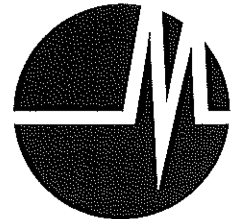
MISSISSIPPI HOSPITAL ASSOCIATION



March 15, 2007

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

Via Overnight Mail to:

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

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

Dear Ms. Norwalk:

The Mississippi Hospital Association ("MHA" or the "Association"), representing over 100 public, non-profit and private hospitals in the State of Mississippi, appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS") proposed rule. Our comments detail specific concerns with the proposed rule and highlight the harm it would cause to our hospitals and the patients they serve, including over 600,000 persons who are enrolled in the State's Medicaid Program. However, our primary recommendation is that CMS withdraw the proposed rule and work with Congress and with state and local stakeholders to develop policy alternatives that would strengthen- not undermine- the nation's health safety net.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. Not only would these changes cause major disruptions to our state Medicaid program, it would also hurt providers and beneficiaries alike. And, in making its proposal, CMS fails to provide data that supports the need for the proposed restrictions.

CMS estimates that the rule will cut $3.9 billion in federal spending over five (5) years. The rule will drastically reduce reimbursement for Mississippi's "safety net" hospitals, which treat the largest number of indigent and uninsured patients, without any evidence such hospitals ever utilized the financial practices these rules are designed to erase.

The preamble describes two financing arrangements which CMS believes are improper: (1) those in which the providers are required to refund a portion of the Medicaid payments received and (2) those in which federal funds are used to absorb costs outside the Medicaid program. Mississippi's Medicaid financing arrangement employs none of these characteristics.

This Rule amounts to a budget cut for safety-net hospitals and state Medicaid programs that bypasses the congressional approval process and comes on the heels of vocal congressional opposition to the Administration's plans to regulate in this area. Last year 300 members of the House of Representatives and 55 senators signed letters to Health and Human Services Secretary Mike Leavitt opposing the Administration's attempt to circumvent Congress and restrict Medicaid payment and financing policy. More recently, Congress again echoed that opposition, with 226 House members and 43 Senators having signed letters urging their leaders to stop the proposed rule from moving forward. This delegation included Mississippi Senator Cochran and Mississippi Congressmen Wicker and Taylor.

We urge CMS to permanently withdraw this rule, and we would like to outline our most significant concerns to the proposed Rule that particularly impact our hospitals and the State of Mississippi's Medicaid program. These concerns include: (1) the limitation on reimbursement of governmentally operated providers; (2) the narrowing of the definition of public hospital; (3) the restrictions on intergovernmental transfers (referred to herein as "IGTs"); and (4) the September 2007 effective date is not achievable.

Limiting Payments to Government Providers

We are opposed to this rule that proposes to limit reimbursement for government hospitals to the cost of providing services to Medicaid patients, and restricts states from making supplemental payments to these safety net hospitals through Medicare Upper Payment Limit (UPL) programs. Limiting a public hospital's Medicaid payment to the undefined "cost" of its services merely punishes those hospitals have struggled to reduce their cost. In addition, since the proposed rules impose these cost limits only on public hospitals, they have the insidious effect of paying government hospitals less than private hospitals. There has been no articulated justification for this policy change.

Mississippi hospitals (which are reimbursed by Medicaid on a per-diem system) do not receive per-diem payments from Medicaid that exceed their average actual costs of providing such services. While our public hospitals receive DSH payments in addition to the Medicaid per-diems which help to reimburse them for providing uncompensated charity care, many of them still only break even or even lose money on their actual costs of providing services to all patients. Therefore reductions in payments to government hospitals as proposed by this rule will cause serious financial harm to many public hospitals in Mississippi.

As you have already heard before in other comment letters you have received, hospitals that do not have profits do not have money to replace obsolete equipment, replace and/or expand infrastructure, invest in information technology and emergency preparedness, or pay for workforce. In addition, implementation of this proposed rule may cause hospitals to reduce services and/or workforce, which would directly negatively impact its employees, its community and the economy of the surrounding area, as well as the State which depend on the hospitals as an important contribution to our economy.

In proposing a cost-based reimbursement system for government hospitals, CMS also fails to define allowable and non-allowable costs. We are very concerned that, in CMS' zeal to reduce federal Medicaid spending, important costs such as graduate medical education and physician on-call services or clinic services would not be recognized as allowable costs and therefore would no longer be reimbursed.

CMS also fails to explain why it is changing its position regarding the flexibility afforded to states under the UPL program. CMS, in 2002 court documents, described the UPL concept as setting aggregate payment amounts for specifically defined categories of health care providers and specifically defined groups of providers, but leaving to the states considerable flexibility to allocate payment rates within those categories. Those documents further note the flexibility to allow states to direct higher Medicaid payment to hospitals facing stressed financial circumstances. CMS reinforced this concept of state flexibility in its 2002 UPL final rule. But CMS, in this current proposed rule, is disregarding without explanation its previous decisions that grant states flexibility under the UPL system to address the special needs of hospitals through supplemental payments.

