

**THE ADMINISTRATION'S REGULATORY ACTIONS
ON MEDICAID: THE EFFECTS ON PATIENTS,
DOCTORS, HOSPITALS, AND STATES**

HEARING

BEFORE THE

**COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM**

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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THE ADMINISTRATION'S REGULATORY ACTIONS ON MEDICAID: THE EFFECTS ON PATIENTS, DOCTORS, HOSPITALS, AND STATES

THURSDAY, NOVEMBER 1, 2007

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m. in room 2157, Rayburn House Office Building, Hon. Henry A. Waxman (chairman of the committee) presiding.

Present: Representatives Waxman, Towns, Cummings, Kucinich, Davis of Illinois, Watson, Higgins, Braley, Cooper, Van Hollen, Hodes, Murphy, Sarbanes, Welch, Davis of Virginia, Shays, Mica, Platts, Foxx, Sali, and Jordan.

Also present: Representative Engel.

Staff present: Phil Barnett, staff director and chief counsel; Kristin Amerling, general counsel; Karen Nelson, health policy director; Karen Lightfoot, communications director and senior policy advisor; Andy Schneider, chief health counsel; Teresa Coufal, deputy clerk; Caren Auchman and Ella Hoffman, press assistants; Kerry Gutknecht and Bret Schothorst, staff assistants; Art Kellerman, fellow; Tim Westmoreland, consultant; Jennifer Safavian, minority chief counsel for oversight and investigations; Kristina Husar, minority counsel; Patrick Lyden, minority parliamentarian and members services coordinator; and Benjamin Chance, minority clerk.

Chairman WAXMAN. The meeting of the committee will please come to order.

Throughout this year our committee has held a series of hearings on making Government work again. We have focused on programs or agencies that once were effective but are now broken or dysfunctional. Today's hearing examines one of our Government's most important agencies, the Centers for Medicare and Medicaid Services at the Department of Health and Human Services. Called CMS for short, the agency is responsible for administering the country's two largest health insurance programs, Medicare and Medicaid, which cover nearly 100 million Americans at a cost of over \$600 billion. As the largest single purchaser of health care in the country, CMS has enormous power to do good or do harm.

Medicaid is funded jointly by the Federal Government and the States. It covers more than 60 million low-income Americans. Medicaid is the largest insurer of infants and children in the United States, covering more than 28 million kids. It is also the largest insurer of people with disabilities, covering almost 10 million people.

Medicaid is the single largest source of funding for our Nation's public teaching hospitals, children's hospitals, and community health centers and public clinics—programs that benefit not only the poor, but everyone in their communities.

Unfortunately, little notice has been paid to a series of Medicaid regulations proposed by the administration over the last 10 months, but these proposals would have enormous impacts. They are, in my opinion, a thinly disguised assault on the health care safety net. If implemented, they would cause major disruptions to State Medicaid programs and the people and institutions that depend on them.

In total, the proposals would shift at least \$11 billion in cost to State and local governments, the largest Medicaid regulatory cost shift in memory. Since these are Federal matching funds, the real cuts in programs at the local level could be at least twice this amount. This could force States to make a difficult choice: either raise taxes or cut vital services.

This morning our committee will examine six rules the Bush administration has proposed. Three of these proposed rules target some of our Nation's most vulnerable citizens by cutting funding and services to disabled children, disabled adults, and elementary school children. The other three would cut billions of dollars in Federal funding from some of our Nation's most vital health care institutions: teaching hospitals, safety net providers, and public hospitals that support trauma centers, burn units, and other vital but unprofitable programs that benefit everyone in the community, insured and uninsured, alike.

What is almost as troubling as the impact of these rules is the manner in which they are being pursued. Some of these proposals have been proposed in the past, but when they were proposed, 300 Members of the House and 55 Members of the Senate signed letters to Secretary Leavitt opposing the efforts.

Undeterred, CMS pressed ahead and proposed these regulations. During the 90 day comment period on the proposed rule, CMS received more than 400 negative comments. The bipartisan National Governors Association, bipartisan National Council of State Legislatures, bipartisan National Association of Counties, numerous State and county governments, and a large number of hospital organizations, professional associations, and consumer groups all raised concerns. Not one person wrote in support of the rule.

In response, Congress imposed a 1-year moratorium on CMS' authority to implement the rule. Despite all this, CMS is still moving ahead.

This rule that I am referring to is just one example. All of the proposed regulations are made up out of whole cloth by CMS. They are reinterpreting laws, some of which have not been changed in 40 years. These changes, in my opinion, are not anchored in statute. They do not have the support of the Congress, and they deserve no deference from the courts.

These actions and the subsequent issuance of five more proposals that shift an additional \$7 billion in costs to the States bring us to today's hearing. The first panel will describe the effects of these rules on individual Americans, their community providers, and the

States. Dennis Smith, the official at CMS who wrote these regulations, will join us on the second panel.

I think that we need to look at what is happening very, very carefully at CMS, and I hope that they will look very carefully at the hearing record today, because, let's be clear, these regulations are not about program integrity. If they were refining guidance and improving accountability, that would be one thing; but since they are prohibiting services that have been successful for decades in order to cut funding that Congress has specifically preserved, this is not a careful surgery on Medicaid; this is a reckless amputation.

I hope CMS will listen carefully to what our witnesses and the members of the committee have to say about their proposals, and I hope they will go back to the drawing board. If there truly are fiscal integrity concerns that need to be addressed through new rules, this committee would work with CMS to accomplish that goal. There is no other committee that has been as active in trying to make sure that we have integrity in our fiscal management than this committee has been.

I look forward to the witnesses, and I hope that this hearing will have an impact.

I ask unanimous consent that my complete opening statement be part of the record in its entirety. Without objection, that will be the order.

[The prepared statement of Chairman Henry A. Waxman follows:]

**Opening Statement of Rep. Henry A. Waxman
Chairman, Committee on Oversight and Government Reform
Hearing on the Administration's Regulatory Actions on Medicaid:
Their Effects on Patients, Doctors, Hospitals, and States
November 1, 2007**

Throughout this year, our Committee has held a series of hearings on making government work again. We've focused on programs or agencies that once were effective but are now broken or dysfunctional.

Today's hearing examines one of our government's most important agencies — the Centers for Medicare and Medicaid Services at the Department of Health and Human Services. Called "CMS" for short, the agency is responsible for administering the country's two largest health insurance programs, Medicare and Medicaid, which cover nearly 100 million Americans at a cost of over \$600 billion. As the largest single purchaser of healthcare in the country, CMS has enormous power to do good or to do harm.

Medicaid is funded jointly by the federal government and the states. It covers more than 60 million low-income Americans. Medicaid is the largest insurer of infants and children in the United States, covering more than 28 million kids. It is also the largest insurer of people with disabilities, covering almost 10 million people. Medicaid is the single largest source of funding for our nation's public teaching hospitals, children's hospitals, community health centers, and public clinics — programs that benefit not only the poor, but everyone in their communities.

Unfortunately, little notice has been paid to a series of Medicaid regulations proposed by the Administration over the last ten months. But these proposals would have enormous impacts. They are a thinly disguised assault on the healthcare safety net. If implemented, they would cause major disruption to state Medicaid programs and the people and institutions that depend on them.

In total, the proposals would shift at least \$11 billion in costs to state and local governments — the largest Medicaid regulatory cost shift in memory. Since these are federal matching funds, the real cuts in programs at the local level could be at least twice this amount. This would force states to make a difficult choice: either raise taxes or cut vital services. This scenario probably understates the potential for damage, as there are almost certainly more proposals to come.

This morning, our Committee will examine six rules the Bush Administration has proposed. Three of these proposed rules target some of our nation's most vulnerable citizens by cutting funding and services to disabled children, disabled adults, and elementary school kids.

The other three would cut billions of dollars in federal funding from some of our nation's most vital healthcare institutions — teaching hospitals that are training America's future healthcare workforce, safety net providers that care for both Medicaid patients and millions of uninsured Americans, and public hospitals that support trauma centers, burn units and other vital but unprofitable programs that benefit everyone in the community — insured and uninsured alike.

Indeed, many of the institutions that will be hardest hit by these CMS rules serve as the cornerstones of their community's disaster response capability, and are therefore essential for homeland security.

What is almost as troubling as the impact of these rules is the manner in which they are being pursued. One of the proposed rules, the one that affects how states may raise funds for Medicaid and use this money to provide extra support for public hospitals, is a case in point.

Over the past few years, the Bush Administration has repeatedly sought to restrict states' flexibility to finance the state share of Medicaid. But when bipartisan majorities of the last Congress rejected these efforts, the President sought to bypass the Congress through rulemaking. In response, 300 members of the House and 55 members of the Senate signed letters to Secretary Leavitt opposing the effort. Following the mid-term elections, the Administration renewed its effort in January, once again proposing to change the way Medicaid pays for public hospital costs. Again, bipartisan majorities of the House and Senate wrote to Secretary Leavitt to express "grave concern" or outright opposition to the Administration's proposal.

Undeterred, CMS pressed ahead.

During the 90-day comment period on the proposed rule, CMS received more than 400 negative comments. The bipartisan National Governor's Association, the bipartisan National Council of State Legislatures, the bipartisan National Association of Counties, numerous state and county governments, and a large number of hospital organizations, professional associations, and consumer groups all raised concerns. Not one person wrote in support of the rule.

In response, Congress imposed a one-year moratorium on CMS's authority to implement the rule. Despite all this, CMS still moved ahead.

The very same day that President Bush signed the moratorium into law, CMS published its final rule, apparently to make sure that the new policy goes into effect immediately upon the expiration of the moratorium.

This is just one example. All of the proposed regulations are made up out of whole cloth by CMS. The most recent change in the underlying statutes that CMS is seeking to “redefine” was passed in 1991 during the first Bush Administration. One statutory provision they are “reinterpreting” hasn’t been changed in forty years. This is clearly lawless regulation, not anchored in statute. It does not have the support of the Congress and it deserves no deference from the courts.

Of course, CMS had other options. It could have gone back to the drawing board to put together regulations that do not threaten the emergency care capacity of many of our nation’s largest cities — cities that are the most likely sites for healthcare disaster needs, such as hurricanes, earthquakes, pandemic flu, and even bioterrorism. It could have developed regulations that do not suddenly shift billions in costs to the states and localities.

Instead, it launched an assault on Medicaid.

These actions, and the subsequent issuance of five more proposals that shift an additional \$7 billion in costs to the states, bring us to today's hearing.

The first panel will describe the effects of these rules on individual Americans, their community providers, and the states.

Dennis Smith, the official at CMS who wrote these regulations, will join us on the second panel.

If past comments are any indication, Mr. Smith will likely assert that CMS is pursuing these rules to preserve the "fiscal integrity" of Medicaid. As I understand this argument, CMS has to destroy Medicaid in order to save it.

Let's be clear: there is no committee in Congress more interested in the fiscal integrity of federal programs than this one.

But let's also be clear: these regulations are not about program integrity. If they were, CMS would be refining guidance and improving accountability. Instead, they seek to prohibit services that have been successful for decades and cut funding that Congress has specifically preserved. This is not careful surgery on Medicaid; this is reckless amputation.

I very much hope that CMS will listen carefully to what our witnesses and the members of this Committee have to say about its proposals, and then go back to the drawing board. If there truly are fiscal integrity concerns that need to be addressed through new rules, this Committee will consider them. But we will not support an unauthorized regulatory offensive against the states, community providers, and Medicaid beneficiaries.

Chairman WAXMAN. Mr. Davis.

Mr. DAVIS OF VIRGINIA. Thank you. Mr. Chairman, I want to thank the chairman for holding today's hearing to review six proposed Medicaid regulations.

I hope these hearings will examine the justification of the proposed changes and their potential impacts not only on the individual beneficiaries, but on the financial sovereignty of the program, as a whole. Preserving the integrity of Medicaid is of great importance to this committee, and most importantly to millions that it serves.

Medicaid is one of the fastest-growing parts of the Federal budget. It is one of the fastest-growing parts of State budgets, as well. But it is also the safety net provider within the health system offering care to our most vulnerable citizens.

In 2006 over 63 million individuals relied on Medicaid program, including children, pregnant women, individuals with disabilities, and the elderly. Given the important role Medicaid plays in the health care system, Congress, States, and the Centers for Medicare and Medicaid Services, CMS, need to be vigilant stewards of Medicaid's financial resources.

Medicaid surpassed Medicare in 2002 to become the largest Government health care program. In 2005 the cost of providing this care exceeded \$300 billion, and it is projected to double in a decade. Such rapid growth strains Federal and State budgets. Fraud and abuse, along with questionable financial arrangements, can contribute to this growth and possibly jeopardize legitimate Medicaid services.

Medicaid is jointly financed by State and Federal Governments. The Federal share of funding is between 50 and 77 percent. While Federal participation is necessary and appropriate, this financing arrangement can incentivize States and providers to shift the cost of non-Medicaid services to the Medicaid program in order to obtain additional Federal funds.

While this is an understandable motivation, especially in light of the pressures on State budgets, it does put additional strain on the Medicaid program and it should be evaluated.

For these reasons and others, the GAO has placed Medicaid on its high-risk list. The GAO found that inadequate fiscal oversight has led to increased and unnecessary Federal spending. Specifically, GAO has pointed to schemes that leverage Federal funds improperly, and inappropriate billing of providers serving program beneficiaries as factors in this designation.

For this reason, I am pleased that Dr. Marjorie Kanof, the Managing Director of Health Care at GAO, is here to speak to these overriding risk factors and fraud and abuse concerns within the Medicaid system.

In the last year, CMS has issued a number of proposed Medicaid regulations. My opening statement doesn't afford me sufficient time to comment on all six. I look forward to an informative discussion that will hopefully lead to a more clear understanding of the genesis of these regulations and their impact on Medicaid beneficiaries, States, and providers.

I do understand that some of these regulations were, in part, prompted by CMS' concern about the diversion or inappropriate use

of Medicaid funds that may not have violated the letter of the law or regulations but are inconsistent with the spirit of the program. For example, as detailed in the proposed rehabilitative services regulation, Medicaid funds have been used to pay for services in wilderness camps in which juveniles are involuntarily confined. It would seem such programs are primarily within the domain of the Justice System and would be provided by the State, regardless of the juvenile's Medicaid eligibility. As such, juvenile detention wilderness camps may be better funded as part of State justice system as opposed to Medicaid health services.

As with any effort to improve fiscal integrity of the Medicaid program and address potentially inappropriate uses of scarce Medicare sources, a delicate balance must be achieved to ensure that legitimate needs and services of beneficiaries are not, in fact, harmed.

I anticipate that a good portion of today's hearing will focus on whether or not CMS has struck the right balance in these proposed regulations, and I look forward to witnesses' feedback on this.

With that in mind, I want to thank today's witnesses for participating in this hearing, and I want to thank the chairman for calling it.

[The prepared statement of Hon. Tom Davis follows:]

Statement of Rep. Tom Davis
November 1, 2007
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HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

TOM DAVIS, VIRGINIA
RANKING MINORITY MEMBER

ONE HUNDRED TENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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Statement of Rep. Tom Davis
Ranking Member
Committee on Oversight and Government Reform
*“The Administration’s Regulatory Actions on Medicaid: The
Effects on Patients, Doctors, Hospitals, and States”*
November 1, 2007

I would like to thank the Chairman for holding today’s hearing to review six proposed Medicaid regulations. I hope this hearing will examine the justification of the proposed changes and their potential impacts, not only on individual beneficiaries, but on the financial solvency of the program as a whole. Preserving the integrity of Medicaid is of great importance to this Committee, and most importantly, to the millions it serves.

Medicaid is the safety net provider within the health system, offering care to our most vulnerable citizens. In 2006, over 63 million individuals relied on the Medicaid program, including children, pregnant women, individuals with disabilities, and the elderly. Given the important role Medicaid plays in the health care system, Congress, states and the Centers for Medicare and Medicaid Services (CMS) need to be vigilant stewards of Medicaid’s financial resources.

Medicaid surpassed Medicare in 2002 to become the largest government health care program. In 2005, the cost of providing this care exceeded \$300 billion and is projected to double in a decade. Such rapid growth strains federal and state budgets. Fraud and abuse, along with questionable financial arrangements, can contribute to this growth and possibly jeopardize legitimate Medicaid services.

Medicaid is jointly financed by state and federal governments. The federal share of funding is between 50 and 77 percent. While federal participation is necessary and appropriate, this financing arrangement can incentivize states and providers to shift the cost of non-Medicaid services to the Medicaid program in order to obtain additional federal funds. While this is an understandable motivation, especially in light of the pressures on state budgets, it does put additional strain on the Medicaid program and should be evaluated.

For these reasons, and others, the Government Accountability Office (GAO) has placed Medicaid on its high risk list. GAO found that, "Inadequate fiscal oversight has led to increased and unnecessary federal spending." Specifically, GAO has pointed to schemes that leverage federal funds improperly and inappropriate billing of providers serving program beneficiaries as factors in this designation. For this reason, I am pleased that Dr. Marjorie Kanof, Managing Director of Health Care at GAO, is here to speak to these overriding risk factors and fraud and abuse concerns within the Medicaid program.

In the last year, CMS has issued a number of proposed Medicaid regulations. While my opening statement does not afford me sufficient time to comment on all six, I look forward to an informative discussion that will hopefully lead to a more clear understanding of the genesis of these regulations and their impact on Medicaid beneficiaries, states, and providers.

I do understand that some of these regulations were in part prompted by CMS concerns about the diversion or inappropriate use of Medicaid funds that may not have violated the letter of the law or regulations but are inconsistent with the spirit of the program. For example, as detailed in the proposed rehabilitative services regulation, Medicaid funds have been used to pay for services in “wilderness camps,” in which juveniles are involuntarily confined. It would seem such programs are primarily within the domain of the justice system, and would be provided by the State regardless of the juvenile’s Medicaid eligibility. As such, juvenile detention wilderness camps may be better funded as a part of the justice system as opposed to a Medicaid health service.

As with any effort to improve fiscal integrity of the Medicaid program and address potentially inappropriate uses of scarce Medicaid resources, a delicate balance must be achieved to ensure that legitimate needs and services of beneficiaries are not in fact harmed. I anticipate that a good portion of today’s hearing will focus on whether or not CMS has struck the right balance in these proposed regulations and I look forward to the witnesses’ feedback on this.

With that in mind, I want to thank today’s witnesses for participating in this hearing and the Chairman for calling it.

Chairman WAXMAN. Thank you, Mr. Davis.

Without objection, since we have eight members on the first panel, I would like to proceed without any further opening statements.

Let me ask unanimous consent that Congressman Elliott Engel, who is not a member of our committee, may wish to join us, and I would ask unanimous consent he be permitted to participate in this hearing.

Mr. DAVIS OF VIRGINIA. No objection.

Chairman WAXMAN. That will be the order.

Now we are going to receive testimony from the witnesses on our first panel.

Mr. David Parrella is the director of Medical Care Administration for the Connecticut Department of Social Services. He is testifying on behalf of the National Association of State Medicaid Directors.

Ms. Barbara Miller is a resident of Rockville, MD. Ms. Miller is a former Medicaid beneficiary who benefited from rehabilitation services, and she is testifying on behalf of the National Council for Community Behavioral Health Care.

Ms. Twila Costigan is program manager for the Adoption and Family Support Program at Intermountain in Helena, MT. Intermountain is a nonprofit organization that provides services to children under severe emotional distress. She is testifying on behalf of the Child Welfare League of America.

Ms. Denise Herrmann is a school nurse with St. Paul public schools in St. Paul, MN. She regularly works with the Medicaid children in the St. Paul school system. She is testifying on behalf of the National Association of School Nurses.

Mr. Alan Aviles is president of the New York City Health and Hospitals Corp. He is testifying on behalf of the National Association of Public Hospitals.

Dr. Sheldon Retchin is vice president for health services at the Virginia Commonwealth University Medical College in Richmond, VA. He is testifying on behalf of the American Association of Medical Colleges.

Dr. Angela Gardner is a practicing emergency physician at the University of Texas Medical Branch in Galveston, TX, and she is testifying on behalf of the American College of Emergency Physicians.

Last but not least, Dr. Marjorie Kanof is Managing Director of Health Care for the Government Accountability Office in Washington, DC. She is testifying on behalf of the GAO.

I welcome all of you. You are, of course, testifying from your own personal knowledge and experiences, as well as on behalf of other organizations who share your point of view. We thank all of you for being here.

It has been the practice of this committee that all witnesses that testify before us are asked to be put under oath, and so I would like to ask each if you if you will to please rise and raise your right hands.

[Witnesses sworn.]

Chairman WAXMAN. The record will indicate that each of the witnesses answered in the affirmative.

We have prepared statements from you, and those statements will be made part of the record in their entirety. What we would like to ask each of you to do is to limit the oral presentation to no more than 5 minutes. You will have a clock in the center. It will be green. When there is 1 minute left, it will turn yellow. And then when the 5-minutes are up, it will turn red. We would like you at that point to conclude your testimony.

I know you have a lot to say, and it is difficult to say in such a short period of time, but it is the only way we can hear from everybody and get questions and answers. But the whole statement will be in the record expressing all of your views, which is what I did in my opening statement, because I have a lot of strong views on this subject which I had in the opening statement, and I want it to be in the record.

Mr. Parrella.

STATEMENTS OF DAVID PARRELLA, DIRECTOR, MEDICAL CARE ADMINISTRATION, DEPARTMENT OF SOCIAL SERVICES, STATE OF CONNECTICUT, HARTFORD, CT, AND CHAIR, EXECUTIVE COMMITTEE, NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS (ON BEHALF OF THE NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS); BARBARA MILLER (ON BEHALF OF NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE); TWILA COSTIGAN, PROGRAM MANAGER, ADOPTION AND FAMILY SUPPORT PROGRAM, INTERMOUNTAIN, HELENA, MT (ON BEHALF OF THE CHILD WELFARE LEAGUE OF AMERICA); DENISE HERRMANN, SAINT PAUL PUBLIC SCHOOLS, SAINT PAUL, MN (ON BEHALF OF THE NATIONAL ASSOCIATION OF SCHOOL NURSES); ALAN AVILES, PRESIDENT, NEW YORK CITY HEALTH AND HOSPITALS CORP. (ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS); SHELDON RETCHIN, VICE PRESIDENT FOR HEALTH SCIENCES AND CEO OF HEALTH SYSTEM, VIRGINIA COMMONWEALTH UNIVERSITY, RICHMOND, VA (ON BEHALF OF THE AMERICAN ASSOCIATION OF MEDICAL COLLEGES); ANGELA GARDNER, ATTENDING EMERGENCY PHYSICIAN, UNIVERSITY OF TEXAS MEDICAL BRANCH, GALVESTON, TX, AND VICE PRESIDENT, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ON BEHALF OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS); AND MARJORIE KANOF, MANAGING DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF DAVID PARRELLA

Mr. PARRELLA. Thank you, Chairman Waxman. Good morning Congressman Davis, members of the committee. My name is David Parrella. For the past 10 years I have had the privilege of serving as Connecticut's director of Medical Care Administration. I am currently the chairman of the National Association of State Medicaid Directors, an affiliate of the American Public Human Services Association.

Thank you for the opportunity to speak briefly with you today about the recent spate of regulations promulgated by my colleagues

at the Federal Centers for Medicare and Medicaid Services, known as CMS.

Let me be clear that, regardless of our differences on these issues, I do regard Dennis Smith and his staff at CMS as colleagues, and I share their commitment to be good custodians of the public dollars that we spend on health care.

Let me begin by summarizing the broad mission of the Medicaid program, which is a State and Federal partnership to provide health care to the neediest and most vulnerable populations in our country.

Medicaid currently provides comprehensive coverage to over 63 million Americans. It is the single largest payer for the long-term care costs that are perhaps the greatest economic challenge that we face in health care as members of my own generation approach retirement.

But Medicaid is more than a long-term care program. It is generally the largest health care program, if not the largest program, period, in most State budgets. It provides support and services for millions of Americans with a wide range of disabilities that enables them to live independent lives in the community. It is the single largest payer of mental health services, the largest purchaser in the Nation of pharmaceuticals, and the source of health insurance coverage for most of the Nation's working poor.

As you debate the future of the State children's health insurance program, please remember that Medicaid is the largest source of care for children in low-income families and is the largest payer in most States for maternity and prenatal care.

Across this immense landscape of health care delivery that is literally from cradle to grave, Medicaid programs have been encouraged, and in many cases mandated, by Congress to work in partnership with other State and Federal programs that touch upon the same populations. Teaching hospitals and substance abuse programs, programs for children with special education requirements and developmental delays, programs for children in the child welfare system, residential placements for people with developmental disabilities, community-based services for persons with mental illness and HIV, child immunization programs and outreach programs to schools to reach DDN-entitled children. All these programs have benefited from collaboration with Medicaid programs around the country as a source of Federal matching funds to help States meet the mandates placed upon them by Federal laws regarding the early and periodic screening, diagnosis, and treatment program—known as EPSDT—IDEA, the Americans with Disabilities Act, etc.

We have done so economically. National budget figures show a very low rate of growth of 2.9 percent in the Medicaid program in fiscal year 2007. Providers will tell you that the rates that we pay for health care services are far from exorbitant. Furthermore, we manage the program in an indirect cost rate that would be the envy of any CEO in the private market.

So, despite the occasional messiness that ensues in a program of this size, we are not a runaway train on spending. Yet, in recent months, we have experienced a stealthy release of regulation after regulation seeking to reduce the scope and breadth of the Medicaid

program. We have seen regulations that would limit facilities that could be reimbursed as public facilities, that would eliminate payment for graduate medical education, regulations that would impose burdensome new accounting measures on the funding for community-based services, and limit the ability to partner with the schools, where millions of Medicaid-eligible children can be enrolled and served.

CMS is seeking to place new limits on how States are able to raise their required State's share for the Federal match, and perhaps most disturbingly, CMS is attempting to redefine what services can be covered under Medicaid as part of the rehabilitation State plan option, likely the single greatest vehicle for creativity and the design of programs for persons with life-long needs.

Now, CMS officials will tell you that they do not seek to harm the Medicaid program, and I am sure they are sincere in this belief. Their rationale is based largely on a two-part premise that allowing Federal matching funds under Medicaid for these purposes is inevitably too tempting for the States and will lead them to create arcane schemes to draw down excess Federal revenues for services that were traditionally a State responsibility.

Let me say here, as someone who has worked in Medicaid for the past 20 years, that they have a legitimate concern regarding program integrity, especially when times are tight in State budgets. But the other part of the premise is simply wrong. They maintain that the elimination of \$20 billion in Federal Medicaid funding for Medicaid administration activities in schools or rehabilitation services for children with developmental delays or graduate medical education is appropriate because these activities were never intended to be part of Medicaid, despite decades of approved State plan amendments across the Nation.

CMS' argument continues that "If States want to fund these activities, they can simply appropriate more money. Special education is purely the responsibility of the Education Department. Services for persons with mental illness should be under the purview of SAMHSA, and disease prevention under Public Health, and medical education is limited to funds appropriated in the budgets of the State teaching hospitals."

However, there is no new appropriation on the horizon to replace Medicaid funding for these services through Federal IDA legislation or elsewhere, and Medicaid is simply reduced in the scope of its activities.

