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Wake Forest University Baptist

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rec'd
7-17-07

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

North Carolina Baptist Hospital

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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.

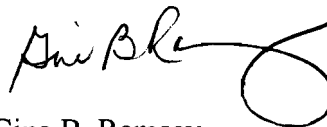
It is estimated if the new definition of unit of government in the proposed rule goes into effect, NCBH would lose approximately \$25,000,000 annually in supplemental Medicaid funding, which is crucial to our ability to fulfill our mission as an academic medical center. We will be forced to eliminate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



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July 13, 2007

Leslie Norwalk, Esq.
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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."

6

Alabama Medicaid Agency



BOB RILEY
Governor

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CAROL A. HERRMANN-STECKEL, MPH
Commissioner

July 10, 2007

VIA FEDERAL EXPRESS

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
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Mail Stop C4-26-05
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Re: Final Rule With Comment Period CMS-2258-FC

Dear Ms. Norwalk:

The Alabama Medicaid Agency respectfully submits this comment letter in opposition to final rule with comment period CMS-2258-FC (the "Final Rule"). The Final Rule was published by the Centers for Medicare & Medicaid Services ("CMS") in the May 29, 2007 edition of the *Federal Register*.¹ In addition to the objections set forth in the Alabama Medicaid Agency's March 16, 2007 comment letter in opposition to notice of proposed rulemaking CMS-2258-P (the "Proposed Rule"),² which apply with equal force to the Final Rule and its revised definition of a "unit of government," the Final Rule is patently invalid and CMS has the responsibility to rescind the Final Rule in its entirety.

CMS violated federal law in promulgating the Final Rule. Publication of the Final Rule was a transparent and clumsy attempt to circumvent Congress's unambiguous command not to take any further action with respect to the Proposed Rule. CMS raced to publish the Final Rule despite the fact that both Houses of Congress previously had approved two pieces of legislation instructing CMS not to do so. The latter piece of legislation became law on the same day that CMS first caused the Office of the Federal Register to publicly display the Final Rule. According to well-established precedent, that law became effective almost nine hours *before* the Final Rule was publicly displayed by the Office of the Federal Register, thereby rendering the Final Rule null and void as matter of law. The Final Rule is also null and void because CMS failed to withdraw the Final Rule prior to its publication in the *Federal Register*.

¹ See 72 Fed. Reg. 29,784 (May 29, 2007).

² See 72 Fed. Reg. 2236 (Jan. 18, 2007).

Our Mission - to provide an efficient and effective system of financing health care for our beneficiaries.

As for the substance of the Final Rule, the revised version of CMS's "unit of government" definition provides additional evidence that CMS's one-size-fits-all reliance upon taxing authority is fundamentally flawed. In revising the definition to eliminate the taxing-authority requirement with respect to certain tribal entities, CMS states that it sought to "address concerns raised about the unique governance arrangements of Indian tribes and tribal organizations."³ Because such "unique governance arrangements" also exist among the panoply of state and local government entities, CMS's continued insistence that taxing authority is the *sine qua non* of a "unit of government" outside the tribal context is irrational.

The Final Rule Generally

On May 24, 2007, both the Senate and House of Representatives approved House Bill 2206.⁴ Section 7002(a)(1) of this bill prohibits CMS from taking any further action with respect to the Proposed Rule. House Bill 2206 became Public Law 110-28 on May 25, 2007.⁵ As enacted, section 7002(a)(1) of Public Law 100-28 reads, in relevant part:

Notwithstanding any other provision of law, the Secretary of Health and Human Services *shall not*, prior to the date that is 1 year after the date of enactment of this Act, *take any action* (through promulgation of regulation, issuance of regulatory guidance, or other administrative action) to—

- (A) finalize or otherwise implement provisions contained in the proposed rule published on January 18, 2007, on pages 2236 through 2248 of volume 72, Federal Register (relating to parts 433, 447, and 457 of title 42, Code of Federal Regulations); [or]
- (B) promulgate or implement any rule or provisions similar to the provisions described in subparagraph (A) pertaining to the Medicaid program established under title XIX of the Social Security Act or the State Children's Health Insurance Program established under title XXI of such Act⁶

It has long been established that unless otherwise required by "substantial justice,"⁷ a statute is deemed effective from the first moment of the day on which it was enacted, regardless of the

³ 72 Fed. Reg. at 29,826.

