part of the 1991 legislation adopting the Provider Tax Amendments, the House conference Report emphasized 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. (Emphasis in the original.)

And, in connection with the adoption of implementing regulations, CMS's preamble explained:

> Prior to the enactment of Public Law 102-234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a States' share of financial

participation in the entire Medicaid program. As mentioned previously, the statutory provisions of Public Law 102-234 do not include restrictions on the use of public funds as the State share of financial participation. Therefore, the provisions of § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.

Nothing has changed in the law since the enactment of the 1991 statute and the implementing regulations (and CMS's May 29 issuance does not cite or rely on any such change) that would warrant CMS to now determine that public funds may not be the basis for certification or transfer, or that such a transfer would be seen as a prohibited provider donation.

4. **CMS is exceeding its authority by intervening in the State's unique role in defining the criteria for a "unit of government."**

CMS exceeds it's authority by intervening in the State's unique role in defining the criteria for a "unit of government." Although CMS made some minor changes, the final rule may still limit the types of entities that could be considered a "unit of government" and may fail to accommodate the various recognized governmental entities established in California. Although CMS will now allow States to make the initial determination of a health care provider's governmental status, CMS reserves the right to reverse the State's determination.

5. **The applicability of the proposed rules to California's programs is unclear.**

Under the Demonstration and other programs, California has made major commitments of funding that rely on certification of expenditures by governmental entities that may not satisfy the extremely restrictive proposed definition in the final rule of those entities that may certify expenditures. Therefore, DHCS urges CMS to provide assurances that the definition of "unit of government" in § 433.50 will not impact California's existing hospital financing programs.

In conclusion, CMS's proposed definition of "unit of government" is an unwarranted limitation that could result in substantial problems for the viability of many of California's public providers that have historically been recognized by CMS as a "unit of government" eligible to receive federal reimbursement using certified public expenditures and intergovernmental transfers. The final rules would not be sound policy for the Medicaid program because of the detrimental impact to California's safety net providers. Therefore, DHCS urges CMS to withdraw the final rules and in particular, the proposed changes to the definition of "unit of government", and return to its traditional position on participation by California's existing public providers in the funding of Medicaid.

Sincerely,

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