It is surprising that this philosophy should come at a time when most experts in the field would say that the Nation's health care system is in a state of crisis. The emergency rooms of our teaching hospitals are bursting at the seams as they try to provide both emergency and non-emergency care to 47 million Americans who have no health insurance.

A greater awareness of autism and spectrum disorders and mental illness among very young children has placed a strain on the entire mental health system. Persons with disabilities are struggling to find more creative alternatives to live independent and productive lives. A retrenchment by Medicaid will only make these struggles more difficult for millions of Americans at a time when

no comprehensive reform of the health care system is even on the horizon.

We are apparently unable to agree on what income levels should qualify a child to receive assistance with health care under S-CHIP, much less comprehensive health reform.

As Chair of the National Association of State Medicaid Directors, I applaud your efforts to review some of the changes that CMS officials have placed. I further appeal to you to continue your efforts to expand the moratoriums that you have already placed on some of these regulatory initiatives. It is the belief outstanding of the National Association of State Medicaid Directors that these issues need to be part of a broader debate on the future of health care here in these chambers. On many of these issues you did debate them during the discussion that led to the Deficit Reduction Act and chose not to act.

Please do not allow CMS to further limit the ability of the States to derive their share of Medicaid from taxes imposed on medical providers.

Please do not allow CMS to eliminate the option for States to use Medicaid funding to pay for graduate medical education.

Please do not permit CMS officials to jeopardize the future of children with developmental disabilities by subjecting the services they receive to an artificial distinction between having lost their cognitive abilities or never having had them at all.

Please do not force persons with disabilities back into institutional settings because States cannot match cost report standards for the community-based services they receive to a Medicare institutional standard.

Please do not cutoff information gathered by school personnel from helping States to determine eligibility for their programs.

Please do not dictate to States what facilities can be designated units of government for reimbursement purposes.

And Please do not take hospital reimbursement back to the future by mandating retro cost-based methodologies.

[The prepared statement of Mr. Parrella follows:]



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

Testimony at the House Sub-Committee on
Oversight and Government Affairs

November 1, 2007

David Parrella, Director of Medical Care Administration
Connecticut Department of Social Services

Good morning Mr. Chairman and members of the Committee. My name is David Parrella. For the past 10 years, I have had the privilege of serving as Connecticut's Director of Medical Care Administration. I also am currently the Chair of the National Association of State Medicaid Directors, an affiliate of the American Public Human Services Association. The National Association of State Medicaid Directors is a bipartisan, professional, nonprofit organization of representatives of state Medicaid. The primary purposes of NASMD are to serve as a focal point of communication between the states and the federal government, and to provide an information network among the states on issues pertinent to the Medicaid program.

Thank you for the opportunity to speak briefly with you today about the recent spate of regulations promulgated by my colleagues at the federal Centers for Medicare and Medicaid Services (CMS). Let me be clear that regardless of our differences on these issues, I do regard Dennis Smith and his staff at CMS to

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be colleagues and I share their commitment to be good custodians of the public dollars that we spend on health care.

Let me begin by summarizing the broad mission of the Medicaid program, which is a state and federal partnership to provide health care to neediest and most vulnerable populations in our country. Medicaid currently provides comprehensive coverage to over 53 million Americans. It is the single largest payer for the long-term care costs that are perhaps the greatest economic challenge that we face in health care as members of my generation approach retirement. But Medicaid is more than a long-term care program. It is generally the largest health care program, if not the largest program, period, in most state budgets. It provides supports and services for millions of Americans with a wide range of disabilities that enables them to live independent lives in the community. It is the single largest payer of mental health services; the largest purchaser in the nation of pharmaceuticals; and the source of health insurance coverage for most of the nation's working poor. As you debate the future of the State Children's Health Insurance Program (SCHIP), please remember that Medicaid is the largest source of care for children in low-income families and is the largest payer in most states for maternity and prenatal care.

Across this immense landscape of health care delivery that is literally from the cradle to the grave, Medicaid programs have been encouraged, and in many cases mandated by Congress to work in partnership with other state and federal programs that touch upon the same populations. Teaching hospitals and substance abuse programs, programs for children with special education requirements and developmental delays, programs for children in the child welfare system, residential placements for persons with developmental disabilities, community-based services

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for persons with mental illness and HIV, child immunization programs and outreach programs through schools to reach needy and entitled children, all of these programs have all benefited from collaboration with Medicaid programs around the country as a source of federal matching funds to help states meet the mandates placed upon them by federal laws regarding the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), IDEA, etc.

And we have done so economically. National budget figures show a very low rate of growth of 2.9 percent in FY 2007. Providers will tell you that the rates we pay for health care services are far from exorbitant. Furthermore, we manage the program at an indirect cost rate that would be the envy of any CEO in the private market.

So despite the occasional messiness that ensues in a program of this size, we are not a run away train on spending. Yet in recent months we have experienced the stealthy release of regulation after regulation seeking to reduce the scope and breadth of Medicaid. We have seen regulations that would limit facilities that can be reimbursed as public facilities, eliminate payment for Graduate Medical Education (GME), regulations that would impose burdensome new accounting measures on the funding for community-based services, and limit the ability to partner with the schools where millions of Medicaid children can be enrolled and served. CMS is seeking to place new limits on how states are able to raise their required state share for the federal Medicaid match. And perhaps most disturbingly, CMS is attempting to redefine what services can be covered under Medicaid as part of the Rehabilitation State Plan option, likely the single greatest vehicle

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for creativity in the design of programs for persons with lifelong needs.

Now, CMS officials will tell you that they do not seek to harm the Medicaid program, and I am sure they are sincere in this belief. Their rationale is based largely on a two-part premise that allowing federal matching funds under Medicaid for these purposes is inevitably too tempting for states and will lead them to create arcane schemes to draw down excess federal funds for services that were traditionally a state responsibility. And let me say here, as someone who has worked in Medicaid for the past 20 years, that they have a legitimate concern regarding program integrity, especially when times are tight in state budgets.

But the other part of their premise is simply wrong. They maintain that the elimination of \$20 billion in federal Medicaid funding for Medicaid administrative activities in the schools, or rehabilitation services for children with developmental delays, or graduate medical education is appropriate because these activities were never intended to be part of Medicaid, despite decades of approved state plan amendments across the nation. CMS's argument continues that *"If states want to fund these activities they can simply appropriate more money. Special Education is purely the responsibility of the Education Department, services for persons with mental illness should be under the purview of SAMHSA, disease prevention under public health, and medical education is limited to funds appropriated in the budgets of the state teaching hospitals."* Although there is no new appropriation on the horizon to replace Medicaid funding for these service through federal IDEA legislation or other areas where it might well belong, Medicaid is simply supposed to reduce the scope of its activities.

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It is surprising that this philosophy should come at a time when most experts in the field would say that the nation's health care system is in a state of crisis. The emergency rooms of our teaching hospitals are bursting at the seams as they try to provide both emergency and non-emergency care to the 47 million Americans who have no health insurance. A greater awareness of autism spectrum disorders and mental illness among very young children has placed a strain on the entire mental health system. Persons with disabilities are struggling to find more creative alternatives to live independent and productive lives. A retrenchment by Medicaid will only make those struggles more difficult for millions of Americans at a time when no comprehensive reform of the health care system is even on the horizon. We are apparently unable to agree on what income level should qualify a child to receive assistance with health care under SCHIP, much less comprehensive health reform.

As chair of the National Association of State Medicaid Directors, I applaud your efforts to review some of the changes that CMS officials have placed on states. I further appeal to you to continue your efforts to expand the moratoriums that you have already placed on some of these regulatory initiatives. It is the belief of the National Association of State Medicaid Directors that these issues need to be part of a broader debate on the future of health care here in these chambers. On many of these issues you did debate them during the discussion that led to the Deficit Reduction Act and chose not to act.

Please do not allow CMS to further limit the ability of the states to derive their share of Medicaid from taxes imposed on medical providers. Please do not allow CMS to eliminate the option for states to use Medicaid funding to pay for graduate medical

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education. Please do not permit CMS officials to jeopardize the future for children with development disabilities by subjecting the services they receive to an artificial distinction between having lost their cognitive abilities or never having had them at all. Please do not force persons with disabilities back into institutional settings because states cannot match cost report standards for the community-based services that they receive to a Medicare institutional standard. Please do not cut off information gathered by school personnel from helping states determine eligibility for their programs. Please do not dictate to states what facilities can be designated units of government for reimbursement purposes. Please do not take hospital reimbursement back to the future by mandating retro cost-based methodologies.

Absent any new sources of funding, to restrict the state option to use Medicaid to fund any of these activities will only make life harder for the millions of poor Americans who look to you for answers on health care. When we finally have that conversation all of these issues will be on the table, along with a host of others. But let's have that discussion as part of a more comprehensive debate, one that is focused on outcomes as well as costs, and that is mindful of the needs of our most vulnerable citizens and medical institutions.

Thank you. I'd be happy to try and answer any questions that you may have.

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Chairman WAXMAN. Thank you, Mr. Parrella. I gave you a little extra time.

Mr. PARRELLA. Sorry, Mr. Chairman.

Chairman WAXMAN. I appreciate that testimony on behalf of all the States that are running the program actually at the State level, which is, of course, a Federal and State program. Thank you very much.

Ms. Miller, we would like to hear from you.

STATEMENT OF BARBARA MILLER

Ms. MILLER. Chairman Waxman and distinguished members of the committee, thank you for the opportunity to testify this morning on behalf of the National Council for Community Behavioral Health Care. My name is Barbara Miller.

Today I am on the road to recovery from a serious mental illness. I am a program assistant at the Hearing Loss Association of America. Before starting that job, I did a lot of volunteer work for senior citizens and people with physical disabilities. I am also deaconess in the Word of Hope Fellowship Church. At the church I volunteer as assistant director of the youth department. There is a teenage girl in my apartment building who needs a steady, sensible adult influence, and I am trying to provide that to her as a mentor.

But my future didn't always look so bright. I was first diagnosed with bipolar disorder in the early 1970's. I lived in the Springfield State Hospital in Sykesville, MD, for 2½ years. Chairman Waxman, it was a terrible experience. The doctors there struggled to give me a proper diagnosis, and I have to tell you the truth: it was like living in a warehouse.

That is what happened to most people with serious mental illnesses in the 1960's and the 1970's: they were warehoused in State mental hospitals.

However, with the help of treatment, rehabilitation, and housing provided by Threshold Services in Montgomery County, MD, I got where I am today.

When I first started participating in rehabilitation services in 1990, I received Assertive Community Treatment at a house where I lived with several other people. Staff would come out regularly to check on me, measure progress on my treatment plan, and see how I was responding to medications. They always provided training about living with mental illness to the pastor and his wife who ran the house.

Some time ago, I moved to the Halpine Apartments. It was a huge step for me because it was the first time I had lived on my own for many, many years.

Threshold Services provided counseling to me during the transition and offered groups where people could support each other and not become isolated.

Threshold Services runs a residential rehabilitation program and offsite psychiatric rehabilitation teams which serve a combined total of 250 people. These rehabilitation programs are important because they prepare people with serious and persistent mental disorders to go back to work and cope with life in the community. Threshold also helps 40 people choose, get, and keep jobs where they work side by side with non-disabled individuals through their

supportive employment initiative, in partnership with St. Luke's House. This is tremendously impressive, because the nationwide unemployment rate among people with severe mental illnesses exceeds 80 percent.

Finally, Threshold has a psycho-educational day program that aims to develop community living skills and improve interpersonal relationships.

With the help of treatment, rehabilitation, and housing provided by Threshold services, I got from where I was to where I am, and now Threshold services helps me maintain my success. So now I give back as a member of the board of directors. God and the members of my church are with me all the way. It takes a lot of faith in God to persevere. Now I give back as a deaconess and assistant youth director in the church.

I was supported by public assistance; now I give back by working and paying taxes.

Mr. Chairman, I am told by the National Council that almost every service that you have heard me describe during this testimony—assertive community treatment, psychiatric rehabilitation, and psycho-educational day programs—are in jeopardy because of a new rehabilitation option rule. In addition to medication and therapy, it is worth noting that these rehabilitation services permit people like me to live in the community and make a contribution to the community. If the Federal Government withdraws financing from them, many more people with serious mental disorders will end up in emergency rooms, inpatient hospitals, nursing homes, or in the prison system.

I want to conclude this testimony with a simple plea: please don't send people with mental illnesses back to places like Springfield State Hospital. We have fought too hard and we have come too far to go back now.

[The prepared statement of Ms. Miller follows:]



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LINDA ROSENBERG, MSW, PRESIDENT & CEO ELIZABETH EARLES, MA, BOARD CHAIR

Testimony of Barbara Miller

**Medicaid Rehabilitative Services Client
Threshold Services, Inc., Silver Spring, Maryland**

On behalf of the National Council for Community Behavioral Healthcare

Regarding

**The Administration's Regulatory Actions on Medicaid: The Effects on
Patients, Doctors, Hospitals, and States**

November 1, 2007

TESTIMONY OF BARBARA MILLER

Chairman Waxman, and distinguished members of the committee, thank you for the opportunity to testify this morning on behalf of the National Council for Community Behavioral Healthcare. My name is Barbara Miller.

Today, I am on the road to recovery from a serious mental illness. I am a Program Assistant at the Hearing Loss Association of America. Before starting that job, I did a lot of volunteer work for senior citizens and people with physical disabilities. I am also a deaconess in the Word of Hope Fellowship Church. At the church, I volunteer as Assistant Director for Youth Department. There is a teenage girl in my apartment building who needs a steady, sensible adult influence, and I am trying to provide that to her as a mentor.

But my future didn't always look so bright. I was first diagnosed with bipolar mood disorder in the early 1970's. I lived at the Springfield State Hospital in Sykesville, MD for two and one half years. Chairman Waxman, it was a terrible experience. The doctors there struggled to give me a proper diagnosis – and I've got to tell you the truth: it was like living in a warehouse. That's what happened to most people with serious mental illnesses in the 1960's and 1970's: they were warehoused in state mental hospitals.

However, with the help of treatment, rehabilitation and housing provided by Threshold Services in Montgomery County, MD, I got where I am today. When I first started participating in rehabilitation services in 1990, I received Assertive Community Treatment at a house where I lived with several other people. Staff would come out regularly to check on me, measure progress on my treatment plan, and see how I was responding to medications. They also provided training about living with mental illness to the pastor and his wife who ran the house.

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Mr. Chairman, I am told by the National Council that almost every service that you've heard me describe during this testimony – Assertive Community Treatment, psychiatric rehabilitation, and psycho-educational day programs – are in jeopardy because of a new rehabilitation option rule.

In addition to medication and therapy, it's worth noting that these rehabilitation services permit people like me to live in the community and make a contribution to the community. If the federal government withdraws financing for them, many more persons with serious mental disorders will end up in emergency rooms, inpatient hospitals, nursing homes or the prison system.

I want to conclude this testimony with a simple plea: please don't send people with mental illnesses back to places like the Springfield State Hospital. We fought too hard.....and we've come too far.....to go back now.

Chairman WAXMAN. Thank you very much, Ms. Miller, for that testimony.

Ms. Costigan.

STATEMENT OF TWILA COSTIGAN

Ms. COSTIGAN. Good morning, Mr. Chairman, members of the committee. My name is Twila Costigan. I live in Helena, MT, and I just want to make it clear that we do have plumbing in Montana. Even though we live way out there in the west, we do have it.

I am here on behalf of the Child Welfare League of America, the Montana Children's Initiative—which is a group of providers across the State of Montana—and Intermountain Children's Home.

Intermountain Children's Home is a magical place where we seek to restore hope to children and their families. We deal only with children with serious emotional disturbance.

I am going to talk to you a little bit about how kids get to be SED, or seriously emotionally disturbed. I want to talk to you about two kids. One's name is Johnny, the other's name is Susie.

Johnny is a young infant. As we all know, the first 3 years is when your brain is going crazy up there wiring, making you who you are going to be, giving you the skills that you will need to be successful in the community.

Johnny lays in his crib and he cries because he needs his diaper changed, because he is hungry, because he is just not comfortable with where his mom is, or his caregiver is. Somebody comes to Johnny. Somebody picks Johnny up, and somebody looks at Johnny and says, you are beautiful. You are my son. You belong. I love you.

I want to talk about Susie next. Susie cries because she is hungry or she needs her diaper changed or she's just not comfortable with where people are. She doesn't feel safe. For Susie, people don't come often enough. People don't pick her up and look in her eyes and talk to her and tell her that she is beautiful and that she is loved and that she belongs. Susie will probably some day be a seriously emotionally disturbed child, removed from her birth home, in the custody of the State, placed in foster care homes, maybe more than one. The average placement is three.

For Susie and for Johnny and for each and every one of us, we are born with a drive to have relationships with other people. It is what we are here for.

After a while, kids like Susie quit crying. Nobody is taking care of them, and they are not going to let anybody into their world. These are the kids who are most severely disfigured by adults in their life. Susie is driven to attach, to connect with this other human being. For our seriously emotionally disturbed kids, most of the time that adult that they are driven to attach to is the one who provides the trauma that leads to the serious emotional disturbance.

In Montana we have a continuum of care. We provide services in the home, in the birth home, to try to keep kids in the home, which is always the best option. We have short-term foster care. Some of those kids are placed in adoptive care. The seriously emotionally disturbed children are a very small percentage of the kids who are in foster care. Most of those kids either go back to their birth

home—about 77 percent in Montana—or a relative, or they are returned to their other parent. A small percentage of them are adopted.

For our program, the rehabilitative services allow us to help these kids to bring hope into their lives, to provide in-home services, to help their parents learn how to deal with them. Our continuum of care is the preservation in the beginning, in the birth home, foster care, therapeutic foster care, therapeutic group home care, residential treatment. The rehab services are a huge piece of the funding of therapeutic foster care and therapeutic group homes.

It is really important for these kids to have some hope, and so I ask you, as you deliberate, as you think about this, think about Susie, who cried and cried and cried and nobody came to help her. Keep the rehab services intact and allow places like Intermountain and other wonderful places across the Nation to provide hope to these children who are our most vulnerable citizens and dependent on us as adults.

Thank you.

[The prepared statement of Ms. Costigan follows:]

**UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM**

HEARING ON

The Administration's Regulatory Actions on Medicaid:

The Effects on Patients, Doctors, Hospitals, and States

November 1, 2007

Written Testimony of

Twila Costigan

Program Manager for the

Intermountain Adoption & Family Support Program

Helena, MT

INTRODUCTION

Good morning! I am Twila Costigan, Program Manager for the Intermountain Adoption & Family Support Program located in Helena, MT. I have worked in the Child Welfare System in Montana for almost 27 years as a group home substitute parent, a counselor in a group home for Seriously Emotionally Disturbed (SED) children, a Child Protective Services Social Worker, an Adoption Approval and Foster Care Licensing Social Worker, and for the past 10 years a Program Manager at Intermountain. Intermountain's Relational Developmental Treatment Model is now 25 years old and continues to provide successful outcomes for SED children and their families.

Our vision at Intermountain is to secure emotional health and a loving, permanent family for each child. Our Adoption & Family Support Program was developed to facilitate permanency for Seriously Emotionally Disturbed children by recruiting, training, matching and supporting therapeutic families to provide permanent homes for children in the custody of the State of Montana due to abuse and neglect and termination of parental rights. We have expanded our program to serve birth, kinship, pre-adoptive and post-adoptive families. In my current position I am responsible for the provision of effective therapeutic wrap-around services for SED children and their parents.

My husband and I have never had birth children. We have been licensed foster parents and co-parented 4 children involved in the Child Welfare System, one of whom we adopted. We have 5 grandchildren aging from 16 months to 19 years.

I have been involved in the Montana State Foster/Adoptive Parent Association for the past 19 years serving in the offices of Secretary, Vice President, President and currently Past President. I am also the Treasurer of our local Foster/Adoptive Parent Association.

On behalf of Intermountain, the children and families of Montana, and the Child Welfare League of America, thank you for this opportunity to testify before you.

MEDICAID AND THE CHILD WELFARE SYSTEM

As a nation we believe that children deserve to have their physical, emotional, intellectual and spiritual needs met in their family of origin. We believe that children deserve to be safe, secure and loved so they can develop into productive citizens of our great country. Unfortunately it is a sad fact that not all children have their needs met by their birth parents. Some of these children come to the attention of teachers, doctors and law enforcement agencies. Some of these children find their way into our Child Welfare System because of the actions of their caregivers. Some of these children witness domestic violence, are physically and/or sexually abused, and most have been severely emotionally if not physically neglected. It is not my intention to speak disparagingly about the caregivers of these children, for in my experience, they often did not

have safe and secure childhoods themselves. These caregivers love their children as best they can, and certainly do not wake up in the morning and plan to abuse their child that day.

Children in our Child Welfare System come to the attention of Child Protective Services due to severe trauma, abuse and/or neglect. Child Protective Services workers recognize that removing a child from their primary caregiver causes harm to children and the decision to remove a child and place them in foster care is only made when the worker believes the child is in danger of further trauma, abuse and/or neglect.

The good news is that, at least in Montana, many of these children are not removed from their birth families, or if they must be placed in temporary protective services substitute care (usually a foster home or shelter) most of them are reunified with their caregiver or placed with another parent or birth family member. According to the Child and Family Services Division in testimony to the 2007 Montana Legislature: 42% of these children return home, 35% are placed with the other parent or another relative (77% placed with birth family members). Some of these children cannot be safely reunified with their parents and are adopted (13%), placed with a guardian (4%), age out or are Emancipated (6%).

The AFCARS (Adoption and Foster Care Analysis and Reporting System) Report by the Administration for children and Families, Administration on Children, Youth and Families, Children's Bureau states that there were 513,000 children in foster care on September 30, 2005 and 114,000 (22%) have been waiting an average of 41.6 months to be adopted. It is estimated in the AFCARS Report as of September 2006 that 60% of the children adopted nationally are adopted by their foster parents. Other children are not adopted by their foster parents and States cannot find permanent homes for them. These children are the most damaged children in our society (due to severe abuse and neglect and multiple placements) and have some of the worst profiles in regards to mental health and well being when they reach adulthood. These children have the government as a parent and are the focus of our discussion today. They have no primary caregiver or birth family member that can provide them a permanent, safe, secure and loving home in which to grow up. As you know, a positive relationship with a nurturing adult that lasts a lifetime is crucial to the growth and development of all children.

The Child Welfare League of America (CWLA) estimates that more than 80% of the children in foster care system have mental health issues, compared with about 10% of all U.S. children. The U.S. Department of Health and Human Services reports that 75 to 80 percent of all children requiring mental health services do not receive them. Children placed by our Child Welfare System may be found to have emotional, behavioral or psychological reactions including: depression, anxiety, anger, conduct problems, learning impairments, attachment and developmental disturbances, dissociation, and posttraumatic stress symptoms. It is not surprising that these children have more mental health needs. They have experienced trauma, abuse, neglect and abandonment from their family of origin. They have been removed from their caregivers due to these safety issues and placed in a home or other setting, thus losing their families,

communities, friends, pets, sense of belonging and sometimes their school and teachers. They have lost everything that a child needs to grow and develop normally. Some of these children are able to attach to new care givers and utilize these relationships to meet their needs for love, security and belonging. Some of these children have been so traumatized that they are unable to connect to adults in healthy ways because they are unable to trust that an adult will protect them or meet their needs.

While I was employed by the State of Montana as a Child Protective Services Social Worker, very little emphasis was placed on the mental health needs of these children. Tragically, in my experience, this has not changed. The agencies responsible for the protection of abused and neglected, children (Child Protective Services) and the agencies responsible for the mental health needs of children in the custody of the State (Medicaid Bureaus) do not work together to meet the physical, emotional, intellectual, spiritual and psychological needs of the children for whom they are responsible.

For youth who age out of the system (turn 18 years of age and are discharged from foster care) the future is bleak. According to the Pew Commission on Children and Foster Care:

"Studies have found significantly lower levels of education, higher rates of unemployment, and higher rates of homelessness for adults who spent time in foster care as children."⁵¹ For example, a study by Westat, Inc. reported that only 54 percent of young adults who grew up in foster care had completed high school, 40 percent continued to rely on public support in some way (were receiving public assistance, incarcerated, or receiving Medicaid) and 25 percent had been homeless for some period.⁵² Other studies indicate that a significant percentage of the homeless population in many cities were adults who once had been foster children."

The Child Welfare League of America (CWLA) has identified other barriers to appropriate Mental Health Services for children in foster care. These barriers include:

- A lack of providers trained in the issues that face children in foster care. Many providers are dissuaded from serving such children because of low reimbursement rates from Medicaid;
- Decreased funding has in some cases limited the number of children who may access services to those who are diagnosed with a serious emotional disturbance or those who are overtly acting out (verbal and physical aggression towards self, others, property). The types of services that are covered may be decreased, and children who are only "moderately unstable" may not receive coverage;
- A lack of continuity as children are moved between placements;
- Foster parents express frustration in finding medical and mental health providers, especially those that will accept cases involving children in the foster care system and those that will accept Medicaid;

- Rural areas have issues with access to mental health services as most service providers are clustered in urban areas;
- High Child Protective Services (CPS) caseloads limit the amount of time that a caseworker can spend on a particular case and high turnover limits effectiveness of services provided. Staff need better training to understand children's foster care and mental health needs. High turnover exacerbates this problem. Many studies cite the need for more training of CPS staff in order to help them identify mental health needs and to understand the treatment options. Better trained staff can also provide counsel and support to foster and adoptive parents attempting to manage and moderate children's problematic behaviors;
- Children in kinship care are less likely than those in non-kin care to have mental health problems; however, studies show that there are many barriers for those that do have mental health issues including; lack of mental health assessments, visits to mental health professionals, as well as receiving only part of the Medicaid benefits for which they are eligible.

THERAPEUTIC FOSTER AND GROUP HOME CARE

There is good news in the Child Welfare System. For the past 15 years the Federal Government has been promoting a children's "system of care" through SAMHSA (see www.mentalhealth.samhsa.gov). The focus has been to provide services to Seriously Emotionally Disturbed children (a diagnosable disorder that severely disrupts social, academic, and emotional functioning. About 7-9 percent of all children ages 9 to 17 have SED per DHHS, 1999) and their families in the least restrictive, most appropriate setting in a community. The principles and vision of systems of care are best practices for working with SED children and their families. Many of the professionals working with abused and neglected children in the temporary or permanent legal custody of the State, work together to meet the needs of these children and families. The services of Therapeutic Foster Care (TFC) and Therapeutic Group Home Care were developed to meet the physical, emotional, intellectual, spiritual and psychological needs of these children in the least restrictive and most appropriate setting. In a continuum of care Therapeutic Foster and Group Home services fall in between regular foster or pre-adoptive care and Residential Treatment Centers. Providers of regular foster care are reimbursed around \$18 per day by the Child Protection Agencies and Residential Treatment Centers are reimbursed around \$300 per day. Reimbursement for Therapeutic Foster and Group Home Care is between these two levels of service.