⁴ See H.R. 2206, 110th Cong. (2007); 153 Cong. Rec. S6823 (daily ed. May 24, 2007) (recording Senate vote approving House Bill 2206); 153 Cong. Rec. H591 (daily ed. May 24, 2007) (recording House vote approving House Bill 2206).

⁵ See U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007, Pub. L. No. 110-28, 121 Stat. 112.

⁶ § 7002(a)(1), 121 Stat. at 187 (emphasis added).

⁷ See *Taylor v. Brown*, 147 U.S. 640, 645-46 (1893); *Louisville v. Savings Bank*, 104 U.S. 469, 478-79 (1881); *United States v. Casson*, 434 F.2d 415, 418-19 (D.C. Cir. 1970).

precise time it was actually approved by the president.⁸ Thus, section 7002(a)(1) of Public Law 110-28 became effective at 12:01 a.m. on May 25, 2007, unless otherwise required by “substantial justice.”

Here “substantial justice” does not require a departure from the general rule. CMS did not cause the Office of the Federal Register to publicly display the Final Rule until 8:45 a.m. on May 25, 2007.⁹ CMS patently disregarded the fact that Congress did not want CMS to take *any* steps in finalizing the Proposed Rule. Passage of the one-year moratorium was by no means surprising to CMS. The moratorium had been the subject of substantial public comment. Indeed, Congress had included identical language in legislation adopted less than one month before.¹⁰

The extraordinary number of typographical errors contained in the Final Rule evidences the speed with which CMS moved in the agency’s unseemly effort to circumvent Congress’s command and the failure to review the Final Rule carefully.¹¹ Because CMS caused the Office of the Federal Register to publicly display the Final Rule *after* 12:01 a.m. on May 25, 2007, and because CMS’s conduct constituted “action . . . to . . . finalize or otherwise implement provisions contained in the proposed rule published on January 18, 2007,”¹² CMS violated the one-year moratorium found in section 7002(a)(1) of Public Law 110-28.

Alternatively, by failing to withdraw the Final Rule prior to its publication in the *Federal Register*, CMS violated the one-year moratorium imposed by Public Law 110-28. It is unclear at what time CMS actually transmitted the Final Rule to the Office of the Federal Register; however, that fact is immaterial for present purposes. What is known is that the Final Rule did not appear in the *Federal Register* until four days *after* House Bill 2206 became law.¹³ CMS made the decision not to withdraw the Final Rule prior to its scheduled publication in the

⁸ See *United States v. Norton*, 97 U.S. 164, 170 (1877); *Lapeyre v. United States*, 84 U.S. (17 Wall.) 191, 198 (1872); *Arnold v. United States*, 13 U.S. (9 Cranch) 103, 119 (1815).

⁹ See 72 Fed. Reg. at 29,836 (bearing notation required by 44 U.S.C. § 1504 that Final Rule was first made available to the public on “5-25-07; 8:45 am”).

¹⁰ See H.R. 1591, 110th Cong. § 6002(a)(1) (2007); 153 Cong. Rec. S5153 (daily ed. Apr. 26, 2007) (recording Senate vote approving House Bill 1591); 153 Cong. Rec. H4158 (daily ed. Apr. 25, 2007) (recording House vote approving House Bill 1591). House Bill 1591 was subsequently vetoed by President Bush because of issues unrelated to the one-year moratorium. See 153 Cong. Rec. H4315 (daily ed. May 2, 2007) (reporting president’s May 1, 2007 veto message).