New Definition of "Unit of Government"

The proposed rule puts forward a new and restrictive definition of "unit of government," such as a public hospital. Hospitals that do not meet this new definition would not be allowed to help finance the state portion of the Medicaid Program.

We understand that some states have created hospitals that are organized separately from local governments, such as public benefit corporations or non-profit corporations engaged in public-private partnerships with their local governments, and that such hospitals in other states are permitted in their states to help finance the non-federal share of the program. However, the 45 public hospitals in Mississippi that help to finance the state match are traditional public hospitals that are owned by the State or by counties or local governments. As has been explained to you in other comment letters, these hospitals (with a few limited exceptions) were structured to have separate budgets and separate governing boards, etc. from their local government-owners to provide them with more autonomy and to equip them to better control costs.

This proposed rule is so restrictive that only the state's teaching hospital University of Mississippi Medical Center (UMMC)) would potentially qualify as a "unit of government." Furthermore, it is questionable that UMMC (the source of over 46% of the total IGTs made in 2006) would meet the definition as it currently does not meet all of the criteria set forth in the proposed rule.

Contrary to CMS' assertion, the statutory definition of "unit of government" does not require "generally applicable taxing authority." There is no basis in federal statute that supports this proposed change in definition.

Restrictions on Intergovernmental Transfers
The proposed rule imposes significant new restrictions on a state's ability to fund the non-federal share of Medicaid payments through IGTs. There is no authority in the statute for CMS to restrict IGTs to funds generated from tax revenue. CMS has inexplicably attempted to use a provision in current law that *limits the Secretary's authority to regulate* IGTs as the source of authority that *all* IGTs must be made from state or local taxes. Not only is the proposed change inconsistent with historic CMS policy, but it is another instance in which CMS has inappropriately interpreted the federal statute. In 2006 only $18,000,000 in IGTs from UMMC of the $82,000,000 total IGTs made by our 45 public hospitals would meet this restriction.

The Financial Impact of the Proposed Rules

The result of the proposed rules would be a deficit of at least a quarter of a billion dollars to the State's Medicaid program!

The restrictions placed on funding from providers and the resulting loss of federal matching funds will leave the state's Medicaid program (including the DSH and UPL program and other supplemental Medicaid payment programs that support the state's health care safety net) with a gaping funding hole of approximately

$266 Million Dollars. Other more profitable states may find ways to fill these gaps, but with Mississippi's economy being the worst in the nation, it is very likely that the state would address the shortfall by leaving potential federal match dollars of 76% (the highest match in the nation) on the table and instead making cuts in services, beneficiaries and/or reimbursement.

With respect to the prospect of reducing coverage, Mississippi has already reduced the rolls by over 60,000 persons in FYE 2006. Another reduction coming so soon on the heels of the previous one would have a devastating effect in the health care needs of the 490,000 citizens in Mississippi (17.4% of the state's population) who do not have and cannot afford health insurance. Furthermore, Mississippi's Medicaid patients are already the most vulnerable and sickest patients in the nation, requiring longer hospital stays than patients in other states. Therefore reducing coverage of services is not a viable option because any services reduction would jeopardize our state's already vulnerable patients and result in even sicker patients.

Regardless of what route the State takes all of these alternatives will have a negative impact on the care the Medicaid beneficiaries receive and would increase the number of uninsured persons in the State rather than help to improve our state's health care system.

The September 1, 2007 Effective Date is not Achievable

The State of Mississippi does not have the time nor the financial and staffing resources in place to overhaul its provider payment system and plug the large budgetary gap (assuming it will even do so) resulting from the required changes in non-federal share financing by September 1, 2007. Our state legislative session ends in less than two weeks at which time the State's budget for fiscal year 2008 will be finalized, long before the final rule is published. Elimination of federal funding of the magnitude proposed in this rule cannot possibly be incorporated and absorbed at this late date.

Further, the State is not obligated to modify the program based on the provisions of a proposed regulation that does not have the force and effect of law. It would not be prudent for the State to undertake restructuring of the program at this time, given that the regulation may undergo a significant change.

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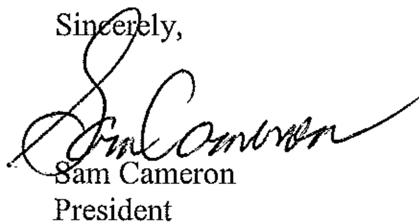
The Association and our member hospitals oppose the rule and strongly urge that CMS permanently withdraw it. If these policy changes are implemented, Mississippi's health care safety net will unravel, and health care services for thousands of our State's most vulnerable people will be jeopardized.

Sincerely,



Sam Cameron
President

Enclosures (2 copies of letter)