With regard to **Therapeutic Foster Care**, a report by the Former Surgeon General, David Satcher, M.D., Ph.D. Chapter 3 titled Children and Mental Health states:

"Therapeutic foster care is considered the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders. Care is delivered in private homes with specially trained foster parents. The combination of family-based care with specialized treatment interventions creates "a therapeutic environment in the context of a nurturant family home" (Stroul & Friedman, 1988). These programs, which are often funded jointly by child welfare and

mental health agencies, are responsible for arranging for foster parent training and oversight. Although the research base is modest compared with other widely used interventions, some studies have reported positive outcomes, mostly related to behavioral improvements and movement to even less restrictive living environments, such as traditional foster care or in-home placement...

There have been four efficacy studies, each with randomized, controlled designs. In the first study, 20 youths who had been previously hospitalized were assigned to either therapeutic foster care or other out-of-hospital settings, such as residential treatment centers or homes of relatives. The youths in therapeutic foster care showed more improvements in behavior and lower rates of reinstitutionalization, and the costs were lower than those in other settings (Chamberlain & Reid, 1991). In another study, which concentrated on youths with histories of chronic delinquency, those in therapeutic foster care were incarcerated less frequently and for fewer days per episode than youths in other residential placements. Thus, at 2-year followup, 44 percent fewer children in therapeutic foster care were incarcerated (Chamberlain & Weinrott, 1990). In a third study, outcomes for children in therapeutic foster care were compared with those of children in standard foster care. Children in therapeutic foster care were less likely during a 2-year study to run away or to be incarcerated and showed greater emotional and behavioral adjustment (Clark et al., 1994). In the most recent study, therapeutic foster care was compared with group care: children receiving the former showed significantly fewer criminal referrals, returned to live with relatives more often, ran away less often, and were confined to detention or training schools less often (Chamberlain & Reid, 1998).

All four studies of treatment effectiveness showed that youths in therapeutic foster care made significant improvements in adjustment, self-esteem, sense of identity, and aggressive behavior. In addition, gains were sustained for some time after leaving the therapeutic foster home (Bogart, 1988; Hawkins et al., 1989; Chamberlain & Reid, 1991)."

With regard to **Therapeutic Group Home** care the same Surgeon General Report states:

"For adolescents with serious emotional disturbances the therapeutic group home provides an environment conducive to learning social and psychological skills. This intervention is provided by specially trained staff in homes located in the community, where local schools can be attended. Each home typically serves 5 to 10 clients and provides an array of therapeutic interventions. Although the types and combinations of treatment vary, individual psychotherapy, group therapy, and behavior modification are usually included..."

There is a dearth of research on the effectiveness of therapeutic group home programs targeted toward emotionally disturbed adolescents. These homes have been developed primarily for children under the care of juvenile justice or social welfare. A dissertation (Roose, 1987) studied the outcomes of 20 adolescents treated in a group home. Adolescents with severe character pathology or major psychiatric disorders were not admitted. Twenty group home adolescents were compared with 20 untreated adolescents. At an 18-month followup, 90 percent of the treated group had fair or good functioning, defined by improved relationships with parents, peers, and fellow workers. Only 45 percent of the untreated group achieved similar functioning.

The treated group experienced a significant decrease in psychopathology, while the untreated group did not.

Therapeutic group homes were compared with therapeutic foster care in two studies. The first study found equivalent gains for youth in the two interventions, but group home placement was twice as costly as therapeutic foster care (Rubenstein et al., 1978). A second study, a randomized clinical trial, compared the outcomes for 79 males with histories of juvenile delinquency placed in either group homes or therapeutic foster homes (Chamberlain & Reid, 1998). The boys treated in therapeutic foster homes had significantly fewer criminal referrals and returned more often to live with relatives, suggesting this to be a more effective intervention. The implication of these studies is that if therapeutic foster care is available, and if the foster parents are willing to take youth with serious behavioral problems, therapeutic foster care may be a better treatment choice for youth who previously would have been placed in group homes.

Existing research suggests that therapeutic group home programs produce positive gains in adolescents while they are in the home, but the limited research available reveals that these changes are seldom maintained after discharge (Kirigin et al., 1982). The conclusion may be similar to that for residential treatment center placement: long-term outcomes appear to be related to the extent of services and support after discharge. Adolescents who have been placed in therapeutic group homes because of mental disorders frequently have histories of multiple prior placements (particularly in foster homes), a situation that is associated with a poor prognosis. Thus, future programs would benefit from assessing alternative strategies for treatment after discharge from group homes."

USE OF MEDICAID REHABILITATION SERVICES TO MEET THESE CHILDREN'S NEEDS

The use of Medicaid Rehabilitative Services is crucial to the provision of Therapeutic Foster and Group Home care for Seriously Emotionally Disturbed children. As reported by the Surgeon General above, these levels of care allow the child to stay in the community, get on a different Mental Health trajectory and avoid higher levels of care and crisis services. In our Adoption & Family Support Program, rehabilitative services are used to allow program staff to go into therapeutic foster homes to model and teach effective interventions to parents and children. Staff also work with the child to help them develop personal skills to allow them to identify and communicate their feelings to the adults in their lives—rather than acting out these feelings of rage, sadness, fear, humiliation, jealousy and anxiousness in destructive ways. Rehabilitative Aides also work with children in community settings such as daycare or group activities to help children gain skills that allow them to feel and act more "normal" thus reducing the effects of their emotional disturbances. In follow-up Studies conducted by Intermountain, children state that Rehabilitation Aides "help me every time when I can't talk to anyone else...they listen and never give up on me...they have done wonders for my social life". In reference to Rehabilitative Aides parents state, "they never give up on us...they give us hope."

The use of flexible Medicaid Rehabilitative funding allows Therapeutic Providers to maintain and develop innovative programs that meet the needs of Seriously Emotionally Disturbed (SED) children and their families. For example, SED children of any age typically do not have the

ability to stay safely at home alone for any length of time. Summer and out-of-school days present major problems for the therapeutic parents. Many SED children cannot be safely served in regular day care settings, and most day care settings are not appropriate for 12-16 year old youth. The Adoption & Family Support Program Summer Program successfully serves SED children ages 3-17 with structured therapeutic interventions funded with the current Medicaid Rehabilitative Services. In the Summer Program, the children participate in social skills building involving education and activities led by Rehabilitation Aides. This begins with a weekly group session based on good character traits with topics such as trustworthiness, responsibility, respect, good citizenship, peer skills and caring/compassion for others. Throughout the week the daily activities are then focused on the character building or social skill of the week. The children have the opportunity, some for the first time, to realize that there are other children like themselves that are struggling with emotional and behavioral issues and to feel acceptance by other children and adults instead of their usual experience of being ostracized because of their disruptive behaviors.

It is my understanding that the State of Montana Children's Mental Health Division has been verbally notified by the Center for Medicare and Medicaid Services (CMS) of the Federal Government that Montana must "unbundle" payment for the services provided to Seriously Emotionally Disturbed children and their families. What is "unbundling"? To answer that question we must first answer the question "what is a bundled rate"? Currently, Therapeutic Foster and Group Home providers receive a daily payment from the Montana Children's Mental Health Division for these services to be provided to children, youth and parents. A bundled rate wraps the costs for all aspects of treatment into a single payment. From the day a child is admitted to Therapeutic Foster or Group Home care the day discharged, providers are paid a daily rate for their services to SED children and families. The bundled daily rate includes active treatment interventions, qualified treatment parents, specialized behavior management techniques, a treatment team, treatment planning, adequate clinical, direct care (such as Rehabilitative Aides) and administrative staff, weekly face to face contact with therapeutic parents, individual treatment meetings with the child or youth two times per month, clinical supervision meetings, treatment plan reports, and 24 hour per day/7 days per week crisis response. Bundling of the rate allows program staff to develop treatment plans with the input of all involved in the child's life (including parents, therapists and school staff if possible), and to ensure that the treatment plan goals, and strategies are been implemented across as many environments as possible (home, school, therapy, community). Program staff can spend the needed amount of time with a particular child and their family working on a particular treatment goal at any time. An "unbundled" rate requires that providers draw from a variety of funded services. Rehabilitation services would be at the core of the provision of Therapeutic Foster or Group Home care because most of the interventions are provided by highly trained and clinically supervised treatment parents and Bachelors level program staff. In the Medical Medicaid model therapeutic providers could be reimbursed for individual, group and family therapy by a licensed therapist and Rehabilitation services. Providers would be required to relegate all activities into face to face specified time-limited block with the possibility of accompanying arbitrary limits on the number of service units that can be provided. The idea of a "program" to serve SED children and their families that included sound clinical direction and seamless treatment, recruitment and training of treatment parents would be fiscally unrealistic without Medicaid Rehabilitation Services funding.

The Montana Children's Mental Health Division worked with Montana providers to create a proposed financial plan for the unbundling of Therapeutic Group Homes Services. Central to this new plan for unbundling are individual, group and family therapy and Rehabilitation Services.

CONCLUSION:

Flexible Federal funding such as Medicaid Rehabilitative services that are used to serve Seriously Emotionally Disturbed children and their families in the community is crucial to the success of the Federal Government's Systems of Care as well as Therapeutic Foster and Group Home care. Medicaid Rehabilitative services are congruent with the President's Freedom Commission on Mental Health which states, "The 'mental health maze' is more complex and more inadequate for children...The most seriously affected children are defined, under Federal regulations, as having serious emotional disturbance".

The loss of the Medicaid Rehabilitative services has the likely consequence of eliminating Therapeutic Foster and Group Home care for the Severely Emotionally Disturbed children in Montana. Montana children who cannot be maintained safely in regular foster care the next level of care will inevitably be the more restrictive and more expensive Residential Treatment Center option.

Chairman WAXMAN. Thank you very much, Ms. Costigan.
Ms. Herrmann.

STATEMENT OF DENISE HERRMANN

Ms. HERRMANN. Mr. Chairman, Mr. Davis, and members of the committee, my name is Denise Herrmann and I am a school nurse from St. Paul, MN. I am privileged to be here today representing the National Association of School Nurses on this critical issue of Medicaid funding regulations.

I commend the committee for bringing attention to the fact that the Centers for Medicare and Medicaid Services have been issuing proposed rules that, if finalized, will negatively impact the lives of school children and the practice of school nursing.

Through my testimony I hope I can explain how school nurses are involved with Medicaid administrative claiming in the areas of eligibility, enrollment, and referrals, and perhaps the best way to do this is to tell you the stories of school nurses, children, and families from across the United States.

Healthy children learn better. School nurses are doing everything they can within Medicaid regulations to enroll eligible children and make appropriate medical referrals. How do we work with Medicaid eligibility? Parents routinely ask school nurses, Where do I go to begin this process of applying for Medicaid? How do I know my child's eligible? How do I enroll?

Our school nurses located in Chairman Waxman's District tell us that in this past month 18 families have gotten medical assistance through the case management and case work of school nurses. This is an appropriate use of Medicaid claiming dollars. They are helping children access much-needed medical and dental care and are keeping them out of expensive and time-consuming emergency health care facilities.

Regarding enrollment, here is a scenario that happens regularly in my district. I call a mother and I say, your child is in my office. This is the second time today. Their asthma is out of control. They are coughing. They are wheezing, and their emergency medication doesn't seem to be working.

I ask the mother, are they taking their regular controller medication that prevents asthma attacks? No. We stopped a month ago. We lost our health insurance and it costs \$120 to get that medication this month. I was hoping he would get by without. And can you keep him in school, because I can't afford to miss work to come and get him.

I remind her that her son was hospitalized a year ago because he hadn't been on his controller medications and I make a promise then to help her find health care for her child and get in one of the State programs.

Health needs and problems are not something children leave at home. They come to school for 6 to 8 hours a day with their health needs and their problems. Parents feel comfortable and they trust the school nurse. It is the school nurse who is often the child's first and only access into that health care system. If society doesn't want our children to be left behind, then we need to be there to help them to be healthy, stay in school, and achieve academic success.

Here is a typical referral example for a little girl I will call Amanda. She is a second grader and has type I diabetes and she needs insulin injections four to six times a day and has to test her blood sugar six to eight times. After being gone 6 months, she came back to our school district without any health insurance. Her diabetes is out of control. The mom had no supplies to test her blood sugar, and only enough insulin to last a week, and no money to buy any more.

It was the school nurse who managed Amanda's care and worked closely with a local clinic to obtain insulin supplies, insulin samples, syringes, test strips so that diabetes could be brought under control. These actions prevented Amanda from being hospitalized over the next 5 months until she was eventually covered by Medicaid.

Members of this committee, I know you must have to deal with lots of tedious and faceless numbers and regulations regarding this issue. I want to put one more face on this. True story, a little girl I will call Ann. Her dad came to enroll her in our school district and she had a heart condition, and the nurse began the paperwork to get her enrolled in Medicaid, but in the meantime had to find a cardiologist who would see her and give her the medication she needed. Members, it is very hard to find a cardiologist who will take care of a kid without health insurance.

I am happy to report that Ann is healthy and doing well today, but without the school nurse's persistence and intervention this family would have had to pursue much more expensive health care, such as a hospitalization or an emergency room visit for a condition that was treated by outpatient care.

In addition, the process for this successful outcome would not have happened if the proposed rule to eliminate Medicaid administrative claiming by schools was in place.

From these examples, I hope you will understand why our association is in disagreement with the CMS position that school-based administrative activities performed by school nurses fail to meet the statutory test of being necessary for the proper and efficient administration of a State plan.

According to the Kaiser Commission, children represent half of all Medicaid enrollees, but only account for 17 percent of total program spending. Therefore, children are by no means draining the fund.

On behalf of the National Association of School Nurses, I implore this committee to do whatever they can to let CMS know the harm that would occur by changing certain Medicaid regulations for administration claiming. It is painfully obvious to school nurses, as we work in these public systems, that by eliminating the Federal financial participation for school-based administrative claiming, the health needs of innocent children will go unmet and preventable consequences will be long-lasting for families and society.

Thank you. I appreciate this opportunity to testify.

[The prepared statement of Ms. Herrmann follows:]



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STATEMENT

OF

DENISE HERRMANN, MS, RN, LSN, CPNP
ON BEHALF OF
THE NATIONAL ASSOCIATION OF SCHOOL NURSES

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

CONCERNING

THE ADMINISTRATION'S REGULATORY ACTIONS ON MEDICAID:
THE EFFECTS ON PATIENTS, DOCTORS, HOSPITALS, AND STATES

PRESENTED ON

NOVEMBER 1, 2007

Supporting Student Success

Mr. Chairman, Mr. Davis, and Members of the Committee, I am Denise Herrmann, a practicing School Nurse from St. Paul, Minnesota, who is privileged to be here today representing the National Association of School Nurses (NASN) on the critical issue of Medicaid funding regulations. I commend the Committee for bringing attention to the fact that the Centers for Medicare and Medicaid Services (CMS) has been issuing Proposed Rules, that if promulgated, will negatively impact the lives of school children and the practice of school nursing.

Through my testimony, I hope to explain how School Nurses are involved with Medicaid Administration Claiming (MAC) in the areas of eligibility, enrollment, and referrals. Perhaps the best way for you to learn how vitally important Medicaid funding is to the lives of children and their families is for me to share some experiences we have gathered from School Nurses who are practicing our profession throughout this country.

NASN's membership of over 14,000 School Nurses are performing duties today that go well beyond what school nursing was like 30-40 years ago when health care costs were affordable and children with chronic health conditions were not "main-streamed." Today, because of Federal laws like the Individuals with Disabilities Education Act, there are children attending school in wheel chairs, on tube feedings, ventilators, central lines, pumps and other complex technologies. School Nurses are there to meet their needs and CMS should acknowledge the level of administrative health care activities that are part of providing services for students. Medicaid Administrative Claiming activities legitimately occur in schools and should be reimbursed. Some school districts use the revenue they receive from MAC to fund School Nurse positions because the laws require that all children have a right to public education. Children with diabetes, asthma and epilepsy have better attendance because a School Nurse can help them be healthy and safe at school. I think you will agree with the research that supports that **Healthy Children Learn Better**. Knowing that healthy children learn better, School Nurses are doing everything they can within the Medicaid regulations to enroll eligible children and make appropriate medical referrals.

School Nurses are knowledgeable about Medicaid **eligibility** in their states, so that they can best serve students and parents who need assistance in applying for Medicaid. Parents routinely ask their School Nurse: "Where do I go to begin the process of applying for Medicaid? How do I know my child is eligible? How do I enroll?" Our School Nurses located in Chairman Waxman's district tell us that just in this past month, 18 families have been enrolled in health insurance through the assistance of the case management work of School Nurses. This type of work performed by the School Nurses is an appropriate use of Medicaid Administrative Claiming and it helps children access much needed medical and dental health care and keeps them out of the expensive and time consuming emergency care at facilities such as the Harbor-UCLA Medical Center.

School Nurses help enroll children in the State Medicaid programs so that they can stay healthy and attend school. Here is an **enrollment** scenario that happens regularly in my practice in St. Paul.

Nurse “Good afternoon, Mrs. Smith, it’s Denise, the School Nurse calling about your son Tommy. He is in my office for the second time today because of his asthma. He is coughing a lot today and the emergency inhaler is not working well. In fact, he says he has been coughing more for the last few weeks. Has he been taking his daily medications to prevent an asthma attack?”

Parent “No he hasn’t, I ran out of his preventive medication about one month ago and I can’t afford the refill. It cost \$120.”

Nurse “I see. Is Tommy still covered by insurance?”

Parent “No. His father and I are working, but our jobs don’t offer health insurance. I was hoping he could get by without it. Please keep him in school. I can’t afford to miss any more work.”

Nurse “I can understand how hard this is, but remember when he was hospitalized last year before starting his preventive medication. We want to prevent that from happening again. I can help you enroll in a program that provides health insurance for children just like Tommy.”

Health needs and problems are not something children can leave at home. When they come to school, their health needs and problems come with them. They spend 6-8 hours per day at school. The School Nurse is a reliable and trusted health care provider and parents feel comfortable consulting with the School Nurse. It is the School Nurse who is often the child’s first and only access into the health care system. We provide frontline care and if society wants children to “not be left behind,” then we need to be there to help them be healthy and stay in school so they can achieve academic success.

Since the role of a School Nurse is to help students stay healthy and attend school, a typical **referral** example can be found in the story of the 2nd grade student with type 1 diabetes. Amanda needed insulin injections 4-6 times per day and tested her blood sugar levels 6-8 times per day. The child left our district for 6 months to live with her father. When Amanda returned to school she no longer had health insurance.

Amanda’s diabetes was out of control. Her blood sugar values were up and down. She went from very high blood sugars that over time lead to serious complications such as blindness and loss of limb, to very low blood sugars that could be life threatening. The mom had no supplies to test Amanda’s blood sugar and only enough insulin for one week; she had no money to purchase insulin and supplies.

The School Nurse worked closely with the local clinic to obtain insulin samples, syringes, test strips and to manage the diabetes to prevent hospitalization over the next five months until Amanda was covered by health insurance. Case management to assist students in accessing cost-effective health services is what School Nurses do every day. Eliminating Medicaid reimbursement to school districts for case management services [as

defined in 1915(g)(2)] will eliminate services for children. Children without insurance do not have a “safety net,” if School Nurses can no longer help children with life-threatening chronic diseases manage their diseases through referral and follow-up services.

Many families served by School Nurses live day-to-day and are stressed in making ends meet. They lack what many of us take for granted. They do not have reliable transportation or money for public transportation. They have no telephones, let alone computers for communication. Some are homeless, and others share close living quarters with other families. Some are unable to read, and many are undereducated. Applying for Medicaid is an overwhelming task. School Nurses identify the children who are most vulnerable and then help them find the best way to receive health care. Without Medicaid reimbursement for that type of school nursing activity, fewer needy children will receive health care services.

Numbers and Regulations can be tedious and faceless. Let me tell you about one little girl with a heart condition, whose story I consider to be a real success. I can also tell you that the successful outcome would not have happened if the Proposed Rule to eliminate Medicaid Administrative Claiming by schools was in place. This past year, a father brought his daughter to our district to enroll in school. I’ll call her Anne. The family had recently moved to our state and they had no health insurance. During the health interview, the father revealed that Anne had a heart condition and lately had not been feeling well. The Nurse began the paperwork to get Anne enrolled in Medicaid so she could see a cardiologist. Over the next six months, the father stopped by the Nurse’s office every 2-3 weeks with additional questions or paperwork that needed to be completed for the Medicaid application. In the meantime, the Nurse found a cardiologist who would see Anne while the Medicaid eligibility was pending. [Remember - there are many health institutions that will not even see you if you don’t have insurance.] It took 6 months for Anne to finally get approved for Medicaid and by that time her father was back into the Nurse’s office, because he needed to do more paperwork for the six months renewal to maintain eligibility. Today Anne is healthy and doing very well in school. Her fear of living with a life-threatening heart problem has greatly diminished. Without the School Nurse’s persistence and intervention, Anne would have continued to suffer emotionally, physically, and scholastically. In addition, the family would have had to pursue much more expensive health care, such as hospitalization, or emergency room visits for a condition that was treatable by outpatient physician care.

Now that I have shown you the ways that School Nurses use MAC to conduct duties related to case management of children in need, you will understand why NASN is in disagreement with the CMS position that the school-based administrative activities performed by School Nurses fail to meet the statutory test under section 1903(a) (7) of “being necessary...for the proper and efficient administration of the State plan.” By performing the health-care related administrative activities, School Nurses help to improve children’s health, reduce inappropriate emergency room visits, and reduce expensive unnecessary hospitalizations. Children with health care needs don’t just disappear. With proper assessment and preventative care, School Nurses are doing

everything they can to keep children in school and out of hospitals and emergency care situations.

A recent NASN study on School Nurse Staffing indicates that seventy-five percent of US Public schools employ School Nurses. Schools in 47 states do some type of Medicaid claiming for health care services provided at school so the child can stay in school – and their parents can remain at work. By eliminating Medicaid administrative claiming reimbursement, the “safety net” that has been woven by School Nurses on behalf of our Nation’s youngest and most vulnerable citizens could harm children and lead to a significant decrease in the number of School Nurse positions. Who would be there with the medical background and the knowledge of the Medicaid process to advocate for the health care of students who have no control over whether or not their family has health coverage?

CMS states there is evidence of “fraud” as a reason for changing school-based Medicaid claiming, although no evidence is presented. In my twenty years of experience as a School Nurse, I have no personal knowledge of a school district conducting improper billing for the purpose of Medicaid claiming. Having **clear and consistent procedures** from CMS and state Medicaid agencies that are compatible with the education laws is the best way to prevent any fraud and abuse of the system. Even if there are examples of isolated improper billings, it has never been shown to be for the purpose of fraud, but rather confusion with a complex system and lack of direction. In fact, the GAO Report issued in April 2000 on Medicaid in Schools indicated that a lack of direction from CMS was a significant contributor to the errors found in state audits.

Children represent half of all Medicaid enrollees, but account for only 17% of total program spending (Kaiser Commission September 2007). Therefore, children are by no means “draining the fund.” On behalf of the National Association of School Nurses, I implore this Committee to do whatever they can to let CMS know the harm that would occur by changing certain Medicaid regulations for administrative claiming. It is painfully obvious to School Nurses as we work within these public systems, that by eliminating the federal financial participation for school-based administrative claiming, the health needs of innocent children will go unmet and the preventable consequences will be long lasting for families and our society.

Chairman WAXMAN. Thank you very much for your testimony.

Mr. Van Hollen, I know you tried to get here in time to hear Ms. Miller's testimony. Do you want to say anything at this time?

Mr. VAN HOLLEN. Thank you, Mr. Chairman. I apologize for being late. I had a prior commitment, but I did also want to welcome my constituent, Barbara Miller. Thank you for your testimony. I had a chance to read your testimony, and I am so pleased you could be here to tell your story as we make these important decisions.

I also want to thank Threshold Services for all that they do in our community. I see Craig Nowel, the executive director, and I want to welcome him and thank them for all the rehabilitation services they provided and allow people like you to be able to tell your story here today. Thank you for all that you have done to share with us today.

Chairman WAXMAN. Thank you, Mr. Van Hollen.

Mr. Aviles.

STATEMENT OF ALAN AVILES

Mr. AVILES. Good morning, Mr. Chairman and members of the committee. I am Alan Aviles, president of HHC, the New York City Health and Hospitals Corp. I am pleased to have this opportunity to testify this morning on behalf of NAPH, the National Association of Public Hospitals and Health Systems.

NAPH is deeply concerned about the severe adverse impact of all of the regulations you are reviewing today. I will focus my attention this morning primarily on the Medicaid cost limit regulation, which is subject to a congressionally adapted 1 year moratorium until May 2008. If that regulation is permitted to go into effect, it has the potential to devastate essential safety net hospitals and health systems in many parts of the country.

In addition to the Medicaid cost limit regulation, HHC and other NAPH members will be severely impacted by the proposed CMS rule affecting graduate medical education and a proposed Medicaid outpatient payment regulation that CMS recently published.

Let me begin by briefly describing my own organization. HHC is the largest municipal health care system in the country. We provide health care to 1.3 million New Yorkers every year. Nearly 400,000 have no health insurance. We operate 11 acute care hospitals, 4 skilled nursing facilities, 6 large diagnostic and treatment centers, more than 80 community health centers, and a home health program.

More than 60 percent of our budget comes from Medicaid. HHC's facilities provide nearly 20 percent of all general hospital discharges and 40 percent of all inpatient and hospital-based outpatient mental health services in New York City. One-third of New York City's emergency room visits occur in HHC hospitals, and we provide 5 million outpatient visits every year.

My submitted written testimony describes the situation of other NAPH member hospitals nationally and also details billions of dollars in potential Medicaid cuts facing those hospitals as a result of these regulations.

Let me briefly touch upon the potential impact of those cuts on the vulnerable patient populations and communities we serve.

While it is not always possible to predict with precision which services will be reduced or eliminated, I can give you a few examples of decisions that might be required if public hospitals are faced with Medicaid cuts of this magnitude.

We believe the impact in New York of the reduced costs and limit regulations would be upwards of \$200 million per year. Faced with cuts of that magnitude, we would have to dismantle significant components of our ambulatory care system and scale down our emergency departments. These Medicaid funds help to support our extensive primary care network that prioritizes prevention, early detection of disease, and engagement of patients in the management of their chronic conditions.

These funds also support the provision of prescription medications to hundreds of thousands of low-income New Yorkers, and the operations of our eleven public hospital's emergency departments and six trauma centers rely heavily on Medicaid funding.

In California Dr. Bruce Chernoff, CEO of the Los Angeles County Department of Health Services has said, "It is the equivalent to shutting down all the outpatient clinics we own and operate, as well as those we contract with in the community."

Gene Marie O'Connell, San Francisco General Hospital CEO and Chair of NAPH, states, "San Francisco General Hospital is just holding its head above water with the current rates. The impact from the Medicaid cost limit rule means the loss of \$24 million, and from the GME rule an additional \$5 million. If these rules become reality, we would need to close three nursing units, or 90 beds out of 550 beds, which would have a dire impact on services to the residents of San Francisco."

In Colorado, Dr. Patricia Gabow, Denver Health CEO and medical director, states, "We need Congress to stop these rules. The impact of this rule on Denver health would be devastating. We might as well turn over the keys. We would no longer be able to serve as the major safety net system for Denver and Colorado and the region. The health of the entire community will be compromised through the impact on our trauma system, our disaster preparedness, and public health."