¹¹ See, e.g., 72 Fed. Reg. at 29,756 (misplacing parenthesis after the phrase “unit such as the county,” describing entities “which may current [sic] certify public expenditures,” and asserting that “[t]his regulation establishes criteria assist [sic] States”), 29,762 (stating that a commenter “provided another scenario and questioned if this would quality [sic] as an appropriate” intergovernmental transfer), 29,812 (placing two periods after sentence ending with phrase “relationship to the Federal government”), 29,822 (using quotation mark to denote possessive form of “CMS”), 29,823 (same), 29,830 (same), 29,831 (stating that CMS “considered the option of limitomg [sic] only those governmentally-operated health care providers” that make intergovernmental transfers).

¹² § 7002(a)(1), 121 Stat. at 187.

¹³ See 72 Fed. Reg. 29,784 (May 29, 2007).

Federal Register, a simple procedure specifically authorized by federal regulation.¹⁴ It is well-established that an agency's failure to act constitutes "agency action."¹⁵ Thus, CMS's failure to withdraw the Final Rule prior to its publication in the *Federal Register* constituted agency action to "finalize or otherwise implement" the Proposed Rule, thereby rendering CMS's inaction an independent violation of the one-year moratorium imposed by Public Law 110-28.

Provisions of the Final Regulations

In publishing the Final Rule, CMS solicited comments only on issues related to the agency's revised definition of a "unit of government."¹⁶ Apart from the Final Rule's fundamental legal defects noted above, the revised definition of a "unit of government" reflects CMS's persistence in asserting that the authority to tax is the *sine qua non* of being a "unit of government" within the meaning of section 1903(w)(6)(A) of the Social Security Act.¹⁷ However, CMS's revised definition deviates from this requirement in the context of tribal entities. In so doing, the Final Rule evinces that CMS's insistence upon the existence of taxing authority as the defining characteristic of a "unit of government" ignores the structure of government in the real world and is irrational.

According to CMS, the agency revised the definition to "address concerns raised about the unique governance arrangements of Indian tribes and tribal organizations."¹⁸ In explaining these concerns in more detail, the Final Rule states:

208C. Comment: . . .

In a related comment, one commenter expressed an opinion that the criteria of the proposed rule to require Indian Tribes to have generally applicable taxing authority to be considered a unit of government or a governmental health provider contradicts over 100 years of treaties, statutes, executive orders, and court decisions recognizing and cementing the unique government-to-government relationship the United States has with Tribal governments. The commenter noted that some tribal governments have taxing authority but do not exercise their taxing authority. The commenter indicated that since many tribal organizations do not have taxing authority, they would not qualify as a unit of government under the proposed rule. The commenter therefore believed that this criteria for purposes of the Medicaid program is both morally wrong and possibly illegal.

¹⁴ See 1 C.F.R. § 18.13(a) ("A document that has been filed for public inspection with the Office of the Federal Register but not yet published, may be withdrawn from publication . . . by the submitting agency. Withdrawals . . . may be made with a timely letter, signed by a duly authorized representative of the agency.").

¹⁵ See 5 U.S.C. § 551(13).

¹⁶ See 72 Fed. Reg. at 29,748.

¹⁷ See 42 U.S.C. § 1396b(w)(6)(A).

¹⁸ 72 Fed. Reg. at 29,826.

In light of the above, commenters suggested amending proposed [42 C.F.R.] § 433.50(a)(1)(i) to specifically address this issue.

