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July 5, 2007

DHS Oregon Department of Human Services

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

Re: Comment Letter §433.50 Unit of Government Definition

Dear Secretary Leavitt:

The Oregon Department of Human Services (DHS) respectfully submits this comment letter in response to §433.50 Unit of Government Definition. DHS agrees with the intent of the rule that seeks to clarify which entities are governmental and can participate in financing the non-Federal share of Medicaid payments.

Background:
DHS responded to the draft rule, Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership. The Centers for Medicare and Medicaid (CMS) made some modifications based on nationwide responses and published the final rule leaving the Unit of Government open for comment.

Analysis of and Responses to Public Comments:
As it is currently written, the provision identifies five types of entities that would be considered as a unit of government: a state, a city, a county, a special purpose district, or other governmental units in the State. To qualify as a unit of government, the entity must have taxing authority or direct access to State or local tax funds. This provision would require that

statutory and regulatory criteria be considered when DHS makes the initial determination about the governmental status of health care providers. The determination will require the use of a form created by CMS, plus careful evaluation of the provider and applicable State law. DHS will be required to maintain these forms, submit to CMS a complete list of governmental providers with the first quarterly expenditure report (after the effective date) and upon request. DHS agrees with the CMS' decision that States are in a better position to make determinations of governmental status of health care providers. And that CMS has responsibility to ensure States are consistent with the Federal statutory and regulatory criteria.

We also agree with the intent of the provision to permit entities that do not have independent taxing authority, but have direct access to tax revenues to be identified as units of government. We concur with the CMS interpretation of "other governmental units" and "special purpose district" as units of government. While these entities are not cities or counties, they share the same basic key qualities for governmental status purposes.

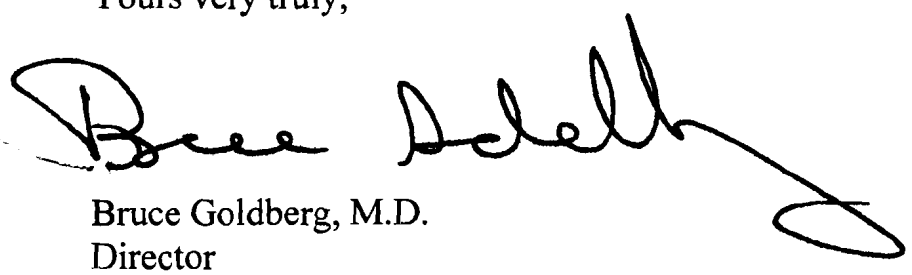
DHS was especially pleased to see that CMS revised the provision to include State university teaching hospitals as a unit of government. It is good that CMS looked beyond just the taxing authority as the standard of determining whether or not an entity is a unit of government. DHS agrees that for purposes of Medicaid payment and financing, the relevant properties of a governmental entity are those that relate to its financial organization including the source of funding and liability for its debts.

We understand CMS' clarification that to qualify as a unit of government, the entity must have taxing authority or direct access to State or local tax revenues. Furthermore, we understand that organizations cannot simply receive appropriated funds or enter into a contractual arrangement with a unit of government to be classified as a unit of government. The entity must have the ability to receive 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. Indian tribes and tribal organizations within the State are units of government because of the their unique criteria. Thus no determination forms are necessary, but tribes and tribal organizations must be included in the list of units of government provided to CMS.

In conclusion, the proposed provision would not have an adverse impact on DHS. Thank you for your ongoing support and attention to this important issue.

Yours very truly,



Bruce Goldberg, M.D.
Director

BG:FPA/malexander/tlemman

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TMC
TRUMAN MEDICAL CENTERS
Better. For Everyone.

Office of the President

June 12, 2007

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

Re: Comments for CMS-2558-P, Medicaid Program; Cost Limit for Providers Operated by Units of Government

Dear Ms. Norwalk:

On behalf of Truman Medical Centers ("TMC"), I am writing to comment on the Centers for Medicare and Medicaid & Medicaid Services' (CMS) proposed rule for fiscal year (FY) 2008 inpatient prospective payment system (PPS). While TMC continues to support the move to a cost-based weighting system, we view many of the other proposed changes as arbitrary and unnecessary. Our responses to the specific aspects of the rule are highlighted below:

Behavioral Offset

TMC opposes the "behavioral offset", a proposed adjustment to neutralize assumed increases in case-mix results caused by changes in coding practices under the MS-DRG system. If implemented the 2.4 percent reduction would cut hospital payments by $24 billion over the next five years.

TMC believes the 2.4 percent reduction is an arbitrary reduction made with limited evidence or data to support that there would be changes in coding behavior under the new the MS-DRG system. It amounts to little more than a backdoor attempt at budget cuts and should be shelved until CMS can document and demonstrate the increase in case mix results resulting from changes in coding practices.

Capital Payment Update

We also oppose the proposed elimination of the capital update factor for urban hospitals (0.8 percent cut) as well as the possible future elimination of IME and DSH adjustments to capital payments.

As Kansas City's urban safety net hospital system, TMC already is facing a capital funding crisis. Currently TMC is only able to fund 1/3 of its annual depreciation expense in annual capital purchases. Reducing capital reimbursement will further hinder TMC

ability to keep up with technology, facilities, and information technology. The result will have a negative impact on TMC ability to provide state of the art patient care for Kansas City's underinsured and uninsured.

This proposed elimination of the urban capital adjustment ignores the tremendous capital needs of today's urban hospital. Moreover this reduction will slow down investment in health information technology, which has been a major objective of Congress and the administration.