Mr. Chairman, my submitted written testimony includes numerous other examples from around the country. For this reason, it is imperative that Congress act now to stop these rules and to reaffirm your role in setting Medicaid policy for this country. We believe that CMS ignored Congress and violated Federal law by moving forward to implement several of these Medicaid regulations. We need the Congress to move quickly by the end of this calendar year to prohibit CMS from implementing the Medicaid cost limit, GME, and Medicaid outpatient regulations.

We strongly urge the members of this committee to support and co-sponsor H.R. 3533, a bill introduced by New York Congressman Elliott Engel and Sue Myrick, which had 133 co-sponsors as of this past Monday.

Once again, I thank you for granting me the opportunity to speak with you this morning on behalf of NAPH. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Aviles follows:]



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TESTIMONY OF ALAN AVILES
President
New York City Health & Hospitals Corporation

On behalf of

**THE NATIONAL ASSOCIATION OF PUBLIC
HOSPITALS & HEALTH SYSTEMS**

before the

HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

November 1, 2007

Mr. Chairman, members of the Committee, I am Alan Aviles, President of the New York City Health and Hospitals Corporation (HHC). I am pleased to have this opportunity to testify this morning on behalf of the National Association of Public Hospitals & Health Systems (NAPH). Both HHC and NAPH are grateful to your Committee for conducting this important oversight hearing on a series of regulations issued by the federal Centers for Medicare and Medicaid Services (CMS) over the last several months.

NAPH is concerned about the severe adverse impact of all the regulations you are reviewing today. I will focus my attention this morning primarily on the Medicaid cost limit regulation, which is subject to a Congressionally-adopted one-year moratorium until May of 2008. If that regulation is permitted to go into effect, it has the potential to devastate essential safety net hospitals and health systems in many parts of the country. In addition to the Medicaid cost limit regulation, HHC and other NAPH members will be severely impacted by the proposed CMS rule affecting Graduate Medical Education (GME), which my colleague from the Virginia Commonwealth University, Sheldon Retchin, MD, is here to address (and which is also subject to the one-year moratorium). Additionally, safety net hospitals will be affected adversely by a proposed Medicaid outpatient payment regulation that CMS recently published. NAPH filed comments earlier this week strenuously opposing that outpatient rule, which we believe violates the Congressional moratorium. Attached are NAPH comments on all three of these regulations, which have been filed with CMS.

I would like to accomplish three things in my prepared testimony this morning:

First, I will provide the committee with some general background information about HHC and NAPH, with particular attention to the vital role HHC and other NAPH members play in our nation's health system.

Second, I will describe the potentially devastating impact that the regulations proposed by CMS will have on safety net hospitals and health systems around the country – and on the vulnerable patient populations we serve.

Third, I will ask the members of this Committee to join with the large and growing number of your House colleagues in bipartisan support for legislation to prohibit CMS from implementing these new regulations.

Let me first say a few words about HHC and NAPH.

HHC is the largest municipal health care system in the country. We provide health care to 1.3 million New Yorkers every year. Nearly 400,000 have no health insurance. We operate eleven acute care hospitals, four skilled nursing facilities, six large diagnostic and treatment centers, more than eighty community clinics and a home health program. More than 60% of our budget comes from Medicaid.

NAPH represents more than 100 of America's most important safety net hospitals and health systems. These facilities provide high-quality health services for all patients, including the uninsured and underinsured, regardless of their ability to pay. In addition to functioning as the country's default national health insurance system, public hospitals provide many essential community-wide services, such as primary care, trauma care, and neonatal intensive care. Public hospitals are also an essential component of our nation's fragile ability to respond to natural and man-made emergencies. NAPH members have been on the frontline of many recent crises. These range from the extraordinary role played by HHC staff and facilities after the tragic events of September 11, 2001, to the essential services provided by my colleagues around the country in the wake of hurricanes, earthquakes, local disasters – like the recent Minneapolis bridge collapse – and the devastating fires this month in Southern California. Finally, most NAPH members are also major teaching hospitals that train many of America's doctors, nurses, and other health care providers.

It may be helpful to show how that national role translates into services in communities across the country. For example:

- HHC facilities treat nearly 20% of all general hospital discharges and 40% of all inpatient and hospital-based outpatient mental health services in New York City. One-third of New York City's emergency room visits occur in HHC's hospitals and we provide 5 million outpatient visits every year.
- In Los Angeles, patients rely on public hospitals for 35 percent of emergency room visits and public hospitals staff 100 percent of burn treatment hospital beds.
- In Houston, over 40 percent of all patients come to public hospitals for outpatient care and nearly one in four babies are born in public hospitals.

- In Miami, the only place patients can access a Level I Trauma Center is at a public hospital.
- In Columbus, Ohio, public hospitals staff one-third of all outpatient visits and nearly one-third of days patients spend in the hospital. Additionally, public hospitals staff 100 percent of burn care treatment beds in the city.
- In Chicago, nearly one in five emergency room visits are at public hospitals and public hospitals staff half of all burn beds.

With that background, let me turn my attention to the impact of the Medicaid cost limit regulation on the nation's health safety net. I will not take time to describe the regulation in detail. Suffice it to say that several aspects of the regulation would severely damage safety net hospitals and health systems and limit the ability of many states to provide vital Medicaid payments to such providers. CMS itself estimates that over \$5 billion in funding would be cut from the program over five years. Based on publicly-submitted comments filed with CMS, press accounts and information from public hospitals around the country provided to NAPH, we believe the impact would be substantially greater than that, and most of that impact would fall on safety net hospitals.

The estimated financial impact around the country includes the following publicly-reported examples:

- In New York, we have estimated that up to \$200 million in annual funding will be eliminated.
- In California, a \$550 million annual cut is expected.
- In Florida, at least a \$932 million annual cut is expected.
- The publicly reported annual impact estimated for other states include: Minnesota (\$100 million), Tennessee (\$250 million), Indiana (\$40 million), Georgia (\$204 million) and North Carolina (\$340 million).

As alarming as those numbers are by themselves, their real impact will translate into the reduction or elimination of essential services for our most vulnerable patients and the potential for diminished community-wide services, such as trauma care. While it is not always possible to predict with precision which services would be reduced or eliminated, let me give you a few examples of decisions that might be required if public hospitals are faced with Medicaid cuts of this magnitude. Many of these examples are already on the public record, either in comments filed with CMS or public statements reported in the press. Additionally a number of my colleagues from public hospital systems in cities across the country provided comments for the public record for this hearing.

- I have been publicly quoted as saying that, in New York City, we would have to dismantle our ambulatory care system and scale down our emergency departments. These Medicaid funds help to support our extensive primary care network that prioritizes prevention, early detection of disease and engagement of patients in the management of their chronic conditions. These funds also support the provision of prescription

medications to hundreds of thousands of low-income New Yorkers; and the operations of our eleven public hospitals' emergency departments and six trauma centers rely on Medicaid funding.

- In California, Dr. Bruce Chernoff, Chief Executive Officer of the Los Angeles County Department of Health Services has said: "It's the equivalent to shutting down all the outpatient clinics we own and operate, as well as those we contract with in the community." [Los Angeles Times, 2/24/07]
- In California, Gene Marie O'Connell, San Francisco General Hospital Chief Executive Officer and Chair of NAPH, states: "San Francisco General Hospital is just holding its head above water with current rates. The impact from the Medicaid cost limit rule means the loss of \$24 million, and from the GME rule an additional \$5 million. If these rules become reality we would need to close three nursing units or 90 beds (out of 550 beds) -- which would have a dire impact on services to the residents of San Francisco."
- In Colorado, Dr. Patricia Gabow, Denver Health Chief Executive Officer and Medical Director, states: "We need Congress to stop these rules. The impact of this rule on Denver Health would be devastating. We might as well turn over the keys. We would no longer be able to serve as the major safety net system for Denver and Colorado and the region. The health of the entire community would be comprised through the impact on our trauma system, our disaster preparedness and public health."
- In Colorado, Jeff Thompson, Director of Government and Corporate Relations at University of Colorado Hospital, has said: "We have the potential of literally having to shut off our care for the medically indigent. It would mean people who have chronic or long-term illnesses - like cancer - would suffer. They simply would not have any outlet for care." [The DenverChannel.com, 3/1/2007]
- In Texas, David Lopez, Chief Executive Officer of the Harris County Hospital District, has said: "If the district loses \$70 million, it may have to cut services and increase the time that patients wait to get treatment....." [Houston Chronicle, 1/27/2007]
- In Florida, Jackson Memorial Chief Executive Officer Marvin O'Quinn says: "Fewer services would be inevitable... already-lengthy ER waits will be stretched even longer; and some people may not get treated. Medical decisions would be difficult: Does a hospital cut a transplant program, primary care or doctors' salaries?" [Miami Herald, 2/25/2007]
- In Missouri, John Bluford, President and Chief Executive Officer of Truman Medical Centers states: "The various Medicaid regulations proposed by CMS would have at least a \$37 million annual impact on Truman Medical Centers (TMC). Such a cut would be potentially devastating to TMC. We would face the impossible task of choosing which services to dramatically restrict, such as Emergency Room availability/trauma and necessary outpatient services. The cuts would clearly force TMC to reduce primary and preventative services, resulting in a much, much greater downstream cost to all."

- In Iowa, Jody Jenner, the Chief Executive Officer of Broadlawns Medical Center in Des Moines states: “Broadlawns Medical Center could lose approximately \$700,000 from the GME proposed rule alone. A loss like that would mean closing down our teaching program, jeopardizing the training of physicians who serve in rural communities throughout Iowa.”
- In Georgia, the Grady Health System has already announced plans to eliminate dialysis services and faces a substantial fiscal crisis even without the threat posed by the new regulations. [Atlanta Business Chronicle, 10/22/07]
- In Minnesota, Lynn Abrahamsen, Chief Executive Officer of Hennepin County Medical Center states: “Hennepin County Medical Center was there when our city needed us when the 35W Bridge collapsed on August 1. If Congress doesn’t stop these rules, our ability to stand ready as Minnesota’s largest Level I Trauma Center would be at risk!”

In conclusion, the harm this rule will cause will not be limited to safety net hospitals and the patients they serve. It will harm everyone’s access to life-saving care. Hospitals like those in the HHC system support vital but unprofitable services like trauma centers, burn units, poison control centers and disaster response capabilities. If we are forced to downsize or close huge numbers of patients will be displaced into a private hospital system that is already badly overloaded. Everyone’s care will be affected – insured and uninsured patients alike.

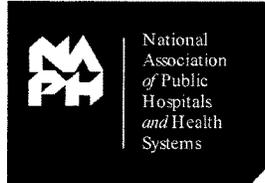
Permit me to thank the members of this Committee, and the 267 members of the full House, for your support in imposing a one-year moratorium on the implementation of the Medicaid cost limit and GME regulations last May. The strong bipartisan support has been essential to the efforts of HHC and my colleagues around the country to continue to carry out our safety net mission. Twenty-eight members of this Committee are on record in opposition to these cuts.

We urge Congress to act now to stop these rules and to reaffirm your role in setting Medicaid policy for this country. We believe that CMS ignored Congress and violated federal law by moving forward to implement several of these Medicaid regulations. States and public hospitals must plan for worst case scenarios that Congress never intended. We are counting on Congress to come to our aid before it’s too late – to tell CMS in no uncertain terms that safety net providers must be protected as essential components of our nation’s health system.

We need the Congress to move quickly – by the end of this calendar year – to prohibit CMS from implementing the Medicaid cost limit, GME and Medicaid outpatient regulations. We strongly urge the members of this committee to support and cosponsor H.R. 3533, a bill introduced by my New York Congressman Eliot Engel (D-NY) and Sue Myrick (R-NC), which has 133 cosponsors as of this past Monday.

* * *

Once again, I thank you for granting me the opportunity to speak with you this morning. I would be happy to answer any questions you may have.



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June 22, 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: CMS-2279—P — Medicaid Program; Graduate Medical Education

Dear Ms. Norwalk:

The National Association of Public Hospitals and Health Systems (NAPH) writes to express our grave concern about the impact that the proposed elimination of Medicaid payments for graduate medical education (GME) will have on our nation's health care system. As you know, Congress has prohibited the Centers for Medicare and Medicaid Services (CMS) from taking any steps to implement this proposal until May 25, 2008. Through the submission of these comments, NAPH does not concede that CMS has the authority to receive or review comments during the period of the moratorium. Moreover, we believe that if the moratorium were to expire without further legislation by Congress, CMS would be required to re-solicit comments at that time before finalizing the regulation.

The proposal -- CMS-2279-P -- Medicaid Program; Graduate Medical Education (the Proposed Rule) -- is premised on a flawed interpretation of the Medicaid and Medicare statutes, defies over 26 years of unambiguous congressional intent, and will seriously undermine the vital services that teaching hospitals provide to Medicaid recipients, to local communities, and to our nation as a whole. NAPH urges CMS to withdraw the Proposed Rule.

NAPH represents more than 100 metropolitan area safety net hospitals and health systems. One way in which many of our members serve their communities is through the training of future physicians and nurses. Eighty-five percent of NAPH members are teaching hospitals (as defined by the Accreditation Council for Graduate Medical Education (ACGME)) and 51 percent are academic medical centers (as defined by the Council of Teaching Hospitals of the Association of American Medical Colleges (COTH)). NAPH members train approximately 18 percent of the doctors who receive their training at acute care facilities nationwide and play an even larger role in their

NAPH Comments on CMS-2279-P
June 22, 2007

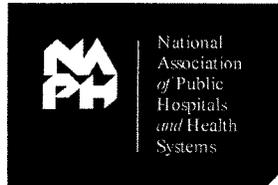
respective communities, training 35 percent of the medical and dental residents. Teaching hospitals, including our members, also provide specialized care generally unavailable at other acute care hospitals and are often the largest employers in their respective communities. Our member hospitals are heavily reliant on government payors, receiving on average approximately 35% of their net revenue from Medicaid and another 20% from Medicare.

The attached comments detail our specific policy and legal concerns about the Proposed Rule. Fundamentally, we oppose the Proposed Rule because it will severely restrict access to care for Medicaid recipients and undermine the already precarious financing of our nation's system of medical education. We urge CMS to withdraw the Proposed Rule. If you have any questions regarding these comments, please contact Barbara Eyman or David Gross at NAPH counsel Powell Goldstein (202) 347-0066.

Sincerely,

A handwritten signature in black ink, appearing to read "Larry S. Gage". The signature is fluid and cursive, with the first name "Larry" being the most prominent part.

Larry S. Gage
President



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June 22, 2007

COMMENTS BY THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS ON PROPOSED RULE: CMS-2279 – P – Medicaid Program; Graduate Medical Education

Prepared on behalf of NAPH by Powell Goldstein, LLP

The National Association of Public Hospitals and Health Systems (NAPH) is deeply concerned about the Centers for Medicare and Medicaid Services' (CMS') proposal to terminate Medicaid support for graduate medical education (GME) – CMS-2279 – P – Medicaid Program; Graduate Medical Education (the Proposed Rule).¹ CMS is incorrect in declaring that it does not have legal authority to provide federal financial participation for Medicaid GME payments; indeed, it is the agency's unilateral reversal of decades of Medicaid policy that lacks legal authorization. But aside from the proposal's legality, the policy choice it represents is extremely shortsighted. CMS proposes to abruptly withdraw longstanding support for the training of our future doctors, without regard to the real world impact on the health care system.

Medicaid has, for decades, provided essential financial support for clinical medical education programs in the United States, and the programs have evolved in reliance on that financial support. States have overwhelmingly opted to provide such support because they recognize what this Proposed Rule ignores – the crucial link between GME programs and the success of Medicaid in ensuring access to care for low income populations. This rule would result in markedly reduced access by withdrawing support for the programs that ensure an adequate ongoing supply of well-trained high quality health care professionals available to serve Medicaid recipients. And it would do so at a time when our population continues to age and to grow and the demand for medical services is expected to increase substantially.

CMS' decision to move forward administratively with this proposal is particularly perplexing. Congress has never questioned either the legality or the underlying policy of CMS' longstanding practice of providing financial support for Medicaid GME payments. Indeed, when the Administration first announced its intent to eliminate Medicaid GME earlier this year, Congress reacted swiftly by beginning work on a moratorium to *prohibit*

¹ 72 Fed. Reg. 28930 (May 23, 2007).

the adoption of any such policy.² Nonetheless, CMS rushed to publish the Proposed Rule before the moratorium could take effect. Given the undeniable impact the Proposed Rule would have on medical education programs, it is mystifying as to why CMS would move forward to change the policy administratively when it clearly does not have the authority to adopt alternative GME funding mechanisms or otherwise mitigate the impact of its actions. If CMS had legal or policy concerns about Medicaid GME, it should have taken its concerns to Congress and sought to work cooperatively with its legislative partners to fashion an appropriate response. In insisting on unilateral policymaking on an issue as important as this, CMS is displaying disregard for Congress and its role in formulating Medicaid policy.³

The Proposed Rule will leave teaching hospitals in an untenable position; they will be forced either to cut back on their teaching programs, depriving the next generation of Medicaid recipients (and all Americans) of a sufficient number of health care providers, or to stop offering other essential services to the communities in which they are located. Regardless, teaching hospitals, their communities, and the nation as a whole, all will be irreparably harmed by this shortsighted policy decision. NAPH urges CMS to withdraw the Proposed Rule.

NAPH's comments are organized into two major categories. After a brief summary of our arguments, we first lay out our major policy concerns about the Proposed Rule. Second, we explain in detail why we believe the CMS proposal is without legal basis. Finally, we request clarification on one aspect of the Proposed Rule.

I. Summary of Comments:

NAPH has serious concerns with respect to the policy implications of this ill-considered Proposed Rule as well as CMS' legal authority to preclude federal financial participation (FFP) for GME expenses. On a preliminary level, the Proposed Rule is premised on a misconception of what clinical medical education is. CMS has based these drastic payment cuts on an understanding of GME activities as separate and distinct from the provision of health services. In practice, this understanding is incorrect, as GME costs are incurred to provide patient care.

The proposed cuts would seriously undermine the infrastructure of the American health care system in the present and for years to come. These cuts would stifle medical education, leaving future Medicaid enrollees, along with the rest of the population, with an inadequate supply of health professionals. These cuts also would directly limit access

² H.R. 2206, 110th Cong., enacted into law by reference in Pub. L. No. 110-28, § 7002(a).

³ This is not the first time this year that CMS has openly defied Congress' role in Medicaid policymaking. NAPH notes the parallels between this proposed GME rule, and CMS' proposal to overhaul the financing of state Medicaid programs, CMS-2258-P. In that case, CMS ignored Congress' clear and repeated bipartisan opposition to administrative policymaking, going so far as to issue a final rule *after* Congress had adopted a moratorium prohibiting such action but a few hours *before* the President signed the moratorium legislation giving it legal effect. 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).

to care for current Medicaid enrollees, as the availability of medical students to treat these individuals is reduced and as hospitals absorb the cuts by limiting their services. The impact of the proposal would most severely be felt by safety net teaching hospitals, which rely to a greater degree than other teaching hospitals on Medicaid funding and which are located in already underserved communities.

The Proposed Rule is a dramatic departure from longstanding CMS policy, which has permitted Medicaid GME funding to become a critical pillar of teaching hospital support. The Proposed Rule removes this financial support suddenly and CMS does not, because it cannot, offer any alternative funding. Further, the cuts will result in a significant, and unjustified, cost shift from the federal government either to states or, more likely, to teaching hospitals themselves. A policy decision of this magnitude should only be made with congressional input.

From a legal standpoint, CMS does not have the authority to deny FFP for state Medicaid program GME expenses. Medicaid payment of GME expenses is expressly authorized under a natural reading of Section 1905(a) of the Social Security Act as payment for inpatient and outpatient hospital services. Reference to the Medicare statute validates this interpretation. Section 1861 expressly defines inpatient hospital services to include most GME activities, and Section 1886 includes all GME reimbursement under the payment methodologies for inpatient hospital services. Further, a historical review of the Medicaid and Medicare statutes indicates that, prior to 1981, inpatient hospital services were reimbursed by Medicaid under a reasonable cost methodology and included GME activities. No congressional action has stripped CMS of this authority.

CMS' statutory analysis also contradicts congressional intent and its own interpretation of the Medicaid statute. Over the past 26 years, Congress has repeatedly indicated its intent for the Medicaid program to reimburse GME activities, through legislative history, congressional publications, and recent legislation. CMS has never before interpreted the Medicaid statute to preclude payment for GME activities, and it permits FFP for many activities that, similar to GME, can be characterized as not "expressly authorized" under Section 1905(a).

Finally, CMS has requested comments on its decision to allow states to retain indirect medical education (IME) payments in their calculation of the upper payment limit (UPL). We believe that legally CMS has no choice but to maintain such a policy and urge CMS to clarify, notwithstanding its misguided direct graduate medical education (DGME) policy, that IME payments are eligible for FFP.

In light of these serious policy and legal concerns, we urge CMS to withdraw the Proposed Rule.

II. Major Policy Concerns:1. *The centerpiece of the training of future physicians is clinical experience.*

The teaching hospital is the centerpiece of the American model of medical education. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. While providing this care under physician supervision, the residents gain practical experience, unavailable in the classroom, to prepare them for the independent practice of medicine. CMS' proposal to discontinue support for medical education through the Medicaid program is not merely a payment cut to teaching hospitals as individual providers; it represents a CMS policy decision to stifle medical training and restrict the supply of future physicians.

2. *Residents provide a significant amount of patient care.*

While receiving clinical training in graduate medical education programs, interns and residents provide a significant amount of direct patient care under the supervision of physicians, including care to Medicaid recipients. In underserved communities, the role of the resident in providing patient care is particularly critical in ensuring adequate access to health care services. CMS ignores this critical patient care role in assuming that all GME is not a health service and not reimbursable as a component of inpatient or outpatient hospital care. And it ignores the direct impact that the Proposed Rule will have on access to care for Medicaid recipients if funding for a substantial portion of the caregivers in teaching hospitals is eliminated.

3. *Teaching programs ensure an adequate future supply of health care professionals to serve Medicaid recipients.*

It is entirely consistent with the goals and purposes of the Medicaid statute for states to support clinical programs that are training future medical professionals to serve the Medicaid population. Indeed, the 1994 report by the Office of the Inspector General cited by CMS recommended adjustments to Medicare GME payment mechanisms to account for the then-prevailing oversupply of physicians.⁴ That oversupply has evolved into a projected significant shortfall,⁵ and it is entirely reasonable for states to seek to address that shortfall through reimbursement policies that will ensure robust clinical training programs.

Instead, CMS is proposing to withdraw all Medicaid support for GME. The result will be shrinking teaching programs, fewer medical education graduates and ultimately a physician workforce that is insufficient to meet the health care needs of the population.

⁴ Office of the Inspector General of the Department of Health and Human Services, *A Study of Graduate Medical Education Costs*, July 28, 1994.

⁵ For example, in a 2005 report, the Council on Graduate Medical Education (COGME) predicted that by 2020, there will be a shortage of physicians in the range of 65,000 to 150,000. COGME, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, January 2005.

Medicaid recipients will likely be hardest hit by such a shortfall as many physicians, confronted by high demand for their services, will prioritize care to patients covered by more lucrative commercial insurance and Medicare.

4. *Teaching hospitals are reliant on Medicaid to help finance the clinical education of future health care professionals.*

Medicaid payments are a critical pillar of support for GME activities throughout the country. As CMS itself notes in the preamble to the Proposed Rule, 47 states and the District of Columbia use Medicaid funds to make GME Payments.⁶ As of 2001, Medicaid GME payments provided approximately 10 percent of the GME financing for teaching hospitals.⁷ Second only to Medicare GME payments, Medicaid GME support has evolved as a crucial financial underpinning of our nation's teaching programs. Unfortunately, private payers generally have not followed suit in providing direct support for clinical education provided by teaching hospitals. And while some communities do provide support, they cannot be expected to replace the funding that would be cut by this regulation. Nor is it realistic to assume, as CMS does in the Regulatory Impact Statement section, that a significant number of states may choose to assume the federal share of GME payments at their current levels through state-only funding. The loss of Medicaid funding if this rule is ever implemented would be devastating to teaching hospitals.

5. *Teaching hospitals provide essential medical services not generally available in other hospitals.*

The benefits that teaching hospitals provide to their communities extend beyond clinical education to future physicians. Most teaching hospitals offer specialized services that are not otherwise available at other hospitals. For example, 25.9 percent of teaching hospitals perform organ transplants, 50.9 percent operate certified trauma centers, and 49.4 percent provide neonatal intensive care. The percentage of all other hospitals providing these services was 2.0 percent, 30.2 percent, and 12.1 percent respectively.⁸ Teaching hospitals also provide a substantial amount of primary care to their communities through the operation of community clinics in underserved areas. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

All of these high-cost and under-reimbursed community services are offered in spite of the fact that teaching hospitals operate at margins well below the industry norm.

⁶ 72 Fed. Reg. at 28932; Association of American Medical Colleges, *Direct and Indirect Graduate Medical Education Payments by State Medicaid Programs*, November 2006 at 2.

⁷ National Health Policy Forum, *Federal and State Perspectives on GME Reform*, June 22, 2001 at 2 (the NHPF Report).

⁸ Association of American Medical Colleges, *Analysis of Fiscal Year 2005 American Hospital Association Data*.

Through the Proposed Rule, CMS has presented teaching hospitals with an ultimatum, and either option is a losing proposition. Because teaching hospitals do not have the revenue to subsidize both their community services and their GME activities, funding cuts will have to be made. And as a result, the medical infrastructure of the next generation will be severely weakened or the communities in which teaching hospitals are located will be deprived of essential medical services. Under either scenario, Medicaid recipients are certain to be harmed.

6. *The Proposed Rule will disproportionately impact safety net teaching hospitals.*

The proposed cuts will cause the greatest amount of harm to safety net teaching hospitals, which serve a disproportionately large share of Medicaid patients. As compared to the average teaching hospital, these safety net hospitals, many of them NAPH members, rely to a much greater extent on the Medicaid program to reimburse their teaching expenses. Medicare GME payments are based on the volume of Medicare services provided, and safety net teaching hospitals serve a much lower proportion of Medicare beneficiaries than the average teaching hospital. As a result, safety net teaching hospitals must rely to a much greater extent on Medicaid GME reimbursement, as their Medicaid patient population is generally much greater proportionally than that of their non-safety net counterparts.⁹ NAPH member hospitals, which serve the greatest number of Medicaid recipients with the most complex medical needs, will therefore suffer the heaviest blow from these proposed payment cuts.

7. *The removal of DGME from the UPL will reduce Medicaid reimbursement to all acute care hospitals.*

By removing DGME from the inpatient hospital UPL, the impact of the Proposed Rule would be felt in some states by non-teaching hospitals as well as teaching hospitals. Under 42 C.F.R. § 447.272(b), the UPL amount is “a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles.” The UPL represents the total amount of federal funds available to the states to make payments to hospitals for inpatient services, and all of these funds are crucial in ensuring adequate hospital reimbursement for the treatment of Medicaid recipients. As CMS notes in the Proposed Rule, “States routinely make payments to hospitals up to the maximum level permitted under the UPL.” The removal of DGME from the UPL does not just affect GME payments to teaching hospitals; it would lower the limit on payments to all hospitals within a state. The lower limit will impact not only GME payments to teaching hospitals, but could also reduce payments to non-teaching

⁹ A comparison of the utilization data of NAPH members (85 percent of whom are teaching hospitals) with the overall major teaching hospital average provides an indication of the disproportionate reliance on Medicaid by safety net teaching hospitals. The average NAPH member’s inpatient population, as measured by discharge volume, is 38 percent Medicaid and 21 percent Medicare, as compared to 20 percent Medicaid and 34.4 percent Medicare for the average major teaching hospital. See National Association of Public Hospitals and Health Systems, *American’s Public Hospitals and Health Systems, 2004*; Association of American Medical Colleges, *Analysis of Fiscal Year 2005 American Hospital Association Data*.

hospitals and non-GME payments to teaching hospitals. As a result, access for Medicaid recipients will be reduced in both teaching and non-teaching hospitals.