208R. Response: CMS has modified the regulation at § 433.50(a)(1)(i) to include Indian tribes as units of government without regard to taxing authority, in light of their unique status and government-to-government relationship to the Federal government.. [sic]¹⁹

States can likewise protest that requiring entities within their respective borders to have generally applicable taxing authority in order to be a “unit of government” contradicts over 100 years of history and the “unique government-to-government” relationship between the States and the Federal government, and, indeed, that the Final Rule violates the most fundamental precepts of “our Federalism.” The Federal government has no business mandating that States confer taxing authority on all units of government if the State wishes to have these entities recognized as such by the Federal government. It makes no difference that the mandate is issued in the context of a Federal benefit program. Congress never contemplated that the Medicaid Program would be used to coerce States into revamping their governmental structures or the locus of power to tax in order to obtain Federal funds. Moreover, the Final Rule’s intrusion upon the authority of the States to define for themselves the entities that are units of government crosses a very blight constitutional line by directing the allocation of an element of sovereignty reserved, by both law and long practice, exclusively to the States. Thus, the Final Rule is ultimately grounded on a rejection of the Federalist structure of our government.

Further, as the Alabama Medicaid Agency explained in its March 16, 2007 comment letter opposing the Proposed Rule, CMS’s proposed definition of a “unit of government” disregards the reality that States depend on funding from a wide variety of legitimate governmental entities that, although they do not possess the power to tax, nonetheless perform essential governmental functions. Many States long ago enacted legislation authorizing the creation of health care authorities and hospital districts that serve as efficient means to finance and oversee the construction and operation of critical health care infrastructures.²⁰ Alabama is by no means unique in this regard.²¹

¹⁹ 72 Fed. Reg. at 29,812.

²⁰ See, e.g., Ala. Code §§ 22-21-50 *et seq.* (legislation first enacted in 1945 authorizing creation of public hospital associations); *id.* §§ 22-21-70 *et seq.* (legislation first enacted in 1949 authorizing creation of county hospital boards); *id.* §§ 22-21-100 *et seq.* (legislation first enacted in 1949 authorizing creation of county hospital corporations); *id.* §§ 11-58-1 *et seq.* (legislation first enacted in 1955 authorizing creation of medical clinic boards); *id.* §§ 22-21-130 *et seq.* (legislation first enacted in 1961 authorizing creation of municipal hospital building authorities); *id.* §§ 22-21-170 *et seq.* (legislation first enacted in 1975 authorizing creation of County and Municipal Hospital Authorities); *id.* §§ 11-62-1 *et seq.* (legislation first enacted in 1979 authorizing creation of Municipal Special Health Care Facility Authorities); *id.* §§ 22-21-310 *et seq.* (legislation first enacted in 1982 authorizing creation of Health Care Authorities).

²¹ See, e.g., U.S. Census Bureau, 2002 *Census of Governments: Volume 1, Number 1, Government Organization* 13 (Dec. 2002) (listing over 1400 total health-related “special district governments”—i.e., independent governmental
(continued)

Leslie V. Norwalk, Esq.
July 10, 2007
Page 6

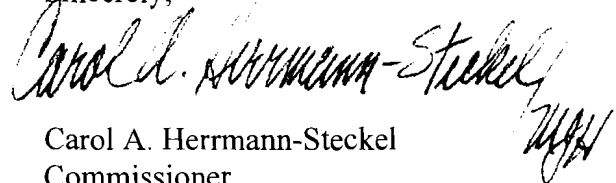
CMS's revised definition of a "unit of government" fails to recognize that States depend on funding from a wide variety of legitimate governmental entities that, although they do not possess the power to tax, nonetheless perform essential governmental functions. CMS itself recognized that taxing authority is not a requirement to be a "unit of government" by adopting a revised definition that does not require tribal entities to have taxing authority. The same rule ought to apply to the States, which are no less sovereign or independent of the Federal government than the tribal entities for whom the exception was created.

* * *

By rushing to file the Final Rule with the Office of the Federal Register, CMS disregarded the express will of Congress and, in turn, violated federal law. By refusing to withdraw the Final Rule prior to its publication in the *Federal Register*, CMS again disregarded the express will of Congress and, in turn, violated federal law. CMS has an obligation to rectify these violations of Public Law 110-28 by immediately rescinding the Final Rule. Moreover, the fact that CMS recognized the unique characteristics of tribal governments in shedding a taxing-authority requirement for such entities confirms that CMS's one-size-fits-all strategy with respect to non-tribal entities lacks a rational basis.