Medicare- Severity Diagnosis- Related Groups (MS-DRGs)

While TMC supports the change to a new patient classification system, we believe the new payment system needs to be thoroughly tested. Since the new DRG system is expected to redistribute $800 to $900 million per year, we believe CMS should delay MS-DRG until FY 2009. This would allow CMS to do further testing as well as make additional refinements. After testing is complete, CMS should phase in MS-DRG over a three year period, similar to the conversion to cost based weights. Not only would a multi-year transition give providers more time to adjust for the full impact of MS-DRG, but it would give CMS adequate time to assess changes in coding behavior under MS-DRG.

TMC appreciates the opportunity to respond to proposed changes to the hospital inpatient prospective payment system.

If you have any questions please contact Al Johnson at 816-404-3525.

Sincerely,

John W. Bluford
President & Chief Executive Officer, Truman Medical Centers, Inc.
Trustee of the American Hospital Association
Trustee of the Missouri Hospital Association

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July 12, 2007

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7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Final Rule with Comment Period CMS-2258-FC

Dear Ms. Norwalk:

The purpose of this letter is to comment on, and to strenuously urge the reconsideration of, your agency's changes to the Medicaid regulations, as described in 72 Fed. Reg. 29, 784 (May 29, 2007). In particular, I am concerned about the proposed revisions to the definition of "unit of government," which, for the first time in the history of the Medicaid program, inserts a requirement that a health care authority or similar entity have "generally applicable taxing authority" to be considered a "unit of government." This change is not legally appropriate for the reasons set forth below.

As you are no doubt aware, section 1903(w)(7)(g) of the Social Security Act provides, in pertinent part: "The term 'unit of government' means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State." Absent from this statutory definition is any mention of the requirement that the entity in question have generally applicable taxing authority. Indeed, the phrase "generally applicable taxing authority" does not appear in the section in question or anywhere else in title XIX of the Social Security Act. Clearly, if Congress had intended this restriction to apply, it could have easily said so. In fact, Congress declined to include this language. See: H.R. Rep. No. 89-682, (1965)(Conf. Rep.), as reprinted in 1965 U.S.C.C.A.N. 228, 22444-45; Pub. L. No. 102-234, 105 Stat. 1793. Given this fact, this agency lacks the statutory authority to amend the definition of "unit of government"; to do so would violate the separation of powers between the

legislative and executive branches. CMS should be mindful of the warning of the Supreme Court that "[a]gencies may play the sorcerer's apprentice but not the sorcerer himself." Alexander v Sandoval, 532 US 275, 291(2001).

The changes raise serious federalism concerns. A federal agency is seeking to insert itself as the sole judge of the form and powers that a public entity created by a state (such as a public health care authority authorized by ALA. CODE § 22-21-310, et seq. (1975 as amended)) must have in order to be considered a governmental entity. While some may, no doubt, argue that the states are not literally coerced to alter the structure and/or powers of their public health care facilities to accommodate this new definition, such an argument ignores these facilities' and the states' dependence on Medicaid and, in turn, the dependence of local communities on these facilities. The states do not have a meaningful choice given the present structure of financing health care. The clear effect of this definition is, then, to intrude on the sovereignty of the State to decide for itself the structure and, more importantly, the powers of its health care authorities and similar entities. In so doing, CMS has apparently given no consideration to whether, consistent with the various state constitutions, arrangements such as it proposes to require can even be practicably accomplished. The position occupied by CMS and Medicaid make this decision uniquely and unduly coercive and an inappropriate intrusion on state sovereignty. Even if this intrusion may not rise to the level of violating the 10th Amendment, the nature and extent of the intrusion make the changes inappropriate.

There is another federalism related concern raised by the final rule - namely, whether the changes violate the Spending Clause of the U.S. Constitution. "The spending power [of the federal government] is of course not unlimited but is instead subject to several general restrictions articulated in our cases." South Dakota v. Dole, 483 U.S. 203, 207 (1987). One such restriction is that "if Congress desires to condition the States' receipt of federal funds, it 'must do so unambiguously ... enabl[ing] the States to exercise their choice knowingly, cognizant of the consequences of their participation.'" Id. (citing Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 17 (1981).). The statutory language quoted above demonstrates that the condition CMS now seeks to impose was not one unambiguously imposed by Congress. Moreover, the Supreme Court has recognized that "in some circumstances the financial inducements offered by Congress might be so coercive as to pass the point at which pressure turns into compulsion." Dole, 483 U.S. at 211 (quoting

Steward Machine Co. v. Davis, 310 U.S. at 590.). Such compulsion is not permitted.

For over forty years, the states have participated in the Medicaid program. The health care systems throughout this country are dependent on the states' participation. Indeed, the present structure of the health care delivery system is a direct result of the states' decision to participate in the system. Any substantial decrease in the level of funding provided by Medicaid will have far reaching and devastating consequences for the delivery of health care to pregnant women, children, and the disabled. In this instance, this change in the definition of "unit of government" will dramatically and adversely affect the state's level of funding of Medicaid. Such a fundamental change in the program at this juncture may well run afoul of the Spending Clause. It cannot be assumed that the states would have participated in Medicaid to the extent that they have and/or would have created the system of public health care founded on this level of participation had they known that such a fundamental change would be, or even could be, altered by regulatory fiat. Given the states' dependence on Medicaid monies, a change such as this, especially in light of the federalism concerns it raises, constitutes coercion that is prohibited by the Spending Clause.

The concerns addressed in this letter are significant and, even if not fatal to the changes, at a minimum, certainly counsel in favor of a rescission of the final rule. I respectfully, but strenuously, urge CMS to rescind the final rule. Such a course of action would show appropriate deference to both Congress and the states.

Sincerely,

Troy King
Attorney General