8. *All GME payments relate to the provision of inpatient hospital services.*

We strongly object to CMS' assertion that "GME is not a health service."¹⁰ This characterization fails to grasp the nature of GME activities, and the teaching methodologies employed in teaching hospitals. Under the Medicare program, GME costs are separated into two components, DGME costs and IME costs. Contrary to CMS' understanding, both DGME and IME activities are health services.

DGME payments compensate hospitals for resident and teaching physician salaries and benefits, as well as teaching program overhead. The DGME payments are incurred by teaching hospitals in the course of providing patient care, as clinical education occurs primarily through the provision of medical services by the residents and teaching physicians. In fact, the presence of a strong clinical training program is a prerequisite for teaching program accreditation.¹¹ The Third Circuit has concluded similarly, noting that residents spend the vast majority of their time administering patient care and that DGME reimbursement "is in a large part a reimbursement for patient care."¹²

IME payments are provided to reimburse hospitals for extra expenses that are incurred as a result of having a teaching program (*e.g.*, for the treatment of high-acuity patients; for additional diagnostic tests ordered by residents who lack the diagnostic skills of a seasoned physician). As CMS notes in the Proposed Rule, the "IME adjustment is intended to compensate teaching hospitals for the additional costs they incur when providing hospital services versus non-teaching hospitals."¹³ CMS' contention that all GME activities are not health services has no basis in fact and cannot support the conclusion that there is no statutory authorization for Medicaid GME funding.

9. *The Proposed Rule irresponsibly shifts costs to states and teaching hospitals.*

To the extent that states, communities, and teaching hospitals decide that their GME programs must continue even in the face of the Proposed Rule, they will have to find a way to replace the federal funding that CMS is withdrawing. Indeed, it appears that CMS is counting on these other entities to pick up the federal government's share as there is no discussion in the preamble to the Proposed Rule of the impact of shrinking the nation's GME programs. Such a massive cost-shifting to states and/or other entities is an inappropriate step for an agency to take without congressional authorization. As

¹⁰ 72 Fed. Reg. at 28931.

¹¹ The Accreditation Council for Graduate Medical Education (ACGME) evaluates and accredits medical residency programs in the United States. One of the core competencies for all residency programs listed in its "Common Program Requirements" is "practice-based learning and improvement," or clinical experience.

¹² *West Virginia University Hospital, Inc. v. Casey*, 885 F.2d 11, 27 (3d Cir. 1989) (*WVUH*) (noting that residents spend approximately 75 percent of their time providing patient care).

¹³ 72 Fed. Reg. at 28932 (*emphasis added*).

explained in more detail below, Congress has long authorized the two major governmental health care programs – Medicare and Medicaid -- to assume a share of the cost of graduate medical education as part and parcel of payment for hospital services. For CMS to decide to shirk the federal government’s share of Medicaid’s portion of those costs is unfair to those entities that will be forced to find replacement funding and is an irresponsible exercise of federal regulatory authority.

10. *CMS improperly has failed to determine the impact of the Proposed Rule.*

CMS improperly fails to evaluate the impact of the Proposed Rule on any of the affected entities, including teaching hospitals and states. In the preamble to the Proposed Rule, CMS declines to undertake a Regulatory Flexibility Act (RFA) analysis of the impact of the regulation on small businesses, including some teaching hospitals. CMS claims that no RFA analysis is necessary because the regulation only affects matching payments to states for GME support and “States may choose to continue to fund direct medical education programs using State-only funding.”¹⁴ At the same time, however, for purposes of Executive Order 13132, CMS finds that the rule will have “no substantial effect on State or local government” since states will not be *required* to continue GME payments.¹⁵ Through this slight of hand, CMS appears to have analyzed away *any* impact of the regulation on *any* entity.

11. *It is inappropriate for CMS to undertake this major policy change administratively.*

The Proposed Rule represents an abrupt reversal of long-standing CMS policy. As CMS notes, it “has previously allowed States to include hospital GME activities as a component of the cost of Medicaid inpatient and outpatient hospital services.”¹⁶ It is inappropriate for CMS to suddenly reverse this policy, one with significant implications for teaching hospitals, Medicaid recipients, and the nation’s health care system as a whole, through the administrative process. Rather, a policy change of this magnitude should be submitted to Congress for approval.

Furthermore, CMS does not appear to object to the existence of hospital-based graduate medical education programs, and presumably would want to see them continue. Yet it has proposed no source of replacement funding for the Medicaid support it is withdrawing – because it does not have the authority to authorize new funding sources unilaterally. This fact alone – that it is unable to provide an alternative funding source for an activity whose value is not in dispute -- should have led CMS to seek a legislative, rather than an administrative, solution to its GME policy concerns.

¹⁴ *Id.* at 28935.

¹⁵ *Id.*

¹⁶ *Id.* at 28931.

III. Major Legal Concerns:

While the policy choices underlying the Proposed Rule are misguided, the legal foundation of the proposal is simply wrong. Contrary to CMS's purported legal basis, the Medicaid statute does authorize FFP for GME costs. This interpretation is validated by looking to the Medicare statute and legislative activity over the past 26 years. From a legal standpoint, CMS is required to offer FFP to states that reimburse providers for GME activities under their Medicaid programs.

1. *The Medicaid statute authorizes FFP for GME payments.*

Contrary to CMS' assertion, the Medicaid statute provides for Medicaid reimbursement of GME costs through the provision of FFP for inpatient and outpatient hospital services. In the Proposed Rule, CMS sets forth an interpretation of Sections 1903(a) and 1905(a) of the Social Security Act that precludes FFP for costs incurred for GME activities. In particular, CMS claims that FFP is not authorized for GME costs because the Medicaid statute only authorizes FFP for "care and services within the scope of medical assistance," as defined under Section 1905(a), and the definition of medical assistance does not include "express authority" for payments for GME.

CMS' cramped interpretation of Section 1905(a) is contrary to a natural reading of the statute. Section 1905(a) includes in the definition of "medical assistance" for which FFP is available, "payment of part or all of the cost of . . . inpatient hospital services" and "outpatient hospital services."¹⁷ Neither Section 1905(a), nor any other provision of the Medicaid statute, defines inpatient or outpatient hospital services. A natural reading of Section 1905(a) expressly authorizes payment for all costs incurred while providing these services and GME costs are clearly incurred by a teaching hospital while providing inpatient and outpatient hospital services. GME payments are intended to reimburse hospitals for the additional expenses associated with running teaching programs, programs which are comprised of teaching physicians and residents who spend a significant amount of their time providing direct patient care.

Just as "inpatient hospital services" and "outpatient hospital services" are indisputably interpreted to include costs such as capital costs, employee education costs, emergency preparedness costs, administrative overhead, maintenance costs, and all of the other reimbursable costs tracked on hospital cost reports, the costs of graduate medical education are equally a part of the costs of delivering hospital care.¹⁸ There is no legal basis for CMS to single out GME costs as the one component of the costs of delivering hospital care that is not reimbursable. GME costs are clearly encompassed among the costs of delivering inpatient and outpatient hospital services and as such are expressly

¹⁷ 42 U.S.C. §1396d(a)(1) and (2)(A).

¹⁸ By contrast, certain costs incurred by hospitals are considered unrelated to patient care and are non-reimbursable. Examples include the costs of flower shops, parking garages, cafeterias and other unrelated businesses, and marketing costs. But unlike GME costs, these costs are not incurred in the course of delivering patient care services.

contained within the definition of “medical assistance” eligible for FFP.¹⁹ In fact, were it not for the GME program, hospitals would be forced to increase their physician workforces in order to continue providing the same amount of patient care. Such replacement physician services would clearly be reimbursable.

2. *The Medicare statute defines inpatient hospital services to include GME activities and considers GME payments to be payments for inpatient hospital services.*

In the absence of a statutory definition of “inpatient hospital services” for Medicaid, it is logical to look to the Medicare statute, which was adopted by Congress at the same time as Medicaid, for guidance as to what Congress intended by the term. The Medicare statute defines inpatient hospital services to include GME activities. In particular, Section 1861(b) explicitly defines inpatient hospital services to include services provided by “an intern or a resident-in-training under [an approved] teaching program.”²⁰ Under Medicare, the services provided by residents and teaching physicians expressly are considered inpatient hospital services.

The inclusion of GME costs under the rubric of reimbursement for the provision of inpatient hospital services under Medicare (and derivatively, under Medicaid) is further buttressed by an examination of the inpatient hospital payment provisions of Title XVIII. The Medicare statute specifically includes GME costs under its reimbursement methodology for inpatient hospital services.²¹ Section 1886 separates inpatient hospital services into several components, including the “operating costs of inpatient hospital services,”²² the “capital-related costs,”²³ and “payments for direct graduate medical education costs.”²⁴ The Medicare program reimburses hospitals for each of these components under a distinct payment methodology. CMS looks solely to the operating cost component of inpatient hospital services²⁵ and, finding that GME costs are excluded from operating costs, appears to leap to the erroneous conclusion that all GME activities are therefore excluded from the definition of inpatient hospital services and that GME payments are not reimbursement for inpatient hospital services.²⁶

Section 1886(a)(4)’s exclusion of GME activities from the operating costs of inpatient hospital services stands for the simple proposition that GME activities are not eligible for reimbursement under the payment methodology used for operating costs. It does not

¹⁹ Although beyond the scope of the Proposed Rule, NAPH would like to point out that GME costs also must be considered costs incurred for furnishing hospital services under Section 1923(g) and included in the calculation of a hospital’s costs of providing services to Medicaid enrollees and the uninsured.

²⁰ 42 U.S.C. §1395x(b)(6).

²¹ See Section 1886(h); 42 U.S.C. §1395ww(h).

²² Section 1886(a)-(b) and (d); 42 U.S.C. §1395ww(a)-(b) and (d).

²³ Section 1886(g); 42 U.S.C. §1395ww(g).

²⁴ Section 1886(h); 42 U.S.C. §1395ww(h).

²⁵ CMS points to language in Section 1886(a)(4) stating that “the term ‘operating costs of inpatient hospital services’ . . . does not include costs of approved educational activities”

²⁶ 72 Fed. Reg. at 28932 (“Medicare expressly excludes costs associated with educational activities from the operating costs that can be included in the cost base used to develop the basic payment amounts under Medicare’s prospective payment system for inpatient hospital services.”)

stand for the broader principle that all GME activities are excluded from the definition of inpatient hospital services or that GME payments are not reimbursement for inpatient hospital services. In fact, the opposite is true. Section 1886 is entitled “Payments to hospitals for inpatient hospital services,” clearly indicating that all the payment methodologies outlined in the section – including GME reimbursement under Section 1886(h) – are reimbursement for inpatient hospital services. Each of operating costs, capital costs, and GME costs are components of payments for the provision of inpatient hospital services, and each is eligible for FFP. Additionally, Section 1886 does not offer a new definition for inpatient hospital services, but incorporates the one found in Section 1861.

Finally, Section 1861(v)(8) of the Medicare statute explicitly enumerates certain costs that are unrelated to patient care and therefore not considered to be “reasonable costs” of providing services to Medicare beneficiaries.²⁷ GME activities are not included on this list (although education expenses for spouses or other dependents of providers *are* on the list). If CMS were right that GME costs were not related to the provision of hospital services they would likely be a part of this list of explicit exclusions. They are not.

The Medicare statute is explicitly clear. For Medicare purposes, most GME activities are included within the definition of inpatient hospital services and all GME payments are characterized as reimbursement for the provision of inpatient hospital services. CMS fails to provide either a legal or policy justification for considering the scope of inpatient hospital services under Medicaid to be narrower than under Medicare.

3. *The Medicaid program historically has had explicit statutory authority to reimburse GME costs.*

A historical analysis of the Medicaid and Medicare statutes demonstrates that Congress intended for the term “inpatient hospital services” to be defined under the Medicaid program as it was under Medicare, a definition that includes GME activities. Prior to 1981, the Medicaid statute required states to pay for inpatient hospital services on a reasonable cost basis.²⁸ The maximum allowable reimbursement amount was the reasonable cost amount determined according to Medicare’s reimbursement methodology. Specifically, each state Medicaid plan was required to provide for “payment of the reasonable cost of inpatient hospital services,” but the payment amount was not to “exceed the amount which would be determined under section 1395x(v) of this title as the reasonable cost of such services.”²⁹ In other words, the pre-1981 Medicaid statute states that the Medicare reimbursement amount for inpatient hospital services is the maximum amount that a state Medicaid plan may reimburse a hospital for these same services. The reasonable cost of hospital services under Medicare prior to 1981 as

²⁷ 42 U.S.C. § 1395x(v)(8).

²⁸ 42 U.S.C. § 1396a(13)(D) (1976).

²⁹ *Id.* (emphasis added). “Section 1395x(v) of this title” describes Medicare reasonable cost payment methodology, which was the basis for Medicare’s payments for inpatient hospital services. 42 U.S.C. §§ 1395x(v); 1395f(b) (1976).

interpreted by the courts and CMS included DGME costs.³⁰ The statute was clear; states were permitted to reimburse hospitals for their DGME costs as part of inpatient hospital services.

The two program's payment methodologies have evolved since 1981, and neither still mandates the payment of reasonable costs for acute care hospital services. The Medicare program pays separately for each component of inpatient hospital services, primarily on a prospective payment basis, and the Medicaid program offers states wide flexibility in creating payment methodologies. Yet there is simply no evidence that as Congress broke the link between the Medicaid and Medicare payment systems and granted states flexibility to experiment with different payment methodologies it eliminated the previous authority for states to reimburse the reasonable costs of GME. In fact, quite the contrary, the legislative history indicates that Congress was concerned that states might adopt payment methodologies that did *not* adequately compensate teaching hospitals for their medical education programs.³¹ The Medicaid program has historically had express statutory authority to provide FFP for GME activities, and no change to the Medicaid or Medicare statutes has stripped CMS of this authority.

4. *Each component of a medical item or service does not need to be "expressly authorized" under Section 1905(a) to be eligible for FFP.*

Section 1905(a) lists 28 different categories of items and services that are considered to be part of "medical assistance" for which states can claim FFP when provided to Medicaid recipients. Of necessity, the categories are drafted broadly, and do not list every single component of the costs that may go into providing the services which are reimbursable. CMS has provided some additional detail in regulatory definitions,³² but even the regulations cannot and do not itemize each element of reimbursable costs. It is disingenuous, therefore, for CMS to make the argument that because GME is not specifically listed in Section 1905(a) as an element of medical assistance, Congress did not authorize CMS to provide FFP for GME expenditures.

Moreover, CMS' proposed prohibition on FFP for GME costs directly conflicts with its own longstanding interpretation of the Medicaid statute. In this instance, CMS has concluded that because GME activities are not enumerated in Section 1905(a), FFP is not authorized for GME costs. Yet CMS repeatedly has permitted FFP for other items and services that, similar to GME, are not included as an enumerated item or service under Section 1905(a). To provide just a few examples:

³⁰ See, e.g., *Loyola Univ. of Chicago v. Bowen*, 905 F.2d 1061, 1073 (7th Cir. 1990) (holding that for Medicare "to disallow [resident and intern stipend] costs would cause the cost of providing services to Medicare beneficiaries to be shifted to other patients . . . [w]e will not be a party to allowing the Secretary to violate the specific and clear congressional intent expressed in [the definition of reasonable costs]."); 42 C.F.R. § 405.421 (1977).

³¹ See discussion accompanying notes 44-47.

³² See 42 C.F.R. § 440.1 - 185.

- CMS provides FFP for expenditures for durable medical equipment as part of the cost of providing home health services,³³ yet such equipment is not expressly authorized under Section 1905(a).
- The State Medicaid Manual defines “personal care services” to include assistance with laundry, meal preparation, grocery shopping, using the telephone, and money management,³⁴ yet none of these services – which appear to be much further afield from the delivery of medical services than the services provided by interns and residents -- are expressly authorized under Section 1905(a).
- CMS provides FFP for oral and written translation services,³⁵ yet these activities are not expressly authorized under Section 1905(a). In many states, such services are provided as a component of delivering hospital services.³⁶
- CMS provides FFP for disease management programs as part of the services provided by “other licensed practitioners” or as “preventive services,”³⁷ yet disease management services are not expressly authorized under Section 1905(a).
- CMS defines “home health care services” to include home health aide services,³⁸ yet home health aide services are not expressly authorized under Section 1905(a).
- CMS continues to provide FFP for payments for capital costs incurred by hospitals, despite the fact that capital payments, similarly to GME, are excluded from the definition of the operating costs of inpatient hospital services under Medicare and are not listed as a separate item or service under Section 1905(a).
- CMS allows states to reimburse the costs of necessary transportation for Medicaid recipients to and from providers pursuant to its authority to identify other medical care as part of medical assistance,³⁹ yet transportation is not expressly authorized under Section 1905(a).
- Similarly, CMS provides FFP for the cost of “emergency hospital services” that are either provided by a non-participating provider or are outside the scope of “inpatient” or “outpatient hospital services” as part of the same catchall authority to identify other medical care, yet such emergency services are not expressly authorized under Section 1905(a).

Congress itself clarified that it did not intend for the items listed under Section 1905(a) to be interpreted narrowly. The concluding paragraph of Section 1905(a) prohibits a state from excluding any service, including counseling, from the definition of medical assistance solely because the service is provided as a treatment for alcoholism or drug dependency. Clearly then, although counseling services are not an enumerated item, they are included within the definition of medical assistance. The only coherent reading of Section 1905(a) is that counseling services falls within one of the 28 general categories.

³³ 42 C.F.R. § 440.70(b)(3).

³⁴ State Medicaid Manual, Publication No. 45, Part 4, Section 4480.

³⁵ Letter to State Medicaid Directors, issued August 31, 2000.

³⁶ See National Association of Public Hospitals and Health Systems, *Medicaid and SCHIP Funding for Language Services*, Research Brief, April 2007, available at <http://www.naph.org/Template.cfm?Section=Publications&template=/ContentManagement/ContentDisplay.cfm&ContentID=8403>.

³⁷ Letter to State Medicaid Directors, issued February 25, 2004.

³⁸ 42 C.F.R. § 440.70(b)(2).

³⁹ 42 C.F.R. § 440.170(a).

Similarly, Section 1903(i) specifies the conditions under which FFP is available to states for organ transplant procedures.⁴⁰ Organ transplants are not specifically listed under Section 1905(a) and also must fall within one of the 28 listed categories.

Through these and countless other examples, it is quite clear that the items and services listed under subsections (1) through (28) were not intended to be and are not interpreted narrowly by CMS. CMS' sudden alarm at not finding express authority in Section 1905(a) for GME reimbursement is at odds with its own reasonable interpretation of the statute over the last 40 years. There simply is no basis to assume that the failure to list a component of a cost of providing a service listed in one of the 28 broad categories of items and services means that no FFP is available for that service. GME is part of the cost of providing inpatient and outpatient hospital services and as such FFP is available for states providing reimbursement for such costs.

5. *Congress has repeatedly indicated its intent for the Medicaid program to reimburse states for GME costs.*

As explained above, prior to 1981, the Medicaid program was required to reimburse hospitals on a reasonable cost basis for inpatient hospital services.⁴¹ The maximum amount of these reasonable costs was Medicare's reasonable costs for the same services.⁴² In the Omnibus Budget Reconciliation Act of 1981 (1981 OBRA), Congress revised the Medicaid statute to permit states to adopt Medicaid payment methodologies that were not on a reasonable cost basis.⁴³ During this revision of the Medicaid statute, Congress did not, and since has not, indicated that GME activities are no longer considered inpatient hospital services for Medicaid payment purposes. In fact, the opposite is true. Congress has repeatedly recognized the importance of federal support, through FFP, of GME activities.

Congressional intent to support medical education through Medicaid financing is most explicitly set forth in the legislative history of the 1981 OBRA. The House report accompanying the initial version of the legislation states that the committee "intends States to recognize that facilities that provide teaching services . . . may have operating costs which exceed those of a community hospital."⁴⁴ The Committee urged states to "take into account the differences in operating costs of the various types of facilities."⁴⁵ The House Conference Report contains similar support for the direction of Medicaid funds towards medical education, and notes that, "[t]he conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement, and [the conferees] are concerned that a State take into account the special situation that exists in these institutions in

⁴⁰ 42 U.S.C. § 1396b(i).

⁴¹ 42 U.S.C. § 1396a(13)(D) (1976).

⁴² *Id.*

⁴³ Section 2173 of the Omnibus Budget Reconciliation Act of 1981, Pub. Law 97-35.

⁴⁴ H.R. Rep. No. 158, 97th Cong., 1st Sess. 294.

⁴⁵ *Id.*

developing their rates.”⁴⁶ Federal courts have similarly found this language persuasive, and the Third Circuit concluded that the “legislative history suggests that Congress intended teaching hospitals . . . to be adequately supported by medicaid plans.”⁴⁷

During the intervening 26 years, Congress has unambiguously acted under the assumption that the federal government provides FFP for state GME costs. In 1993, the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce published an updated version of the “Medicaid Source Book: Background Data and Analysis” (the Yellow Book). The Yellow Book provides an overview of state Medicaid plan payment methodologies, and notes that many states adjust their Medicaid rates based on the “presence of teaching programs.”⁴⁸ The Yellow Book gave no indication that these increased payments for teaching programs were not eligible for FFP under the Medicaid program.

Congress again recognized Medicaid’s authority to provide FFP for GME activities in section 705(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).⁴⁹ In section 705(a) of BIPA, Congress explicitly instructed CMS to adopt an aggregate Medicare-related UPL. Enacted 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 applied to State medicaid spending for inpatient hospital services . . . by applying an aggregate upper payment limit to payments made to governmental facilities that are not State-owned or operated facilities.” In requiring that the final regulations be based on the proposed rule issued on October 5, 2000, Congress explicitly endorsed the establishment of a UPL based on Medicare payment principles, which included payments for GME.

Congress most recently expressed its understanding that the Medicaid program is authorized to provide FFP for GME activities during the passage of the Deficit Reduction Act of 2005 (DRA).⁵⁰ Section 6085 of the DRA limited Medicaid payments to certain emergency service providers for emergency services provided to enrollees of a Medicaid managed care plan. Congress set the maximum payment amount as the maximum Medicaid payment amount, minus any payments that would otherwise be made for “indirect costs of medical education and direct costs of graduate medical education.” This GME carve-out illustrates both congressional understanding that FFP generally is available for GME costs and CMS’ explicit authority to continue providing FFP for GME costs under all other circumstances.

⁴⁶ H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. 962, reprinted in U.S. Code Cong. & Admin. News 1010, 1324.

⁴⁷ *WVUH*, 885 F.2d at 27.

⁴⁸ Yellow Book, at 316.

⁴⁹ H.R. 5661, 106th Cong., enacted into law by reference in Pub. L. No. 106-554, § 1(a)(6) (BIPA).

⁵⁰ S. 1932, 109th Cong., enacted into law in Pub. L. No. 109-171 (DRA).

6. *CMS is required to provide FFP for costs related to IME activities.*

CMS asked for comments on the propriety of including Medicare IME adjustments as part of the UPL calculation. NAPH does not believe that comments are necessary on this issue, as CMS does not have the authority to exclude IME adjustments from the UPL calculation. The inclusion of IME payments in the UPL is an acknowledgement that IME costs are part of the costs of providing inpatient hospital services. We agree with CMS that under Medicare statutory payment principles, IME expenses are not only inpatient hospital services, but are part of the operating costs of inpatient hospital services. Section 1886(d) applies an IME adjustment to Medicare reimbursement of a hospital's operating costs for inpatient hospital services. Even under CMS' narrow interpretation of Section 1886, IME adjustments must be considered reimbursement for operating costs of inpatient hospital services and eligible for reimbursement under the Medicaid program. CMS is required to provide FFP for IME costs, and will exceed its statutory authority if it should make any attempt to restrict these matching payments.

IV. Clarifications:

1. *CMS should clarify that it will provide FFP for IME activities.*

CMS recognizes that the Medicare statute includes IME costs as a component of the operating costs of inpatient hospital services and expressly authorized under Section 1905(a). Therefore, CMS has not excluded IME costs in the calculation of the UPL under proposed 42 C.F.R. § 447.272 and proposed 42 C.F.R. § 447.321. However, proposed 42 C.F.R. § 447.201 provides that a state plan may not include "payments for graduate medical education" or "include costs of graduate medical education as an allowable cost." Additionally, proposed 42 C.F.R. § 447.257 prohibits FFP for any "expenditures for graduate medical education." We urge CMS to clarify these latter two provisions and indicate that a state plan may include payments for IME expenses.

V. Conclusion:

The payment cuts set forth in this Proposed Rule are in contravention to federal law and will cause serious harm to Medicaid beneficiaries, teaching hospitals, and our nation as a whole. We urge CMS to withdraw the Proposed Rule.



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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:

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.

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 Health 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

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 status¹⁶), 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*).

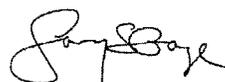
CRA. Section 801(a)(3) of the CRA states that the earliest that a rule may be effective is sixty (60) days from publication.¹⁸ Since the Final Rule was published on May 29, 2007, the earliest it could be effective under the CRA (moratorium aside) is July 30, 2007. In most States, the State plan rate 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

1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

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



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.

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.

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

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 Colleges⁴²) 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.

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.

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 1991⁶¹ 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.



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October 29, 2007

Mr. Kerry N. Weems
 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: CMS-2213-P — Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit

Dear Mr. Weems:

The National Association of Public Hospitals and Health Systems (NAPH) writes to express our serious concern regarding the issuance of the above-referenced Proposed Rule.¹ This Rule (1) unnecessarily narrows the definition of outpatient hospital services, with a significant but unacknowledged impact on disproportionate share hospital (DSH) payments; and (2) is overly prescriptive in dictating upper payment limit (UPL) methodologies for private outpatient hospitals and clinics. Of more concern, however, the Proposed Rule violates a recent legislative moratorium² (the Moratorium) on implementation of a cost limit on payments to governmental providers or restrictions on Medicaid graduate medical education (GME) payments. For these reasons, NAPH urges CMS to withdraw the Proposed Rule immediately.³

NAPH represents more than 100 metropolitan area safety net hospitals and health systems. Our members are 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. Member hospitals represent only 2% of the acute care hospitals in the country but provide 25% of the uncompensated hospital care. As a result, these hospitals rely upon Medicaid disproportionate share hospital (DSH) and other supplemental payments, including supplemental outpatient payments, for survival; without supplemental payments, overall NAPH member margins would drop to a negative 10.5 percent. NAPH members serve a

¹ 72 Fed. Reg. 55158 (Sep. 28, 2007).