For these reasons, and for those reasons set forth in the Alabama Medicaid Agency's March 16, 2007 comment letter opposing the Proposed Rule, we respectfully submit that CMS should recognize that it has overstepped the bounds of its authority and rescind the Final Rule as soon as possible. Thank you for your attention to this vitally important matter.

Sincerely,


Carol A. Herrmann-Steckel
Commissioner

units, other than school district governments, that exist as separate entities with substantial administrative and fiscal independence from general purpose local governments—dispersed throughout thirty-five States).



MAR 13 11

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CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

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 the California Association of Public Hospitals and Health Systems ("CAPH"), 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. While some of the clarifications and changes to this section were appropriate, we assert that, even as revised, the definition of unit of government improperly limits states' ability to fund the nonfederal share of Medicaid expenditures. The rule continues to narrow 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. These restrictions are not authorized by statute and are inconsistent with Congressional intent. As CAPH explained in its extensive comments on the proposed rule, the result for safety net providers and the communities they serve across the country will be devastating. (A copy of CAPH's previous comments is attached and incorporated by reference.) CAPH urges you to withdraw the entire final rule, including the provision addressing units of government in Section 433.50.

CAPH represents 21 public hospitals, health care systems and academic medical centers, located in 16 counties in California. Our hospitals are a cornerstone of the State's health care system. Public hospitals operate nearly 60% of California's top-level trauma centers, which are state-of-the-art emergency medical units that treat the most catastrophic, life-threatening injuries. We also operate almost 45% of the State's burn centers and provide more than 60% of California's emergency psychiatric care. In addition, our members operate other types of providers that participate in the Medicaid program, including clinics, Federally Qualified Health Centers, and managed care organizations. By adopting a narrow definition of unit of government, the Centers for Medicare and Medicaid Services ("CMS") will limit the financial resources available for these services. If implemented as currently drafted, the rule will

¹ 72 Fed. Reg. 29749 (May 29, 2007).

likely result in a reduction in those critical health care services that public hospitals are uniquely qualified to provide, thereby limiting services and health care access.

As you know, Congress has expressed its overwhelming opposition to this rule in a number of different ways. When it was published as a proposed rule, a bipartisan letter lead by Congresswoman Eshoo and Congressman King, which expressed strong opposition to the implementation of the rule, was signed by 226 members of Congress. A similar bipartisan letter circulated by Senators Dole and Durbin received 43 signatures. Congress has now statutorily prohibited CMS from taking any steps to implement this rule until May 25, 2008.² In addition, the National Governors Association, the National Association of Counties, and hundreds of other interested parties have formally registered their opposition to the rule. This rule is clearly contrary to the will of Congress, and is opposed by many organizations with the expertise to predict its impact. CMS' rush to publish this final rule, after Congress had already approved the legislative moratorium, reflects a blatant disregard for Congress' intent to stop this inappropriate change in policy. If the moratorium imposed by Congress expires without further legislative action and CMS intends to move forward with the rule, CMS should at least re-issue the entire rule for timely public input.

Specific Comments on the Unit of Government definition.

CAPH urges CMS to withdraw the final rule in its entirety. In the event that CMS does not do so, we urge you to consider the following:

The narrow definition of unit of government is inconsistent with the Medicaid statute and will inappropriately limit states' ability to fund the nonfederal share of Medicaid expenditures.

Taken together with other aspects of the rule, Section 433.50 would inappropriately limit those entities qualified to provide the non-federal share of Medicaid expenditures. CMS relies on Sections 1902(a)(2)³ and 1903(w)(6) and (7)⁴ of the Social Security Act ("Act") in support of these changes. As discussed in our earlier comments, CAPH asserts that the legal analysis presented in support of the proposed rule is flawed. While the changes reflected in the final rule are an attempt to address some of these concerns, they do not change the fundamental legal problems with the rule.

First, there is nothing in Section 1902(a)(2) that supports restrictions on the types of units of government that can make Medicaid certified public expenditures ("CPEs") or intergovernmental transfers ("IGTs"). That section of the Medicaid statute recognizes the states' authority to use public funds, in addition to state funds, to finance Medicaid expenditures. Section 1902 (a)(2), which has been in place in its current form since 1967, has never been interpreted by CMS in any regulation or formal policy statement to support such narrow restrictions on the categories of public entities that can participate in Medicaid financing. The longstanding policy has been to allow a broad range of public agencies to make CPEs or IGTs.

² Pub. L. No. 110-28, Sec. 7002.

³ 42 U.S.C. § 1396a(a)(2).

⁴ 42 U.S.C. § 1396b(w)(6) and (7).

Section 1902(a)(2) remains unchanged and, as discussed below, the 1991 legislation adding Section 1903(w) was not intended to change this result.⁵

Second, the regulatory definition, even as revised, is inconsistent with the plain language of the statutory definition of unit of government on which CMS relies.⁶ Section 433.50 conspicuously adds to the statutory definition. While CMS appropriately broadened the definition in response to specific comments, it did not go far enough. If Congress had intended to impose these additional requirements, it would have done so. Instead, Congress adopted a broad definition with the intent of maintaining then existing policy allowing any public agency to fund Medicaid.

Third, the rule applies the term “unit of government” well beyond its stated applicability. Section 1903(w)(7) expressly limits the scope of the terms defined therein to be used only “for purposes of this subsection.” CMS goes far beyond this limitation and would use the term 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) of 1903(w) were intended to protect the states’ ability to use local public funds to finance the non-federal 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.⁷ By limiting the definition of unit of government, the rule is directly contrary to this express Congressional purpose.

As noted in our previous comments, California safety net providers are concerned that the unit of government definition would eliminate the use of Alameda County Medical Center funds as the nonfederal share of Medicaid expenditures and would preclude the use of University of California teaching appropriations for Medicaid funding purposes. While CMS has attempted to address the concerns regarding the University of California providers, even with the changes in the final rule, Alameda County Medical Center apparently would be precluded from funding Medi-Cal services.

Alameda County Medical Center (“ACMC”) is a public entity that expends public funds in the provision of hospital services to Medi-Cal beneficiaries. However, ACMC is operated by a public hospital authority that is separate from Alameda County. It is the County, and not the separate authority, that has the generally applicable taxing authority. Under the proposed regulation, California could not have relied on the IGTs or CPEs generated at ACMC as a source of Medicaid funding. The modification to the rule, adding to the definition of units of government those with “direct access to tax revenues” does not change this result. According to the preamble discussion of this change, CMS would continue to require that the unit of government with taxing authority (in this case, Alameda County) have “full responsibility for

⁵ See Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Pub. Law No. 102-234) (“1991 Medicaid Amendments”).

⁶ See § 1903(w)(7)(G); 42 U.S.C. § 1396b(w)(7)(G).

⁷ H.R. Conf. Rep. No. 102-409, at 1444 (1991).

funding a health care provider's expenses, liabilities, and deficits..."⁸ Even as revised, CMS apparently does not intend to recognize independent public entities like APMC as units of government under this rule. This result is inconsistent with Section 1903(w)(6) of the Act, which precludes CMS from restricting the use of public funds for Medicaid, unless prohibited provider-related taxes or donations are involved.

For the reasons discussed above, as applied to APMC, Section 433.50 is inconsistent with the Medicaid statute, and therefore must be stricken from the rule. If the overly restrictive definitional component to this rule is implemented, California safety net hospitals generally, and APMC specifically, will lose an important source of funding. There is no legitimate federal interest in imposing these restrictions on California's ability to fund its Medi-Cal program. While the rule would result in federal savings, those savings would be accomplished in violation of the State's right to use local funds as the nonfederal share of Medicaid expenditures under Section 1902(a)(2) of the Act.