² U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, Section 7002(a).

³ NAPH does not concede through submission of these comments that CMS has the authority to propose these provisions, nor to request, receive or review related comments, during the period of the Moratorium.

critical role in their communities of ensuring access to ambulatory care for uninsured and Medicaid patients. In 2004, NAPH members provided more than 29 million non-emergency outpatient visits, which represented more than one-third of all ambulatory care visits at safety net providers (including community health centers). Of the non-emergency visits at NAPH members, approximately 59 percent were for specialty care services and 41 percent for primary care services. The vast majority of this ambulatory care is reimbursed as outpatient hospital services.

The attached comments detail the following policy and technical concerns with the Proposed Rule:

- CMS has violated the congressional Moratorium and, in any event, failed to clarify how this Proposed Rule interacts with the Moratorium.
- The Proposed Rule will have a potentially significant impact on DSH payments, which CMS does not acknowledge.
- The Proposed Rule discourages hospitals from expanding important ambulatory care services.
- The Proposed Rule ignores significant differences in the scope and purposes of the Medicaid and Medicare programs in requiring coterminous coverage of outpatient hospital services, and in any event requires clarification.
- CMS' definition of outpatient hospital services to exclude services otherwise covered by the State Plan is not required by the Medicaid statute and is inconsistent with language in the preamble to the Proposed Rule.
- The overly prescriptive proposed outpatient UPL excludes the costs of interns, residents and supervising physicians, potentially resulting in millions of dollars in losses for providers in certain states, reduces state flexibility, and does not capture all Medicare-covered costs.
- The proposed private clinic UPL prohibits cost-based reimbursement without justification and includes a circular definition of the UPL for otherwise excluded dental services.

Because the Proposed Rule violates the Moratorium, CMS is legally obligated to withdraw it, and we urge you in the strongest terms to do so immediately. Congress enacted the Moratorium specifically to prevent CMS from taking "any action" to develop new policies in areas in which this Proposed Rule purports to regulate. Moreover, the Proposed Rule is bad policy, and would have a significant negative financial impact on both governmental and private hospitals serving Medicaid and uninsured patients. Coming in the wake of several other regulations issued by CMS that would impose large cuts on these hospitals—including the rule imposing a governmental provider cost limit and restricting sources of non-federal share funding,⁴ the rule to eliminate Medicaid funding for graduate medical education,⁵ and the proposed rule which has never been

⁴ 72 Fed. Reg. 29748 (May 29, 2007).

⁵ 72 Fed. Reg. 28930 (May 23, 2007).

finalized adopting narrow new DSH policies⁶—CMS' latest administrative action would be devastating to public, teaching and other safety net hospitals. Cumulatively these rules would eviscerate the health care safety net as well as jeopardize care for all Americans in communities across the country.

NAPH urges CMS to step back and consider the cumulative effect of its ever more restrictive Medicaid policies on the nation's safety net and the patients who rely on it for care. In addition to covering care for eligible populations, Medicaid supports an institutional safety net of health care providers that are critical to the well-being of their communities. If enacted, these rules would mean that such providers will no longer be able to train the next generation of doctors and health care professionals, to serve as the health care backbone of local emergency response systems, to provide critical yet under-reimbursed specialized services such as trauma care, burn care, neonatal intensive care and emergency psychiatric care, or to provide access where none would otherwise exist for the nation's poor, uninsured and underinsured individuals. Absent a more thorough analysis of real world implications of proposed policies and their impact on the health care system, we are relying on Congress to stop these policies in their tracks. We urge you to withdraw this regulation and all of the above mentioned pending regulations immediately. We need policies that strengthen, rather than dismantle, essential components of our nation's health care infrastructure.

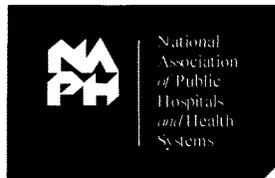
If you have any questions, please contact Barbara Eyman or Charles Luband of NAPH counsel Powell Goldstein LLP at (202) 347-0066.

Respectfully,



Larry S. Gage
President

⁶ 70 Fed. Reg. 50262 (Aug. 26, 2005).



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October 29, 2007

**COMMENTS BY THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS
 ON PROPOSED RULE: CMS-2213-P-Medicaid Program; Clarification of Outpatient
 Clinic and Hospital Facility Services Definition and Upper Payment Limit**

Prepared on Behalf of NAPH by Powell Goldstein LLP

MAJOR POLICY CONCERNS

**I. The Issuance of the Proposed Rule Directly Violates the Recently Adopted
 Congressional Moratorium.**

CMS' action in issuing the above-referenced Proposed Rule¹ violates a recent legislative moratorium² (the Moratorium) prohibiting "any action" to implement a rule to impose a cost limit on Medicaid payments to governmental providers (CMS-2258-FC, the Cost Limit Rule)³ or similar provisions, or any rule restricting payments for Medicaid graduate medical education (GME). For this reason alone, the rule should be withdrawn immediately.

A. The Proposed Rule violates the Medicaid GME provision of the Moratorium.

The Proposed Rule effectively prohibits states from including GME costs in the outpatient UPL, thereby narrowing states' flexibility to support GME through outpatient payments and thus violating the Moratorium. The language of the Moratorium prohibits CMS from "tak[ing] any action (through promulgation of regulation, issuance of regulatory guidance, or other administrative action) to ... promulgate or implement any rule or provisions restricting payments for graduate medical education under the Medicaid program."⁴ CMS' detailed new requirements for calculating cost for purposes of the outpatient hospital UPL excludes GME costs from the equation, essentially prohibiting states from providing outpatient-related GME payments.⁵ Because states have never before been prohibited from providing outpatient GME support, CMS' proposal directly violates the Moratorium.

¹ 72 Fed. Reg. 55158 (Sep. 28, 2007).

² U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, Section 7002(a).

³ 72 Fed. Reg. 29748 (May 29, 2007).

⁴ Pub. L. No. 110-28, Section 7002(a).

⁵ A more complete discussion of how CMS' proposed UPL methodology precludes states from reimbursing outpatient related GME costs is contained in technical section II.A.1. below.

B. The Proposed Rule violates the Moratorium by reissuing regulatory provisions contained in the Cost Limit Rule.

In the Proposed Rule, CMS reissued regulatory language from the final Cost Limit Rule redefining the categories of providers (state, non-state governmental and private) subject to upper payment limits (UPLs).⁶ The outpatient UPL in effect at the time of the Moratorium applied to three categories of providers: “State government-owned or operated facilities ... Non-State government-owned or operated facilities ... [and] Privately-owned and operated facilities.”⁷ The Cost Limit Rule amended these categories to “State government operated facilities ... Non-State government operated facilities ... [and] Privately operated facilities,” essentially removing all references to ownership.⁸ The language of the Moratorium prohibits CMS from “tak[ing] any action (through promulgation of regulation ...) to ... finalize or otherwise implement provisions contained in the [Cost Limit Rule]”⁹ In proposing to reissue the revised category language from the Cost Limit Rule in this Proposed Rule, CMS has violated Congress’ directive not to take any action to implement any provision of that rule.

C. The Moratorium violations completely disregard the clearly-expressed views of Congress on Medicaid policy.

These violations of the Moratorium continue a pattern in which CMS has ignored Congress’ statutory direction and contravened legislative intent regarding proper interpretation of the Medicaid Act. President Bush’s FY 2007 and 2008 budget requests contained several Medicaid policy proposals to be implemented through administrative action.¹⁰ Some of the proposals had previously been proposed as legislative measures but Congress declined to act on them.¹¹ In response to the administrative proposals, an overwhelming majority of both the House and Senate expressed public opposition to CMS’ plans.¹² CMS moved forward nonetheless in issuing proposed cost limit and GME regulations. Congress responded swiftly by adopting the Moratorium in both areas, which was initially vetoed as part of a larger supplemental appropriations bill,¹³ and later

⁶ See 42 C.F.R. § 447.321(a), as revised by the final Cost Limit Rule, 72 Fed. Reg. at 29835, and reissued in the Proposed Rule, 72 Fed. Reg. at 55165-66.

⁷ 42 C.F.R. § 447.321(a).

⁸ 42 C.F.R. § 447.321(a), as revised by 72 Fed. Reg. 29748, 29835 (May 29, 2007).

⁹ U.S. Troop Readiness, Veterans’ Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, Section 7002(a).

¹⁰ Budget of the United States Government, Fiscal Year 2007, at 125-27; Budget of the United States Government, Fiscal Year 2008, at 68-69.

¹¹ Budget of the United States Government, Fiscal Year 2005, at 149-50; Budget of the United States Government, Fiscal Year 2006, at 143; Letter from Michael O. Leavitt, Secretary of HHS, 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 HHS, 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).

¹² In 2006, 55 Senators and 300 Members of the House publicly opposed the cost limit and IGT restrictions. In 2007, 65 Senators and 263 Members of the House have gone on record against these proposals and the proposed GME restrictions.

¹³ H.R. 1591, 110th Congress (2007).

included in a revised bill that the President signed.¹⁴ In an apparent rush to regulate and “beat the clock,” CMS issued the final cost limit rule on May 25, 2007, the very day that CMS knew the President would sign the Moratorium into law. NAPH believes the issuance of the Final Rule itself violates the Moratorium, as by its terms the Moratorium took effect at 12:01 AM on May 25, the date of enactment.¹⁵ Legalities aside, however, it is disconcerting to NAPH that an agency would deliberately disregard the clearly-expressed views of Congress in this manner. Unfortunately, the issuance of the Proposed Rule appears to indicate a troubling pattern.

II. The Proposed Rule Will Have a Potentially Significant Impact on DSH Payments.

Perhaps the most damaging aspect of this Proposed Rule is its indirect impact on disproportionate share hospital (DSH) reimbursement for private and governmental hospitals alike—an impact that is not even acknowledged by CMS. NAPH is concerned that to the extent the proposed outpatient hospital definition excludes services a state is currently treating as outpatient hospital services, CMS will take the position that the uncompensated care costs associated with those services could no longer be included in a hospital’s DSH cap. Our members report that their states are currently including the costs of services that would be excluded under the proposed definition, including dental care (primarily care to children as required under the Medicaid EPSDT benefit), routine vision, psychiatric, observation, and physician services, and provider-based FQHC services.¹⁶

NAPH opposes any narrowing that will reduce the resources available to safety net hospitals to provide access to care for Medicaid and uninsured patients. The DSH program, over the years, has become the “lifeblood” for many safety net hospitals. DSH 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. CMS has already proposed a rule that would cut back on what it would allow to be considered costs for DSH payment purposes.¹⁷ Policy changes in DSH payments directly affect the ability of these hospitals to provide access to care for Medicaid and uninsured patients.

If this proposal would in fact narrow the costs reimbursable through DSH, CMS may have significantly underestimated the fiscal impact of the Proposed Rule, which it determined would not have “significant economic effects.”¹⁸ In that case, this Proposed

¹⁴ Pub. L. No. 110-28, Section 7002(a).

¹⁵ See, e.g., *Arnold v. United States*, 13 U.S. (9 Cranch) 104, 119 (1815); *United States v. Casson*, 434 F.2d 415, 419 (D.C. Cir. 1970).

¹⁶ In the case of provider-based FQHC services, hospitals that have established FQHCs, which are paid at clinic rather than hospital rates, include the uncompensated costs of providing these services in their DSH cap.

¹⁷ 70 Fed. Reg. 50262 (Aug. 26, 2005).

¹⁸ 72 Fed. Reg. at 55158, 55164 (Sep. 28, 2007).

Rule potentially should have been a major rule, requiring a longer period after final publication before implementation and certainly warranting a longer comment period than 30 days.

III. The Proposed Rule Discourages Hospitals from Expanding Important Ambulatory Care Services.

In prohibiting states from reimbursing certain ambulatory services provided by hospitals as outpatient hospital services, CMS is effectively reducing the reimbursement rate for those services because reimbursement for non-hospital services cannot include hospital overhead. In addition, CMS has stated that hospitals may not receive DSH reimbursement for non-hospital services. Therefore, a narrowing of the definition of outpatient hospital services is essentially a cut in hospital Medicaid reimbursement. Moreover, restrictive upper payment limit policies similarly have a direct impact on hospital funding. The cut discourages safety net hospitals from providing exactly the type of community-based primary and preventive ambulatory care services that have proved so effective in driving down health care costs yet are in short supply in so many states. NAPH questions the policy basis for such a proposal.

NAPH members and similarly situated hospitals play a critical role in the provision of outpatient services, particularly for low-income Medicaid and uninsured patients. In response to increasing demand for accessible ambulatory care, NAPH hospitals have established 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, with ambulatory care volume increasing by 49 percent between 1993 and 2003. These 89 hospital systems alone provided over one-third of all outpatient visits provided by safety net hospitals and community health centers (the other two-thirds were provided by 914 HRSA community health centers). The specialty ambulatory care provided by NAPH members is often the only such care available for patients referred from community health centers and other federally funded primary care clinics.

As explained in more detail below, this Proposed Rule narrows the definition of outpatient hospital services in multiple ways, many of which would have the effect of reducing reimbursement for the very ambulatory care services that states have sought to encourage our members to provide. It is inconceivable that CMS would adopt this policy when it admits that it has found no actual violations or problems with current state practices.¹⁹

¹⁹ 72 Fed. Reg. at 55164 (“As part of our review process, we have determined that only one of the 32 States currently defines non-hospital services as part of the outpatient hospital Medicaid State plan service benefit. . . We believe the fiscal impact would be minimal.”).

LEGAL AND TECHNICAL ISSUES

In addition to our broad policy concerns, NAPH has several technical concerns and questions about the Proposed Rule:

I. Narrowing the Definition of Outpatient Hospital Services (*II. D. Background, Medicaid Outpatient Hospital Services Definition; III.B. Provisions of the Proposed Rule, Proposed § 440.20*)

The Proposed Rule would limit the scope of services included in the definition of outpatient hospital services by: (1) excluding any services not reimbursed as outpatient hospital services under Medicare; (2) excluding services provided by entities that are not provider-based departments of a hospital; and (3) excluding services covered elsewhere in the State Plan. This proposed narrow definition will result in less support for safety net hospitals and potentially significant losses in DSH funding. If, however, CMS insists on adopting a more precise definition, we believe that more clearly specifying that outpatient hospital services must be provided in a provider-based setting would adequately address any potential concerns.

A. CMS should remove the requirement to align Medicaid outpatient hospital services with Medicare, or at the very least provide necessary clarification.

1. *Medicaid and Medicare legitimately include a different range of services in the outpatient hospital services benefit.*

CMS justifies the requirement to include only Medicare-reimbursed outpatient hospital services as “provid[ing] greater consistency between the two federally funded programs” and aligning Medicaid outpatient hospital services with the “industry-accepted class of services” recognized as outpatient hospital under Medicare regulations.²⁰ Given the separate statutory authority for the Medicare and Medicaid programs, it is unclear why “consistency” would provide a sufficient statutory basis for this regulation. Moreover, NAPH questions the policy basis for insisting on rigid, coterminous definitions when the two programs are very different in scope, have very different purposes and cover different populations, with Medicaid’s focus on providing services to low-income populations with differing needs. For example, Medicare completely excludes from coverage services such as dental care for children or vaccinations that policymakers have determined are critical to the health of Medicaid populations. Medicare also does not include outpatient hospital reimbursement for vision, psychiatric services and observation that state Medicaid programs have seen the value of reimbursing at a hospital rate to meet specific needs of their patient populations.

Recommendation: The Proposed Rule should be amended to eliminate the requirement that the Medicaid definition be no broader than the Medicare definition.

²⁰ *Id.* at 55161.

2. *CMS should provide clarification regarding reimbursement as an outpatient hospital service under alternate payment methodologies.*

If CMS retains this requirement, additional clarification is necessary for states and providers on how to determine whether a service is reimbursed as an outpatient hospital service under an alternate Medicare payment methodology sufficient to be included under the proposed definition. For example, physician services provided in an outpatient hospital setting could conceivably be considered to be reimbursed as an outpatient hospital service—they are reimbursed under the physician fee schedule as the professional component of outpatient hospital services, which is an alternative payment methodology—but CMS explicitly excludes them from the proposed definition. Laboratory services are similarly reimbursed under a fee schedule, yet are explicitly included as outpatient hospital services under the proposed definition.²¹

Recommendation: CMS should provide clarification as to the scope of services paid under alternate Medicare payment methodologies as outpatient hospital services that would be included under this proposed definition.

3. *CMS should clarify the interpretation of Medicare OPPS regulations as they apply to the proposed definition.*

Title 42, Section 419.2(b) of the Code of Federal Regulations (CFR), as referenced in proposed section 440.20(a)(4)(i),²² sets out an illustrative, but not exclusive, list of costs that may be included in the outpatient prospective payment system (OPPS).²³ Additional provisions list costs explicitly excluded from outpatient prospective payment rates,²⁴ and services excluded from payment under the hospital OPPS.²⁵

Recommendation: CMS should confirm that costs for services not explicitly excluded from the OPPS are therefore includable (assuming that these services meet the other proposed criteria). If this is the case, NAPH requests that CMS clarify how it will permit states to factor these other costs into the highly prescriptive private hospital outpatient UPL.

²¹ See *id.* (stating that “[f]or example, States may cover and reimburse prosthetic devices, prosthetics, supplies, and orthotic devices, durable medical equipment, and clinical diagnostic laboratory services as outpatient hospital services.”). In addition, there is concern that Medicare criteria for coverage of hospital versus non-hospital laboratory services are themselves complicated and that more detailed guidance is necessary to determine appropriate Medicaid coverage.

²² Proposed 42 C.F.R. § 440.20(a)(4)(i), *id.* at 55165.

²³ 42 C.F.R. § 419.2(b) (“these costs include, but are not limited to…”).

²⁴ *Id.* § 419.2(c).

²⁵ *Id.* § 419.22.

Title 42, Section 419.20(b) of the CFR also excludes certain categories of hospitals from the Medicare hospital OPPTS.²⁶

Recommendation: CMS should clarify that Medicaid outpatient hospital services in these categories of hospitals are includable under the proposed definition.

B. CMS should remove the exclusion of services covered elsewhere under the State Plan from the definition, or at the very least provide necessary clarification.

The Proposed Rule would further exclude from the outpatient hospital services definition those services that are covered and paid “under the scope of another Medical Assistance service category under the State Plan,”²⁷ though states “may continue to cover any service that is authorized under section 1905(a) of the Act within the State Plan under a coverage benefit that is distinct from outpatient hospital services.”²⁸

1. *This exclusion is not required by the language of the Medicaid statute.*

Nothing in the language or the history of the Medicaid statute requires categories of covered services to be discrete and mutually exclusive. Indeed, the U.S. Court of Appeals for the Fifth Circuit implicitly rejected mere reliance on a service being referenced in a different enumerated category from outpatient hospital services under section 1905(a)(2) of the Act as sufficient reasoning for excluding the service from the regulatory definition of outpatient hospital services.²⁹ Because CMS’ proposed insistence on discrete categories prohibits hospitals from receiving full outpatient hospital reimbursement for services that are clearly provided by outpatient hospital departments, CMS should abandon this unnecessary requirement.

Recommendation: CMS should amend the Proposed Rule to allow services covered elsewhere in the State Plan to be included in the outpatient hospital definition when provided to individuals receiving care in hospital outpatient settings.

2. *CMS’ proposed definition appears inconsistent and requires clarification.*

If CMS nonetheless chooses to retain this requirement, CMS should clarify apparent inconsistencies between the requirement and preamble language listing outpatient hospital services under the proposed definition. CMS explicitly provides that “states may

²⁶ *Id.* § 419.20(b) (excluding Maryland hospitals, critical access hospitals, hospitals located outside of the 50 states, DC and Puerto Rico, and hospitals of the Indian Health Service).

²⁷ Proposed 42 C.F.R. § 440.20(a)(4)(iii), 72 Fed. Reg. at 55165.

²⁸ 72 Fed. Reg. at 55161.

²⁹ *Louisiana Dep’t of Health and Hosps. v. CMS*, 346 F.3d 571 (5th Cir., 2003) (“CMS analyzes the term ‘hospital services’ [as used in the DSH statute] with the premise that ‘outpatient hospital services’ and ‘rural health clinic services’ are mutually exclusive. CMS notes: (1) federal statutes and regulations distinguish the terms in at least two places, see 42 U.S.C. §§1396d(a)(2) (enumerating categories of medical assistance services, including outpatient hospital services and rural health clinic services)...CMS assumes, without explanation, that any service that a RHC renders may never be considered an outpatient hospital service even if the service fits within the regulatory definition of ‘hospital outpatient service.’”).

cover and reimburse prosthetic devices, prosthetics, supplies, and orthotic devices, durable medical equipment, and clinical diagnostic laboratory services as outpatient hospital services.³⁰ Yet, prosthetic devices,³¹ laboratory services,³² and rehabilitative services³³ are each separate benefit categories under section 1905(a) of the Social Security Act. NAPH agrees that these services should be encompassed by the outpatient hospital services definition; however, states and providers require consistent guidance in order to apply this requirement to other services.

C. Other details of the proposed definition require further clarification.

Our members also seek more specific clarifications related to the following aspects of the proposed outpatient hospital definition:

- CMS should confirm that rehabilitative services currently considered outpatient hospital services under Medicare would continue to be considered outpatient hospital services under Medicaid, clarifying potentially inconsistent guidance in the preamble and proposed regulations.³⁴
- CMS should clarify that this Proposed Rule, in conjunction with current inpatient service regulations, would not prohibit state Medicaid agencies from reimbursing hospitals for services provided discharged patients waiting for an available skilled nursing facility (SNF) bed as hospital services (either outpatient or inpatient) under the state plan.³⁵

³⁰ 72 Fed. Reg. at 55161.

³¹ See SSA § 1905(a)(12) (42 U.S.C. § 1396d(a)(12)) (“prescribed drugs, dentures, and prosthetic devices...”).

³² See *id.* § 1905(a)(3) (42 U.S.C. § 1396d(a)(3)) (“other laboratory and X-ray services”). It is possible that this reference could be interpreted to include only those services other than lab services provided as outpatient hospital services in (a)(2) (or inpatient in (a)(1)), and therefore that outpatient hospital lab services are not a distinct service category.

³³ See *id.* §§ 1905(a)(11) (“physical therapy and related services”), 1905(a)(13) (“other diagnostic, screening, preventive, and rehabilitative services...”).

³⁴ The text of proposed section 440.20(a) explicitly defines outpatient hospital services to continue to include “rehabilitative services,” and Medicare reimburses hospitals under an “alternate payment methodology” for therapy provided by hospital outpatient departments, in accordance with proposed section 447.321(a)(4)(i). In the preamble, however, CMS states that rehabilitative services may be an example of “non-traditional outpatient hospital services.” 72 Fed. Reg. at 55160; see also 72 Fed. Reg. at 55159 (“outside the normal responsibility of outpatient hospitals”).

³⁵ In at least one state, the Medicaid program pays hospitals based on a SNF rate for these patients, though Medicare apparently does not reimburse hospitals for these services. Covering these services under the Medicaid SNF benefit does not adequately address the issue for these hospitals, as they may then be faced with the substantial administrative burden of pursuing state licensure as a SNF in order to provide what would newly be defined as “non-hospital” services to these patients.

II. Restriction of the Outpatient Hospital and Clinic Upper Payment Limits
(II.E. Background, Upper Payment Limits—Proposed Rule; II.B. Provisions of the Proposed Rule)

A. The proposed outpatient hospital UPL methodologies are too prescriptive.

NAPH objects to the limitations that the Proposed Rule would impose on state flexibility in calculating the upper payment limit for outpatient hospital services provided by private hospitals. The flexibility available under the current regulation³⁶ permits states to accurately capture the costs (or payments) made to hospitals for outpatient care while ensuring compliance with statutory requirements. CMS could clarify the requirements for calculating the UPL by describing examples of acceptable methodologies, i.e. cost-to-charge and payment-to-charge calculations, without precluding the use of other methodologies. A state should be permitted to develop another methodology more tailored to its circumstances if it is a reasonable approximation of what would be paid under Medicare payment principles.

1. *CMS should permit adjustments to the Medicare allowable costs on the cost report.*

The Proposed Rule would require that services appear on the outpatient-specific Medicare cost report worksheets in order to be included in the outpatient hospital UPL,³⁷ and would not permit adjustment of these costs.³⁸ NAPH is extremely concerned that in dictating the specific sections of the Medicare cost report that a state may use in calculating cost information for the outpatient UPL, CMS effectively excludes GME costs from the outpatient costs that a state can include. The preamble explicitly references the “cost-to-charge ratios as found on Worksheet C, Column 9 . . . of the CMS 2552-96.”³⁹ However, the cost-to-charge ratios contained at Worksheet C, Column 9 are calculated by taking information from Worksheet B, Column 27—which explicitly excludes all costs related to interns, residents, and supervising physicians. Given that Medicare pays for GME separately from outpatient (and inpatient) reimbursement, it makes sense that for Medicare purposes these costs would not be included in the outpatient cost-to-charge ratios. Similarly, the Medicare outpatient cost-to-charge ratio also excludes costs for teaching physicians for those hospitals that have chosen the election under Title 42, Section 415.160 of the CFR. Although Medicare reimburses these costs separately, they remain outpatient hospital costs that should be reimbursable through Medicaid. Federal law does not prohibit states from covering these costs as part of Medicaid outpatient reimbursement.

³⁶ See 42 C.F.R. § 447.321. Under current regulations, CMS has avoided a specific formal UPL, and instead negotiated UPL methodologies with states as long as payments to all private hospitals on an aggregate basis do not exceed a “reasonable estimate of the amount that would be paid for services furnished by the group of facilities under Medicare payment principles.”

³⁷ Proposed 42 C.F.R. § 447.321(b)(1)(i)(A), 72 Fed. Reg. at 55166.

³⁸ 72 Fed. Reg. at 55162.

³⁹ *Id.*

Recommendation: CMS should clarify that outpatient costs related to interns, residents, and supervising physicians, as well as costs related to cost-based reimbursement for teaching physicians, can be included in calculating the private outpatient hospital UPL.⁴⁰

In addition, some members have expressed concern that the cost report references specified by CMS may not be capturing all Medicare-covered outpatient hospital payments and charges, specifically related to physical therapy and durable medical equipment. *NAPH requests that CMS review these references to ensure that the payments and charges for all outpatient hospital services reimbursed by Medicare under the OPPI or alternative methodologies are captured by these references.*

2. *CMS must make allowances for "flat rate" hospitals that have exceptions for Medicare cost reporting purposes.*

CMS' methodology, by prescriptively referencing the Medicare cost report methodology, is particularly inappropriate where Medicare has permitted exceptions to its cost report methodology. In particular, Medicare has allowed "flat rate" hospitals with alternative charge structures to complete their Medicare cost report by using statistics to allocate costs instead of using the cost-to-charge methodology usually used in the Medicare cost report. The rationale for these exceptions is because the cost-to-charge calculation does not make sense where the charge structure is not consistently maintained. A payment-to-charge ratio would be similarly distorted. CMS' inflexible proposed UPL methodologies appear not to allow an exception where Medicare itself has allowed an exception from the rigorous use of charges.

Recommendation: CMS should allow states to use an alternative methodology to calculate the UPL related to flat rate hospitals.