B. CMS should clarify the treatment of university teaching hospitals as units of government.

The University of California hospitals are owned and operated by the Regents of the University of California ("UC"), a constitutionally created unit of State government. The Regents do not have independent taxing authority and the University hospitals are not considered an integral part of those units of state government that do have such authority. In its previous comments on the proposed rule, CAPH 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. Though CMS addressed this concern through changes to Section 433.50, the changes require further clarification.

As revised, a unit of government would include "a State university teaching hospital with direct appropriations from the State treasury..." In California, the State appropriation for the University generally goes to the Regents, and is allocated by the Regents among its educational functions, including the medical education teaching programs in the UC medical centers and other UC providers. We 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.

In our view, the University of California health care providers would qualify to participate in Medi-Cal funding under two provisions of the rule: (1) The Regents, which own and operate the UC health system, receive direct appropriations from the State, and clearly qualifies as a unit of government under Section 433.50(a)(1)(i); and (2) The UC medical centers receive appropriated funding as state university teaching hospitals, and therefore qualify under Section 433.50(a)(1)(ii).

⁸ 72 Fed. Reg. at 29753.

If CMS is permitted to implement 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 hospitals.

C. The procedural changes regarding implementation of the rule are helpful, but do not go far enough.

Although they do not resolve the fundamental legal flaws in the rule, CAPH supports the procedural changes discussed in the preamble to the final regulations regarding the process for implementing the rule.⁹ CAPH supports the decision to apply any determination that an entity no longer qualifies as a unit of government on a prospective basis only. This will provide states with time to address the funding shortage that will be created by the determination.

CAPH also agrees that CMS should allow the states to make the initial determination regarding the status of entities as units of government for purposes of the Medicaid rule. Doing so suggests some acknowledgement of the States' important role in implementing the Medicaid program. However, it is clear from the preamble discussion that CMS does not intend to sufficiently defer to the States' determinations, and instead will impose its own interpretation of the rule. We urge CMS to recognize that the States, rather than the federal government, more appropriately understand their governmental structures and should be entitled to determine the use of local funds for Medicaid services.

D. The impact of the revised definition of unit of government on California's demonstration project is unclear.

In the preamble to the final regulation, CMS has assured California and its providers that the cost limit rule will not affect the State's Hospital/Uninsured Care Demonstration Project approved under Section 1115 of the Act ("Hospital Waiver").¹⁰ CMS does not expressly address, however, whether Hospital Waiver funding will be reduced if ACMC or the UC providers no longer qualify as units of government for purposes of funding the non-federal share of Hospital Waiver expenditures. Because the Special Terms and Conditions for the Hospital Waiver expressly recognize the ability of these entities to provide IGTs and CPEs in support of the program, CAPH urges CMS to confirm that Section 433.50 will not change this result as long as the Hospital Waiver remains in effect.

⁹ 72 Fed. Reg. at 29750.51.

¹⁰ 72 Fed. Reg. at 29813-15.

Conclusion

The final regulations issued on May 29, 2007 are 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. Even if the Congressionally imposed moratorium is permitted to expire in May 2008, CMS should withdraw the final rule in its entirety and reconsider its approach to limiting federal Medicaid expenditures.

CMS must not disregard the necessity to clarify the entities to whom the definition of "unit of government" applies. If the rule in its present form is not withdrawn, CMS must revise the rule to recognize APMC as a unit of government. Additionally, CMS must expressly recognize that the University of California and its teaching hospitals are units of government for purposes of the rule.

Sincerely,



Melissa Stafford Jones
President and CEO



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8

North Carolina Hospital Association

July 12, 2007

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

Re: Comments on Unit of Government Definitions 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 Federal Register, 29748), May 29, 2007.