3. *CMS should clarify that the cost methodology proposed for UPL calculations does not apply to DSH cost limits.*

CMS should confirm that the cost calculation described in this Proposed Rule for the purposes of calculating an outpatient hospital UPL is not mandatory for purposes of calculating either the DSH limit or the limit under the Cost Limit Rule. DSH explicitly covers a full range of covered and uncovered Medicaid services for both Medicaid recipients and the uninsured, and the restrictions imposed on the calculation of hospital costs for purposes of the outpatient UPL would be completely inappropriate with respect to DSH.

Recommendation: CMS should confirm that this rule has no impact on DSH limit calculations.

⁴⁰ We reiterate the point made earlier, that the exclusion of intern, resident, and supervising physician costs from the UPL violates the Moratorium.

B. Elimination of Cost-Based Reimbursement for Private Clinics

NAPH is extremely concerned that the limited methodologies permitted for calculating the UPL for private clinic services under the Proposed Rule would in effect prohibit states from paying private clinics cost-based rates.⁴¹ CMS provides no justification for allowing a cost-based UPL for hospitals but not clinics, simply stating that “Medicare does not typically pay for clinic services on the basis of cost as reported by the facility.”⁴² Furthermore, CMS does not appear to have considered that a cost-based UPL would be the most reasonable for services, such as dental services, that are not reimbursed under Medicare. Instead, CMS’ proposed dental component of the UPL, defining the UPL as “that amount that Medicaid would pay,”⁴³ is circular and, in effect, is no limit at all.

Recommendation: CMS should revise the proposed regulation to permit a cost-based UPL for private clinics.

C. Other UPL Clarifications

1. *The Proposed Rule fails to clarify the scope of the category of private providers that would be subject to the UPL during the period of the Moratorium.*

This Proposed Rule would apply a more restrictive UPL to “privately operated facilities,” defined under Section 447.321 as revised by the cost limit rule. CMS should clarify that if this rule is finalized during the period of the Moratorium, the proposed, restrictive UPL will apply only to those hospitals and clinics considered private prior to issuance of the Cost Limit Rule. Specifically, ***CMS should clarify that the more flexible governmental UPL, not this revised UPL, will continue to apply to state or non-state government-owned and privately operated facilities until the expiration of the Moratorium.***⁴⁴

2. *CMS should clarify that the provisions of this Rule will apply prospectively.*

CMS claims in the preamble that they currently require compliance with one of these outpatient hospital UPL methodologies when states submit State Plan Amendments related to outpatient hospital services.⁴⁵ CMS should clarify that the requirements of this Proposed Rule will only be prospectively applied after proper issuance of a final rule. Given the significant policy changes required by this proposed rule, it would be improper to implement these requirements without notice and comment rulemaking.

⁴¹ See Proposed 42 C.F.R. § 447.321(b)(1)(ii), 72 Fed. Reg. at 55166.

⁴² 72 Fed. Reg. at 55163.

⁴³ Proposed 42 C.F.R. § 447.321(b)(1)(ii)(C), *Id.* at 55166.

⁴⁴ We reiterate the point made above that CMS’ modifications to the categories of providers subject to the UPL violates the Moratorium.

⁴⁵ 72 Fed. Reg. at 55162.

Chairman WAXMAN. Thank you very much, Mr. Aviles.

Mr. Towns.

Mr. TOWNS. Let me just say, first off, thank you so much for being here. He heads the largest public hospital system in the United States. Of course, I am delighted for you to come and share with us your views and we hope to be able to talk further as we move forward into the question and answer period. I want to thank you so much for taking time from your busy schedule to come to share with us today.

Thank you, Mr. Chairman. I yield back.

Chairman WAXMAN. Thank you, Mr. Towns. Thank you very much, Mr. Aviles.

Dr. Retchin.

STATEMENT OF SHELDON RETCHIN

Dr. RETCHIN. Thank you, Chairman Waxman, Mr. Davis, members of the committee. I am Sheldon Retchin. I am vice president for Health Sciences at Virginia Commonwealth University and CEO of the VCU Health System in Richmond, VA. I am here to testify before the committee about the detrimental impact of the proposed CMS rule to eliminate Federal matching payments for graduate medical education [GME], under the Medicaid program.

I am also here on behalf of the Association of American Medical Colleges and I want to put a face to the devastating consequences these cuts would have on the Nation's teaching hospitals.

The VCU Health System is really two health systems. On the one hand it is a tertiary care center and is the region's only level one trauma center, and one of only two burn centers in the entire Commonwealth of Virginia. We perform solid organ transplants and attract referrals from not only across the Commonwealth, but all up and down the Mid-Atlantic region.

On the other hand, we are also a primary provider of hospital and intensive services and primary care services for inner-city Richmond. Let me tell you why.

Over the past three decades, there has been a migration of approximately 750 hospital beds from the city of Richmond to the surrounding suburbs. These beds were not replaced and, in fact, led to the closure of four major hospitals in the city of Richmond, three of which relocated into more affluent suburbs. So today the VCU Health System is the last remaining health system with a major hospital in the inner city, downtown Richmond.

So what happens is we take care of the inner city of Richmond, and during the past year we had 8,400 hospital discharges covered by Medicaid, 26 percent of all hospital inpatient work. Medicaid beneficiaries crowd our emergency rooms, they overwhelm our clinics. We had 65,000 outpatient Medicaid visits this past year. And that is not the whole story. In addition to the Medicaid population, the VCU provides a significant amount of care for low-income but income too high to be eligible for Medicaid. These are indigent patients.

So, taken together, Medicaid and indigent care represent about 45 percent of all the care our teaching hospital provides. So this devotion to care for the disadvantaged in our region is unrivaled.

Now, we do this judiciously. We are very careful stewards of these precious resources, and, not only that, we are innovators. So we contract with primary care physicians in the community to decompress the emergency room, and we contract with those inner-city community physicians, about 30 different practices, with funds that are not even Medicaid. That is because we want to be judicious, and we are doing this and putting band-aids as much as we can on the solution.

Believe me, this is a safety net, not a safety hammock.

CMS suggests that the Medicaid program should not make payments toward the cost of graduate medical education. The timing of this proposal is especially perplexing. As you all know, the Nation faces a looming physician shortage in conjunction with the rise in the health care demands that are being placed on it by baby boomers. This rule would undo a history of support that stretches back more than two decades.

During this time, CMS has long recognized graduate medical education as a legitimate and authorized Medicaid expenditure, has consistently approved State plans for this expenditure, and has always matched Medicaid GME payments along the way.

In 2005, 47 States and the District of Columbia made and provided GME payments under the Medicaid program. In Virginia this past year we received \$6.7 million in direct GME Medicaid costs.

I assure you, Virginia's Medicaid funding for GME is a Federal-State partnership split 50/50, so you have to ask why so many States like Virginia are making this commitment to graduate medical education that are now proposed for Federal reduction. That is because sustenance of the physician work force is at least as important, if not more so, for Medicaid beneficiaries than it is for Medicare.

While adequate access is vulnerable for beneficiaries of both programs, I can assure you that physician Medicaid participation in most States is even more sensitive than Medicare to the work force supply.

Over the past 20 years, despite modest health care reforms, unfortunately we have made little progress reducing the total number of our citizens who remain uninsured. That certainly has had its consequences in downtown Richmond. Employer-based coverage has eroded during the past 7 years, as we all know, and most of the uninsured and Medicaid beneficiaries are hard-working Americans who are either self-employed or employed by businesses, small businesses who cannot afford health care coverage for their employees.

With all due respect, I feel like we are walking up a down escalator. These cuts will merely unravel the safety net yet further and make health reform and expanded coverage that much harder to accomplish in the horizon ahead.

With 47 million Americans uninsured and another 40 million Americans on Medicaid or under-insured, the safety net is stretched tight, and the teaching hospitals are holding the corners.

I thank you for the opportunity to testify today. The teaching hospital community greatly appreciated the 1-year moratorium preventing regulatory action on this rule until May 2008, and we contend that this moratorium may have already been violated. We are

also very grateful to Representatives Engel and Myrick and over 133 bipartisan co-sponsors for advocating in support of the Public and Teaching Hospital Preservation Act to extend the moratorium for an additional year.

My fellow teaching hospital and medical school leaders and the Association of American Medical Colleges look forward to working closely with you on these issues which are of such importance to the health and well-being of all Americans.

Thank you.

[The prepared statement of Dr. Retchin follows:]



Statement

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President

On

The Administration's Regulatory Actions on Medicaid:
The Effects on Patients, Doctors, Hospitals, and States

Presented to the

The Committee on Oversight and Government Reform
United State House of Representatives

By

Sheldon M. Retchin, MD, MSPH
Chief Executive Officer, Virginia Commonwealth University (VCU) Health System and
Vice President for Health Sciences, VCU Medical College of Virginia Hospitals

November 1, 2007

Good morning, Mr. Chairman and Members of the Committee. I am Dr. Sheldon M. Retchin, Chief Executive Officer of the Virginia Commonwealth University (VCU) Health System. I also am Vice President for Health Sciences at VCU in Richmond, Virginia.

The VCU School of Medicine, and its teaching hospital, MCV Hospitals, is a long-standing member of the Association of American Medical Colleges (AAMC), which represents almost 400 major teaching hospitals and health systems, 126 accredited U.S. medical schools, and 94 academic and professional societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 67,000 medical students, and 104,000 resident physicians.

The VCU Health System includes MCV Hospitals, with 779 licensed beds; MCV Physicians -- a 600-physician-faculty group practice; and Virginia Premier, a Medicaid Health Maintenance Organization with 110,000 enrollees from across the Commonwealth of Virginia. The VCU Health System has the region's only Level 1 Trauma Center, is one of only 2 burn centers in the entire state, and its Massey Cancer Center was the first cancer center in Virginia designated by the National Cancer Institute more than 30 years ago. It offers state-of-the-art care in more than 200 specialty areas, many of national and international note, including organ transplantation, head and spinal cord trauma, burn healing and cancer treatment. The VCU Medical Center includes the Schools of Medicine, Allied Health, Dentistry, Pharmacy and Nursing, as well as a School of Public Health planned for 2010. We have more than 4000 students on our medical center campus who are being educated as pharmacists, dentists, dental hygienists, doctors, nurses, and physical therapists, to name but a few of the training programs. We have 650 post-graduate trainees in medical and surgical specialties across the full spectrum of care. Our students and post-graduates form the backbone of the health care workforce of Virginia, and many move on to other states across the country.

I am honored to testify before the committee about the detrimental impact of the recent CMS Medicaid regulatory actions, and particularly its proposed rule to eliminate federal matching payments for graduate medical education (GME) made under the Medicaid program. I, and indeed the entire teaching hospital community, greatly appreciated Congressional passage of the one-year moratorium preventing any regulatory action on this rule until May 2008. We also are grateful to Reps. Eliot Engel (D-NY), Sue Myrick (R-NC), and over 110 bipartisan cosponsors for advocating in support of the "Public and Teaching Hospital Preservation Act" (HR 3533) to extend the moratorium for an additional year. However, I hope today's testimony demonstrates that the Medicaid GME proposed rule would severely, and perhaps irrevocably, compromise the unique missions of teaching hospitals, with the result that Congress will act quickly to prevent promulgation and implementation of this short-sighted policy.

Teaching Hospitals and Medical Schools are Major Healthcare Providers for Medicaid Beneficiaries

Teaching hospitals, medical schools, and their clinical faculties historically have served as fundamental components of the nation's health care safety net. While representing just 20 percent of the nation's hospitals, teaching hospitals account for 42 percent of all Medicaid discharges. In fact, Medicaid represents 17 percent of the healthcare services provided by medical school faculty compared to 9 percent of services provided to Medicaid patients by private, community-based multispecialty physician groups. Nationwide, 51 percent of newborns are delivered at teaching hospitals—many covered by Medicaid. Among medical school faculty practices, 27 percent of obstetric services and about 40 percent of pediatric care is provided to Medicaid patients. Obstetrics and pediatrics are two specialties where there are particular physician workforce shortages in our state.

At Virginia Commonwealth University we are, by a wide margin, the largest Medicaid provider in the region. At our institution Medicaid beneficiaries represented approximately 8,400 discharges last year, or 26% of all discharges from our medical center. In addition to the inpatient services provided, Medicaid recipients also accounted for approximately 15,600 (or 26%) of the 60,000 Emergency Department visits that did not result in an admission. This population also had 65,000 outpatient visits, or approximately 16% of the total outpatient volume for our institution. Like many other inner city academic medical centers, the 1,633 Medicaid deliveries that occurred at VCU Health System last year represented a disproportionate number (over 63%) of the total deliveries in our institution. Unfortunately, this was also the case for admissions to the Neonatal Intensive Care Unit. In 2007, approximately 65% of babies discharged from the NICU were Medicaid beneficiaries; in 2006, Medicaid babies represented 70% of the discharges from the unit. There are multiple factors that influence negative birth outcomes and the support provided through the combination of patient care, education, research and ingenuity through the academic affiliations of medical centers who care for this population would be severely impacted if funding is depleted in the future.

In addition to the Medicaid population, the VCU Health System provides a significant amount of care for low income, or indigent patients. The indigent patients, who are primarily working adults who do not qualify for Medicaid, accounted for approximately 4,800 (or 15%) discharges and over 15,000 (or 25%) emergency department visits. In addition, the indigent population represented approximately 26% of the outpatient volume in our institution. These numbers, combined with the services to Medicaid populations, represent a significant amount of the health care provided by our facilities. These numbers are unrivaled by other hospitals in our area – making the future of the academic medical center tenuous at best in geographic regions that are experiencing increases in the ranks of the uninsured.

Thus, for major teaching hospitals like MCV Hospitals, Medicaid payments represent a significant segment of their total revenue. Any Medicaid cuts, and

particularly those of the magnitude proposed, will directly affect the fiscal condition of major teaching hospitals and could threaten their ability to maintain services offered to Medicaid and other patients, including many services that few other hospitals provide. For example, in 2005 major teaching hospitals provided nearly one-half of all hospital charity care. These institutions maintain one-half of all pediatric intensive care beds and nearly one-third of all intensive care beds for premature/seriously ill newborns. The nation's teaching hospitals were among the first to offer comprehensive care for AIDS patients, whom often rely on Medicaid for their health coverage. Most recently, teaching hospitals are looked to as front-line responders, with stand-by capacity, in the event of a biological, chemical, or nuclear disaster. At VCU, we have devoted significant resources to fulfilling that role.

Nearly 90 percent of major teaching hospitals offer emergency psychiatric service compared to just 25 percent of non-teaching hospitals. At VCU, our own teaching hospital and medical school maintain the area's most comprehensive psychiatric treatment center for children and adolescents. This past year we had 2600 outpatient visits and had 440 admissions for behavioral health problems; 90 percent of the admissions were for kids on Medicaid or SCHIP. But our capacity is very limited. The average time for a new patient appointment is 3 months. It is one of the principal sites in the Commonwealth where Virginia's future child mental health professionals are trained. In view of the recent tragedy at Virginia Tech, this role is of heightened importance. Acknowledging the limited availability of mental health services available in many communities – especially for the uninsured, emergency departments have begun to play a significant role in addressing the issues of patients in need of psychiatric care. The VCU Health System Emergency Department has responded to this need through the creation of programs such as a Crisis Stabilization Unit. This program, which cares for over 450 patients annually, provides an area for patients discharged from the emergency department who still require intervention for up to 23 hours and intensive support for psychiatric issues. With close to 50% of our emergency room volume

represented by Medicaid and indigent patients, there is an ongoing need to make these types of services readily accessible for those in need.

Medicaid Payments for Graduate Medical Education

The teaching hospital mission of training the next generation of physicians has never been more important. According to the U.S. Census Bureau, the number of elderly will double by 2030. With this will come a sizable increase in demand for health care services. According to data from the National Ambulatory Medical Care Survey, patients aged 65 and older typically average six to seven physician visits per year. If the annual number of physician visits continues at this rate, the U.S. population will make 53 percent more trips to the doctor in 2020 than in 2000, which means that we will need to produce many more physicians per year than we are producing now. The Health Resources and Services Administration's (HRSA) Bureau of Health Professions projects that the nation will have a shortage of at least 55,000 physicians by the year 2020. This has enormous implications for health care policy. Indeed, given the amount of time it takes to educate and train a physician—four years of medical school, plus multiple years of residency training—2020 is now, and we must take action immediately. In fact the Federal Council on Graduate Medical Education (COGME) issued a report in 2005, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, that recommended that medical school enrollment be increased and that the cap on resident positions supported by the Medicare program be increased.

Many state Medicaid programs have long recognized the need to make additional payments to teaching hospitals to help offset additional costs these facilities incur as a result of their special missions of educating physicians and caring for patients who require more intense, complex care. Following Medicare's lead, many states have implemented two payments similar to the direct graduate medical education (DGME) payment (for residency education costs) and the indirect medical education (IME) payment (for higher patient care costs) under Medicare's system. According to a study

commissioned by the AAMC, in 2005, 47 states and the District of Columbia provided DGME and/or IME payments under their Medicaid programs. As mentioned earlier, the nation's major teaching hospitals provide a disproportionate amount of health care services for Medicaid beneficiaries and the uninsured, while simultaneously maintaining core missions of medical education, biomedical research, and innovative patient care. Given these vital and unique missions, it is important that the Medicaid program and states be allowed to maintain their financial commitments to teaching hospital missions.

However, CMS's proposed rule would rescind important support for teaching hospitals by seeking to eliminate the payments that support the direct costs associated with residency education. Specifically, the proposed rule would modify 42 C.F.R. §447.201 by adding a new section (c) that states that state Medicaid plans:

Must not include payments for graduate medical education to any provider or institution or include costs of graduate medical education as an allowable cost under any cost-based payment system. . . .

Additionally, the proposed rule would modify the Medicaid upper payment limit (UPL) regulations at 42 C.F.R. §447.272(b) to exclude Medicare direct GME payments from the UPL calculations.

We were surprised and greatly disappointed by CMS' decision to pursue this action given the important role of teaching hospitals in caring for Medicaid patients and training the physicians that serve them. As noted in the attached AAMC comment letter submitted in response to the proposed rule, this rule would undo a history of support that has extended more than twenty years. CMS and its predecessor, the Health Care Financing Administration, have long recognized GME as an authorized Medicaid expenditure and consistently have approved state plans and matched state Medicaid GME payments.

The decision by CMS to propose this action is even more alarming because of the agency's recognition that the "Federal Government has no way to directly determine the number of States making GME payments, amounts States are spending or claiming as GME or the total number of hospitals receiving such payments." Not surprisingly, we believe that the Agency underestimates the impact of eliminating DGME payments partly because of their inability to capture these payments as well as their erroneous assumption that States would use other options to address funding for graduate medical education.¹

Impact on the Physician Workforce

Because the Medicaid proposed rule on GME would endanger the ability of teaching hospitals to maintain their mission of training physicians, it represents surprising disregard for the future viability of our nation's healthcare system. The timing of this proposal is problematic, as the U.S. faces a looming physician shortage in conjunction with a rise in the healthcare demands of baby boomers. The mission of our teaching hospitals to train the next generation of physicians is more important than ever, yet training programs face severe funding cuts. Eliminating Medicaid GME funding would be dangerously shortsighted.

Medicaid GME payments help teaching hospitals sustain a core responsibility: providing clinical education for future physicians. Within a supervised patient care team of health care professionals, physician residents provide needed care to Medicaid and other patients as part of their training programs. These clinical experiences prepare them for their future independent practice of medicine and help ensure the competencies necessary to care for vulnerable populations. Training future physicians and other health care professionals has never been more important given the numerous studies predicting current and future physician shortages.

¹ Federal Register/ Vol 72, No. 99/ May 23, 2007/ Proposed Rule p. 28935.

Implications for Virginia and VCU

Virginia makes both Direct and Indirect Medical Education payments through Medicaid using methodologies similar to those used to determine Medicare's payments. Payments for to the VCU Health System for Medicaid Direct Medical Education were \$6.7M in fiscal year 2007. The federal and state portions of these payments are split approximately 50:50. If these Medicaid GME payments were reduced, or worse – eliminated, our teaching hospital would be faced with a Hobson's choice: reduce costs or curtail efforts to continue to modernize our aging physical plant. I suspect we would most likely choose the former, because, like most teaching hospitals, our physical plant is already disadvantaged compared to other hospitals in the community. And, since our role is to be the place where cutting edge technologies and procedures are first developed, and evaluated, we are in a very capital-intensive environment. For instance, MCV Hospitals was one of 3 teaching hospitals in the U.S. where the techniques for the world's first heart transplant were developed. Thus, most teaching hospitals will be forced to reduce their costs – and reductions in Medicaid GME may lead to reductions in training positions for the physicians who care for Medicaid and other patients. For instance, training slots for pediatricians and obstetricians could be affected, decreasing access for all patients now and in the future. At the VCU Health System, we have 63 pediatric post-graduates and 24 post-graduates in obstetrics and gynecology.

Concern About Other Recent Regulatory Changes to Medicaid

As our fellow panelists have discussed/will discuss in greater detail, CMS has either finalized or proposed several other rules that will further reduce Medicaid payments to hospitals such as mine. My organization is greatly troubled by the impact they will have. Over the past 3 decades there has been a migration of

approximately 750 hospital beds from the city of Richmond to the surrounding suburbs. These beds, which were not replaced, were lost due to the closure of 4 major hospitals in the city, 3 of which subsequently relocated to the suburbs. At the present time, there is only one major hospital in the inner city of Richmond. I am the CEO of the health system that includes that hospital. Thus, the VCU Health System is the last remaining health system in downtown Richmond.

Our nation's teaching hospitals will be the first to celebrate health reform that expands health care coverage to the nation's uninsured and disadvantaged. However, it would be illogical to first reduce Medicaid payments, inter-governmental transfers and upper payment level payments before consensus has been developed on how to expand health care coverage. We know the nation's disadvantaged walk a very thin tightrope – their safety net is threadbare and frayed.

Teaching hospitals are disproportionately represented among the nation's safety net hospitals. Like other teaching hospitals in major metropolitan areas, and those in rural settings, the VCU Health System embraces care of the disadvantaged as one of its core missions – and we do so judiciously, often with innovation. Thus, at VCU, like many teaching hospitals, we have been effective stewards of Medicaid funds. For instance, we established the Virginia Coordinated Care Program (VCC). Through the VCC, we have contracted with under-represented minority primary care physicians in the inner city to see uninsured patients who, otherwise, would crowd our emergency rooms. This program has been funded from our bottom line generated from commercial payors, not from Medicaid, IGT payments or UPL sources.

There have been several moments of moral victory in the fight for health care for the disadvantaged in the nation's history. It began with Title XVIII and Title XIX in 1965, with the enactment of Medicare and Medicaid, respectively. In recent years, there was SCHIP, which added millions of uninsured children to the rolls of those with health care coverage. Now, at the dawn of a Presidential election that promises to include health care as a centerpiece of the debate, why would Congress support a decrease of funding

to the most vulnerable members of our population? At a time when experts are acknowledging significant physician workforce shortages over the next 10 to 15 years, why would Congress adopt a policy that sharply reduces funds for training the current level of graduate physicians?

We are also troubled by the poor policy judgments and unreasonable regulatory process utilized by CMS. In fact, we believe that the language of the proposed rule on Medicaid payments for outpatient services violates the current moratorium by excluding GME costs from the outpatient upper payment limit calculation.

Lastly, there is an additional concern that needs to be acknowledged. Since the middle 1990s, more than two-thirds of state Medicaid programs have moved to develop managed care arrangements for their beneficiaries. Virginia is one of those states, and approximately half of Virginia's Medicaid beneficiaries are enrolled in a managed care plan. And yet, under managed care, Medicaid support for GME is at risk. For instance, while Medicaid managed care rates include historical payments for GME in some states, the managed care organizations are not bound to distribute these dollars to hospitals. Many states make Medicaid GME payments directly to teaching hospitals under capitated managed care, but this policy is inconsistent.

Conclusion

For 40 years, the Medicaid program, major teaching hospitals, and medical schools have collaboratively ensured that all patients, including Medicaid beneficiaries, can access the healthcare services they need. Through graduate medical education training programs and Medicaid GME payments, they have also assured that all patients continue to have a sufficient supply of physicians well into the future.

We believe strongly that if Medicaid's support for teaching hospitals and medical schools deteriorates, then their very missions will be in great jeopardy. If their patient

care, research and educational infrastructure begins to falter, the effects will be extremely difficult to reverse. Most of the uninsured and Medicaid beneficiaries are hard-working Americans who are either self-employed, or are employed in small businesses that cannot afford health care coverage for their employees. Over the past 20 years, despite modest health care reforms, we have made little progress in reducing the total number of our citizens who remain uninsured. For Medicaid, there has been growth in the number of beneficiaries, at least in part because of erosion of employer-based coverage in recent years. In essence, these programs have been necessary for us to stay-in-place. Without the nation's safety net, many of our most vulnerable citizens would have fallen. With 47 million Americans uninsured, and another 40 million on Medicaid, the safety net is stretched tight and teaching hospitals are holding the corners.

I thank you for the opportunity to testify today. I'm sure my fellow teaching hospital and medical school leaders and the AAMC look forward to working closely with you on these issues, which are of such importance to the health and well-being of all Americans.

Chairman WAXMAN. Thank you very much, Dr. Retchin.
Dr. Gardner.

STATEMENT OF ANGELA GARDNER

Dr. GARDNER. Thank you, Mr. Chairman and members of the committee. My name is Dr. Angela Gardner. I am an assistant professor at the University of Texas Medical Branch in Galveston. I have been providing emergency care to Texans for more than 20 years. I am also vice president of the Board of Directors for the American College of Emergency Physicians [ACEP]. We represent 25,000 emergency physicians in 53 chapters across the Nation.

I would like to thank you for allowing me to testify today on behalf of ACEP to discuss the impact on vulnerable populations and safety net hospitals if CMS is allowed to reduce Medicaid payments to States by approximately \$5 billion, as it has proposed to do in the regulatory process. Today I would like to share with you several important factors that make the care received in the emergency department unique and how the proposed Medicaid cuts will further erode access to life-saving emergency medical care in Texas and the rest of the Nation.

Actually, I would like to tell you a story.

I worked in the emergency department on Tuesday night, and on my arrival all 48 of my beds were full. We had 22 patients in the hallway. We had 14 patients in the waiting room. We had three ambulances unloading and two helicopters waiting to land. That is a normal day. And, as I hear from Dr. Retchin and Mr. Aviles, that is a normal day in New York and Denver and San Francisco, as well.

When I arrived, 25 percent of my beds were taken up by patients who were waiting on a bed inside the hospital, four of those on respirators waiting on ICU beds. This is a normal Tuesday night.

At midnight I got a patient who arrived to me comatose from the back seat of his mother's car. He had been driven 250 miles to my emergency department to get our care. I will call this man Norman to preserve his privacy.

Norman had been having headaches for about a month. On the third week, when his right hand wouldn't work any more and he started vomiting, his mother said, you have to go to the hospital. They went to the emergency department at their local hospital, where he was diagnosed with a brain tumor on the left side of his brain.

They don't have a neurosurgeon at this hospital—and this is a regular-sized city—so they called UTMB for a transfer. We accepted the patient to neurosurgical service.