Dear Ms. Norwalk:

On behalf of the 100 North Carolina acute care hospitals, both public and non-public, participating in the State's Hospital DSH and Medicaid Supplemental Payment Program, we appreciate this opportunity to comment on the Centers for Medicare and Medicaid Services May request for additional comments on the definition of a unit of government that was included in this final rule. This rule does not change the most detrimental aspects of the January 18 proposed rule for which we also provided comments. We reiterate our strong opposition to this final rule, and specifically the definition of unit of government, because of the significant harm these policy changes would cause to North Carolina hospitals and the patients and communities they serve.

The North Carolina program is based upon the certified public expenditures of approximately 43 public hospitals, used to draw down matching federal funds to make enhanced Medicaid and Disproportionate Share Hospital payments to both public and non-public hospitals that provide essential hospital services to all patients, including Medicaid and uninsured. Approximately \$340 million goes to these safety net hospitals each year to provide quality health care to our state's most vulnerable residents. Hospitals in our state are facing numerous challenges with the growing level of the uninsured and continued threats to reimbursement from government payers and others. In North Carolina, about one-third of our hospitals operate with negative operating margins, while another one-third have operating margins of less than five percent, much less than the expected level needed to adequately fund ongoing operations.

The definition of unit of government as used in the context of the final rule will have a huge detrimental impact on North Carolina. In order for a public hospital to meet this new definition, it must demonstrate that it has generally applicable taxing authority or is an integral part of a unit of government that has generally applicable taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Nowhere in the Medicaid statute, however, is there any requirement that a "unit of government" have "generally applicable taxing authority." This new restrictive definition would disqualify many long-standing truly public hospitals from certifying their public expenditures. All of North Carolina's public hospitals are considered public under applicable State law. There is no basis in federal statute that supports a change in definition.

Existing federal Medicaid regulations allow North Carolina hospitals to receive payments under our State's program to offset a portion of the costs incurred when caring for Medicaid patients. Even with these payments, however, hospital Medicaid revenues for most North Carolina hospitals still fall significantly short of allowable Medicaid costs. If the final rule is implemented with the definition of unit of government and this vital hospital funding stream is eliminated, those losses would be exacerbated. Hospitals would be forced either to raise their charges to insured patients or to reduce their costs by eliminating costly but under-reimbursed services. The first choice would raise health insurance costs by an estimated four percent, further exacerbating the increasing numbers of the uninsured who cannot afford such high premiums. The second would eliminate needed services, not only for Medicaid patients but also for the entire community. Eliminating those services likely would result in the elimination of almost 3,000 hospital jobs in North Carolina, with a total statewide economic impact of nearly 11,000 lost jobs and \$600 million in lost revenues.

If this devastating rule with the definition of a unit of government is not withdrawn, North Carolina hospitals will lose approximately \$340 million immediately, or almost \$2 billion over five years. The rule's estimated "savings" to the federal government of \$3.87 billion nationwide are significantly understated.

The North Carolina Hospital Association opposes the definition of a unit of government and urges CMS to immediately and permanently withdraw it, leaving such determinations as a matter of state law. If these policy changes are implemented, the state's health care safety net will unravel, and health care services for thousands of our state's most vulnerable people will be jeopardized.

If you have questions about these comments, please contact Millie Harding (919/677-4217) or Hugh Tilson (919/677-4229) at NCHA.

Sincerely,

NORTH CAROLINA HOSPITAL ASSOCIATION



William A. Pully
President

cc: Members of North Carolina's Congressional Delegation

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, NO. 102), May 29, 2007

Dear Ms. Norwalk:

WakeMed Health & Hospitals is an 870-bed private, non-profit health system in Raleigh, North Carolina. WakeMed consists of two acute care hospitals, one inpatient rehabilitation facility, two skilled nursing facilities, one home health agency, two outpatient facilities, and six outpatient rehabilitation facilities. WakeMed opposes 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



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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. WakeMed 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.

WakeMed 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, WakeMed 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.

Sincerely,

A handwritten signature in cursive script that reads "Rebecca Andrews".

Rebecca Andrews
Vice President, Finance

cc: Christine Sibley
Christine Craig
Thomas Meehan