Unfortunately, we didn't have a bed. The process is he has been put on a list to get a bed when one becomes available.

After waiting 8 days for his bed in the hospital there in his home town, Norman, in pain and vomiting and unable to move out of that bed, begged his parents to take him home to die, and they did.

He went home to die, and when he became comatose his mother loaded him in the back seat and brought him to me. I put him on a ventilator. I gave him drugs. I got him a neurosurgeon. What I could not get him was a bed.

If you will excuse me, this is emotional. I left the hospital Wednesday morning. I do not know if Norman died, but I believe that he will die in that trauma bay. He will never see the inside of a hospital. He will have his neurosurgeon, but he will not have a bed.

As you sit here and absorb the impact of the story, I would like to let you know something. Norman is not indigent. Norman is a working man with health insurance. The problem with the cuts that Medicaid wants to make, the cuts to Medicaid that are being proposed, is that it affects not only the indigent but everyone out there. This could happen to you, it could happen to someone that you love.

Of our children in Texas, 32 percent are on Medicaid. Another 18 percent of them are uninsured. That is 50 percent of our children who are under-insured or lacking access to health care. I can't see that any cut in that program is going to help anyone.

More to the point, we don't have beds, and we don't have beds in the same way that New York doesn't, in the same way that other colleges in Virginia don't. Cutting our programs is not going to give us beds. It is not going to help people like Norman, whose main need is a neurosurgeon and a bed.

I would like to wrap up today by thanking you for allowing me to be here, by tolerating my emotion for my patients, and by asking you: please, don't cut funding to our valuable public hospitals.

[The prepared statement of Dr. Gardner follows:]

Statement of

Angela F. Gardner, M.D., F.A.C.E.P.

Assistant Professor
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American College of Emergency Physicians (ACEP)
Vice President
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before the

House Committee on Oversight and Government Reform
U.S. House of Representatives

Hearing on

"The Administration's Regulatory Actions on Medicaid: The
Effects on Patients, Doctors, Hospitals, and States"

Presented
November 1, 2007

Introduction

Mr. Chairman and members of the committee, my name is Angela Gardner, M.D., F.A.C.E.P. I am a practicing emergency physician from Texas where I have treated patients for more than 20 years. I completed my emergency medicine residency and internship at the Texas Tech Regional Academic Health Center in El Paso, Texas. Currently, I serve as an Assistant Professor in the Division of Emergency Medicine, Department of Surgery, at the University of Texas Medical Branch, as well as Vice President of the American College of Emergency Physicians' (ACEP) Board of Directors.

ACEP is the largest specialty organization in emergency medicine, with more than 25,000 members committed to improving the quality of emergency care through continuing education, research, and public education. ACEP has 53 chapters representing each state, as well as Puerto Rico and the District of Columbia, and a Government Services Chapter representing emergency physicians employed by military branches and other government agencies.

Thank you for allowing me to testify today on behalf of ACEP to discuss the severe impact on vulnerable populations and safety net hospitals if the Centers for Medicare & Medicaid Services (CMS) is allowed to reduce Medicaid payments to states by approximately \$5 billion, as it has proposed to do through the regulatory process. Today, I will share with you several important factors that make the care received in the emergency department unique and how the proposed Medicaid cuts will further erode access to lifesaving emergency medical care for everyone – not just the uninsured – in my home state of Texas, as well as around the country.

Let me begin by expressing our belief that Medicaid is an essential component of the nation's health care safety net. Since the program's inception in 1965, it has improved the health of millions of people who might otherwise have gone without medical care for themselves and their children. Medicaid provides access to health care for more than 50 million Americans and is vital to hospitals and other health providers serving this vulnerable population.

Background of CMS Regulation

On January 18, 2007, CMS published a draft regulation in the *Federal Register* that would alter the criteria of eligible state funds used for the non-federal share of Medicaid. CMS has stated its goal is to improve the fiscal integrity of the Medicaid program and ensure that states are held accountable for sources and amounts of funds used to secure federal matching dollars. However, we take issue with the restrictions in the proposed definitions of the sources of eligible state funds and what is considered an allowable payment to public providers. **There is no question that this proposal will jeopardize the viability of public and other safety net hospitals.**

For a number of years, CMS' Medicaid policy permitted payment to public hospitals that was greater than actual costs in recognition of the burden public hospitals bore for uncompensated care and for the fact that Medicaid payment rates are often below provider costs. In many cases, these policies have been approved by CMS through annual state plan amendments.

Reducing Medicaid payments to states by approximately \$5 billion, with no transition period, would further impair an already overtaxed public health system held together by doctors and nurses who are still dedicated to providing the best care for their patients. It is unrealistic to expect that states will be able to fund this shortfall, and we are deeply concerned that states will limit Medicaid eligibility, be forced to reduce benefits, or further reduce provider payments. Any of these options would not only harm access to primary care and specialty medical services for Medicaid beneficiaries, but the result would disproportionately burden America's already strained emergency departments, which will affect everyone's access to emergency care.

In my home state, about 3.7 million Texans (16.2 percent of the state's population) lived at or below the federal poverty level in 2005, and approximately 39 percent of these were children under age 18. Thirty-two percent of all children are enrolled in Medicaid. It is estimated that another 1.3 million children are uninsured, placing Texas 51st (worst) in a state ranking performed by "The Commonwealth Fund." Thirty percent of adults (ages 18 – 64) and 20 percent of children (up to age 17) are uninsured in Texas, also resulting in a 51st ranking among all states. Most telling of all, nearly 20 percent of Texas adults reported that they went without seeing a doctor when needed because they could not afford the care.

Current State of Emergency Care

According to the most recent Centers for Disease Control and Prevention (CDC) report, more than 115 million patient visits were made to emergency departments in 2005, representing a 20 percent increase in patient visits over 10 years. During this same period, the number of emergency departments in this country decreased by nine percent. Medicaid/SCHIP beneficiaries accounted for more than 28 million (24 percent) of emergency department visits in 2005.

Along with the increase in volume and decrease in capacity over the past decade, emergency departments have been faced with numerous other challenges. According to the findings of the Institute of Medicine (IOM) report "Hospital-Based Emergency Care: At the Breaking Point," released in June 2006, emergency departments are overcrowded, surge capacity is diminished or being eliminated altogether, ambulances are diverted to other hospitals, patients admitted to the hospital are waiting longer for placement to inpatient floors, and the shortage of medical specialists is worsening. Simply put, our patients are suffering at an alarming and increasing rate.

It is imperative that policymakers understand the environment and the impediments to care that our patients face on a daily basis – and how payment cuts will contribute to the collapse of our nation's safety net health care system that is barely being held together now. With that knowledge, you will have a better sense of how access to emergency care will be further harmed by the CMS rule. For this reason, I would like to explain in some detail the issues that make emergency departments unique among all health care providers.

EMTALA

First, and foremost, is the federal mandate of the Emergency Medical Treatment and Labor Act (EMTALA) of 1986. The congressional intent of EMTALA, which requires hospitals to provide emergency medical care to everyone who requests it, regardless of their ability to pay or insurance status, was commendable and ACEP has long supported its goals as being consistent with the mission of emergency physicians.

However, having the only universal mandate for providing health care in this country, America's emergency departments have become a portal for providing care to individuals from all walks of life, rich and poor, children and adults, insured and uninsured. There is a popular perception that the United States already has universal health care coverage because the emergency department treats everyone equally, regardless of their ability to pay, and we are open 24 hours a day, seven days a week, 365 days a year.

Medicaid pays most health care providers less than the cost of providing that care. ACEP believes cuts of the magnitude projected under the proposed rule will adversely affect access and the viability of our nation's safety net providers. As Medicaid physician payment continues to lose ground to growing practice costs, fewer physicians will accept Medicaid and even more recipients will end up seeking care in the emergency department.

Emergency physicians believe we have an ethical and moral obligation to provide this care, but we are operating at or over capacity on a daily basis with already limited resources at our disposal. The health care safety net that we provide is at the breaking point. The impact of the CMS rule on emergency department overcrowding, availability of on-call specialists, reimbursement, ambulance diversion and lack of surge capacity, would only reduce our limited resources further with potentially devastating consequences to every community around the country.

Emergency Department Overcrowding

Every day in emergency departments across America, critically ill patients line the halls, waiting hours – sometimes days – to be transferred to inpatient beds. This causes gridlock, which means other patients often wait hours to see physicians, and some leave without being seen or against medical advice. Contributing factors to overcrowding

include reduced hospital resources, which would be further restricted under the CMS rule; a lack of hospital inpatient beds; a growing elderly population and an overall increase in emergency department utilization; and nationwide shortages of nurses, physicians and hospital technical and support staff.

I would also like to dispel the misconception that emergency department overcrowding is caused by patients seeking treatment for non-urgent care. According to the latest CDC emergency department data, less than 14 percent of all emergency department visits are classified as "non-urgent," meaning the patient needed to be treated within 24 hours.

Overall, almost 70 percent of the patients arriving at the emergency department need to be seen within two hours and 15.3 percent of those patients need to be seen within 15 minutes.

In addition, emergency care is cost efficient, representing less than 5 percent of the nation's \$1.5 trillion in health care expenditures. While emergency departments have additional "stand-by" costs because we are available 24 hours a day, the average cost of a non-urgent visit to an emergency department is comparable to a private physician's office visit.

On-Call Shortage

As indicated by the IOM report, another factor that directly affects emergency patient care, which will be made worse by the CMS proposal, is the shortage of on-call specialists due to: fewer practicing emergency and trauma specialists; lack of compensation for providing these services to a high percentage of uninsured and underinsured patients; substantial demands on physicians with busy practices outside the hospital; increased risk of being sued/high insurance premiums and the relaxed EMTALA requirements for on-call panels.

Reimbursement and Uncompensated Care

The patient population can vary dramatically from hospital to hospital, and the differences in payer-mix have a substantial affect on a hospital's financial condition. Of the 115 million emergency department visits in 2005, people with private insurance represented nearly 40 percent, 25 percent were Medicaid or SCHIP enrollees, 17 percent were Medicare beneficiaries and another 17 percent were uninsured. These numbers demonstrate the large volume of care provided in the emergency department to individuals who are underinsured or uninsured.

According to an American Hospital Association (AHA) statement from 2002, 73 percent of hospitals lose money providing emergency care to Medicaid patients while 58 percent lose money for care provided to Medicare patients. Even private insurance plans still frequently deny claims for emergency care because the visit was not deemed an emergency in spite of the "prudent layperson standard" which ACEP has strongly advocated for years.

While emergency physicians stand ready to treat anyone who arrives at their emergency department, uncompensated care can be an extreme burden at hospitals that have a high volume of uninsured patients, which now exceeds 47 million Americans and continues to rise. Hospital emergency departments are the providers of last resort for many people, including undocumented aliens, who have no other access to medical care. As such, emergency departments experience a high-rate of uncompensated care.

Ambulance Diversion

A potentially serious outcome from overcrowded conditions and lack of resources in the emergency department is ambulance diversion. The GAO reported two-thirds of emergency departments diverted ambulances to other hospitals during 2001, with crowding most severe in large population centers where nearly one in 10 hospitals reported being on diversion 20 percent of the time (more than four hours per day). A study released in February 2006 by the National Center for Health Statistics/CDC found that, on average, an ambulance in the United States is diverted from a hospital every minute because of emergency department overcrowding or bed shortages. According to the AHA, nearly half of all hospitals (46 percent) reported time on diversion in 2004, with 68 percent of teaching hospitals and 69 percent of urban hospitals reporting time on diversion.

As you can see from the data provided, this nation's emergency departments are having difficulty meeting the day-to-day demands placed on them. Overcrowded emergency departments lead to diminished patient care and ambulance diversion. We must take steps now to avoid a catastrophic failure of our medical infrastructure and we must take steps now to create capacity, alleviate overcrowding and improve surge capacity in our nation's emergency departments.

Conclusion

Unless Congress acts decisively, the moratorium enacted in May will expire and the nation's public hospitals and emergency departments will sustain a devastating fiscal blow from which recovery may be impossible. Congress has three times this year sent a loud and clear signal to the nations most vulnerable – our children – that providing them with health care is a priority. Let's be equally resolute in this hour of need for the poor individuals and families served by the Medicaid program.

Chairman WAXMAN. Thank you very much, Dr. Gardner.
Dr. Kanof.

STATEMENT OF MARJORIE KANOF

Dr. KANOF. Mr. Chairman, Mr. Davis, and members of the committee, I am also pleased to be here with you today as you explore recent regulatory actions of CMS related to the Medicaid program and the potential impacts of these actions on patients, providers, and States. I think we have heard several examples of this this morning.

Medicaid fulfills a crucial role in providing health coverage for a variety of vulnerable populations, but ensuring the program's long-term sustainability is critically important.

Starting in the early 1990's and as recently as 2004, we and others identified inappropriate Medicaid financing arrangements in some States. These arrangements often involved supplemental payments made to government providers that were separate from and in addition to those made at a State's typical Medicaid payment rates.

In March 2007, we reported on a CMS initiative that was started in 2003 to end these inappropriate arrangements. My remarks today will focus on Medicaid financing arrangements involving supplemental payments to government providers. I will discuss our findings on these financial arrangements, including their implications for the fiscal integrity of the Medicaid program and on CMS' initiative begun in 2003 to end these.

In summary, for more than a decade we and others have reported on financing arrangements that inappropriately increased Federal Medicaid matching payments. In these arrangements, States received Federal matching funds by paying certain government providers, such as county-owned or-operated nursing homes, amounts that greatly exceeded Medicaid rates. In reality, the large payments were often temporary, since States could require the government providers to return all or most of the money back to the States.

States could use these Federal matching funds received in making these payments, which essentially made a round trip from the State to the provider and back to the State, at their own discretion. Such financing arrangements have significant fiscal implications for the Federal Government and the States. The exact amount of additional Federal Medicaid funds generated through these arrangements is unknown, but it is estimated that it was billions of dollars.

Despite congressional and CMS action taken to limit such arrangements, we have found, even in recent years, that improved Federal oversight was still needed.

Because they effectively increased the Federal Medicaid share above what is established by law, these arrangements threaten the fiscal integrity of Medicaid's Federal and State partnership. They shift costs inappropriately from the State to the Federal Government and take funding intended for covered Medicare costs from providers who do not under these arrangements retain the full payment.

The consequences of this arrangement are illustrated in one State's arrangement in 2004 which increased Federal expenditures without a commensurate increase in State spending. The State made a \$41 million supplemental payment to a local government hospital. Under its Medicaid matching formula, the State paid \$10.5 million, CMS paid \$30.5 million as the Federal share of a supplemental payment. After receiving the supplemental payment, however, in a very short time the hospital transferred back to the State approximately \$39 million of the \$41 million payment, retaining just \$2 million.

This March we reported on CMS' initiative to more closely review State financing arrangements through their State plan amendment process. From August 2003, to August 2006, 29 States ended one or more arrangements for financing supplemental payments because providers were not retaining the Medicaid payment for which States had received Federal matching funds.

We found CMS' action to be consistent with Medicaid payment principles that payment for services is consistent with efficiency and economy. We also found, however, that the initiative lacked transparency, and that CMS had not issued any written guidance about the specific approval standards.

When we contacted 29 States, only 8 reported receiving any written guidance or clarification from CMS. State officials told us it was not always clear what financing arrangements were allowed and why arrangements were approved or not approved. This lack of transparency raised questions about the consistency with which States had been treated in ending their financial arrangements.

We recommended that CMS issue guidance about allowable financial arrangements.

In conclusion, as the Nation's health care safety net, the Medicaid program is of critical importance to beneficiaries and providers. The Federal Government and States have a responsibility to administer the program in a manner that ensures expenditures benefit those low-income people for whom benefits were intended.

Congress and CMS have taken important steps to improve the financial management of Medicaid, yet more can be done to ensure the accountability and fiscal integrity of the Medicaid program.

Mr. Chairman, this concludes my statement. I will be happy to answer questions.

[The prepared statement of Dr. Kanof follows:]

United States Government Accountability Office

GAO

Testimony
Before the Committee on Oversight and
Government Reform, House of
Representatives

For Release on Delivery
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MEDICAID FINANCING

Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight

Statement of Dr. Marjorie Kanof, Managing Director
Health Care



November 1, 2007



Highlights of GAO-08-255T, a testimony before the Committee on Oversight and Government Reform, House of Representatives

MEDICAID FINANCING

Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight

Why GAO Did This Study

Medicaid, a joint federal-state program, financed the health care for about 60 million low-income people in fiscal year 2005. States have considerable flexibility in deciding what medical services and individuals to cover and the amount to pay providers, and the federal government reimburses a proportion of states' expenditures according to a formula established by law. The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for overseeing Medicaid.

Growing pressures on federal and state budgets have increased tensions between the federal government and states regarding this program, including concerns about whether states were appropriately financing their share of the program. GAO's testimony describes findings from prior work conducted from 1994 through March 2007 on (1) certain inappropriate state Medicaid financing arrangements and their implications for Medicaid's fiscal integrity, and (2) outcomes and transparency of a CMS oversight initiative begun in 2003 to end such inappropriate arrangements.

What GAO Found

GAO has reported for more than a decade on varied financing arrangements that inappropriately increase federal Medicaid matching payments. In reports issued from 1994 through 2005, GAO found that some states had received federal matching funds by paying certain government providers, such as county operated nursing homes, amounts that greatly exceeded established Medicaid rates. States would then bill CMS for the federal share of the payment. However, these large payments were often temporary, since some states required the providers to return most or all of the amount. States used the federal matching funds obtained in making these payments as they wished. Such financing arrangements had significant fiscal implications for the federal government and states. The exact amount of additional federal Medicaid funds generated through these arrangements is unknown, but was in the billions of dollars. Because such financing arrangements effectively increase the federal Medicaid share above what is established by law, they threaten the fiscal integrity of Medicaid's federal and state partnership. They shift costs inappropriately from the states to the federal government, and take funding intended for covered Medicaid costs from providers, who do not under these arrangements retain the full payments.

In 2003, CMS began an oversight initiative that by August 2006 resulted in 29 states ending inappropriate financing arrangements. Under the initiative, CMS sought satisfactory assurances that a state was ending financing arrangements that the agency found to be inappropriate. According to CMS, the arrangements had to be ended because the providers did not retain all payments made to them but returned all or a portion to the states. GAO reported in 2007 that, although CMS's initiative was consistent with Medicaid payment principles, it was not transparent in implementation. CMS had not used any of the means by which it normally provides states with information about Medicaid program requirements, such as the published state Medicaid manual, standard letters issued to all state Medicaid directors, or technical guidance manuals. Such guidance could be helpful to inform states about the specific standards it used for reviewing and approving states' financing arrangements. In May 2007, CMS issued a final rule that would limit Medicaid payments to government providers' costs. GAO has not reported on CMS's rule.

To view the full product, including the scope and methodology, click on GAO-08-255T. For more information, contact Marjorie Kanof at (202) 512-7114 or kanofm@gao.gov.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you explore recent regulatory actions of the administration related to the Medicaid program and the potential effects of these actions on patients, providers, and states. Medicaid, a joint federal and state program that covered about 60 million people in fiscal year 2005, fulfills a crucial role in providing health coverage for a variety of vulnerable populations, including certain low-income children, families, and individuals who are aged or disabled. Ensuring the program's long-term sustainability is therefore very important.

The federal government and the states share responsibilities for financing and administering Medicaid. Within broad federal requirements, states have considerable flexibility in deciding what medical services and individuals to cover and the amount to pay providers, and the federal government reimburses a proportion of states' expenditures according to a formula established by law.¹ The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for overseeing states' Medicaid programs and ensuring the propriety of expenditures for which states seek federal reimbursement. Total Medicaid expenditures are significant and growing, totaling an estimated \$317 billion in fiscal year 2005, and are expected to continue to grow.²

Growing pressures on federal and state budgets have increased tensions between the federal government and the states regarding Medicaid. In recent years, tensions have arisen regarding CMS's actions in overseeing the appropriateness of provider payments for which states have sought federal reimbursement, including whether states were appropriately financing their share, that is, the nonfederal share of these payments. Starting in the early 1990's and as recently as 2005, we and others have reviewed aspects of inappropriate Medicaid financing arrangements in some states, often involving supplemental payments made to government providers that were above and beyond states' typical Medicaid payment rates. We have also reviewed CMS's oversight of such arrangements, most recently reporting in March 2007 on an initiative started in 2003 to end inappropriate arrangements. In May 2007 CMS issued a final rule that

¹States and the federal government share in Medicaid expenditures. The federal share can range from 50 to 83 percent.

²This figure represents estimated federal and state Medicaid program expenditures for provider services and administration in fiscal year 2005.

would affect state Medicaid financing arrangements. In my testimony today I will summarize and describe our findings (1) on past inappropriate state Medicaid financing arrangements, including their implications for the fiscal integrity of the Medicaid program; and (2) on the outcomes and transparency of CMS's 2003 initiative, which provides context for considering the effect of the May rule on various stakeholders. My testimony is based on our previous work assessing various Medicaid financing arrangements and federal oversight of these arrangements. We conducted this body of work from June 1993 through March 2007. We have not reported on CMS's May 2007 rule. We conducted our work in accordance with generally accepted government auditing standards.

In summary, we have reported for more than a decade on varied financing arrangements that inappropriately increase federal Medicaid matching payments. In reports issued from 1994 through 2005, we reported on various arrangements whereby states received federal matching funds by paying certain government providers, such as county owned or operated nursing homes, amounts that greatly exceeded established Medicaid rates.³ The large payments were often temporary since some states required the government providers to return all or most of the money to the states. States used the federal matching funds received for these payments—which essentially made a round-trip from the states to providers and back to the states—at their own discretion. Such financing arrangements had significant fiscal implications for the federal government and states. The exact amount of additional federal Medicaid funds generated through these arrangements is not known, but was in the billions of dollars. Despite congressional and CMS action taken during those years to limit such arrangements, we found in recent years that improved federal oversight of such arrangements was needed. Because such financing arrangements effectively increase the federal Medicaid share above what is established by law, they threaten the fiscal integrity of Medicaid's federal and state partnership. They shift costs inappropriately from the states to the federal government, and take funding intended for Medicaid providers, who do not under these arrangements retain the full payments.

CMS's oversight initiative, started in 2003 to end inappropriate state financing arrangements, by August 2006 had resulted in 29 states ending financing arrangements in which providers did not retain the supplemental payments they received. Although we found that CMS's initiative was

³See related GAO products at the end of this statement.

consistent with Medicaid payment principles, we also found that more transparency was needed regarding the way in which CMS was implementing its initiative and the review standards it was using to end certain financing arrangements. For example, to inform states about the specific standards it used for reviewing and approving states' financing arrangements under its new initiative, CMS had not used any of the means by which it typically provides information to states about the Medicaid program, such as its published state Medicaid manual, standard letters issued to all state Medicaid directors, or technical guidance manuals. Consequently, states were concerned about standards that were applied in CMS's review of their arrangements and the consistency with which states were treated. These observations provide some context for the controversy surrounding CMS's May 2007 rule. We have not reported on CMS's May 2007 rule or other rules related to Medicaid financing issued this year. The extent to which the rule will address concerns about the transparency of CMS's initiative and review standards will depend on how CMS implements it.

Background

Title XIX of the Social Security Act establishes Medicaid as a joint federal-state program to finance health care for certain low-income children, families, and individuals who are aged or disabled.⁴ Medicaid is an open-ended entitlement program, under which the federal government is obligated to pay its share of expenditures for covered services provided to eligible individuals under each state's federally approved Medicaid plan. States operate their Medicaid programs by paying qualified health care providers for a range of covered services provided to eligible beneficiaries and then seeking reimbursement for the federal share of those payments.⁵

CMS has an important role in ensuring that states comply with statutory Medicaid payment principles when claiming federal reimbursements for payments made to institutional and other providers who serve Medicaid beneficiaries. For example, Medicaid payments must be "consistent with efficiency, economy, and quality of care,"⁶ and states must share in

⁴42 U.S.C. §§ 1396 et seq. (2000).

⁵Throughout this statement, we refer to funds used by state Medicaid programs to pay providers for rendering Medicaid services as "payments." We refer to federal funds received by states from CMS for the federal share of states' Medicaid payments as "reimbursements."

⁶See 42 U.S.C. § 1396a(a)(30)(A) (2000).

Medicaid costs in proportions established according to a statutory formula.⁷

Within broad federal requirements, each state administers and operates its Medicaid program in accordance with a state Medicaid plan, which must be approved by CMS. A state Medicaid plan details the populations a state's program serves, the services the program covers (such as physicians' services, nursing home care, and inpatient hospital care), and the rates of and methods for calculating payments to providers. State Medicaid plans generally do not detail the specific arrangements a state uses to finance the nonfederal share of program spending. Title XIX of the Social Security Act allows states to derive up to 60 percent of the nonfederal share from local sources, as long as the state itself contributes at least 40 percent.⁸

Over the last several years, CMS has taken a number of steps to help ensure the fiscal integrity of the Medicaid program. These include making internal organizational changes that centralize the review of states' Medicaid financing arrangements and hiring additional staff to review each state's Medicaid financing. The agency also published in May 2007 a final rule related to Medicaid payment and financing.⁹ This rule would, among other things, limit payments to government providers to their cost of providing Medicaid services. The Secretary is prohibited by law from implementing the rule until May 25, 2008.¹⁰

⁷Under the formula, the federal government may pay from 50 to 83 percent of a state's Medicaid expenditures. States with lower per capita incomes receive higher federal matching rates. 42 U.S.C. § 1396d(b) (2000).

⁸See 42 U.S.C. § 1396a(a)(2) (2000). Local governments and local government providers can contribute to the nonfederal share of Medicaid payments through mechanisms known as intergovernmental transfers, or IGTs. IGTs are a legitimate feature in state finance that enable state and local governments to carry out their shared governmental functions, for example through the transfer of revenues between governmental entities.

⁹See 72 Fed. Reg. 29,748 (May 29, 2007).

¹⁰See Pub. L. No. 110-28, § 7002, 121 Stat. 112, 187 (2007).

**Concerns about
Certain Medicaid
Financing
Arrangements that
Undermine Medicaid's
Fiscal Integrity Are
Long-Standing**

From 1994 to 2005, we have reported numerous times on a number of financing arrangements that create the illusion of a valid state Medicaid expenditure to a health care provider. Payments under these arrangements have enabled states to claim federal matching funds regardless of whether the program services paid for had actually been provided. As various schemes have come to light, Congress and CMS took several actions from 1987 through 2002, through law and regulation, to curtail them (see table 1).

Table 1: Medicaid Financing Schemes Used to Inappropriately Generate Federal Payments and Federal Actions to Address Them, 1987–2002

Financing arrangement	Description	Action taken
Excessive payments to state health facilities	States made excessive Medicaid payments to state-owned health facilities, which subsequently returned these funds to the state treasuries.	In 1987, the Health Care Financing Administration (HCFA) issued regulations that established payment limits specifically for inpatient and institutional facilities operated by states.
Provider taxes and donations	Revenues from provider-specific taxes on hospitals and other providers and from provider "donations" were matched with federal funds and paid to the providers. These providers could then return most of the federal payment to the states.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 essentially barred certain provider donations, placed a series of restrictions on provider taxes, and set other restrictions for state contributions.
Excessive disproportionate share hospital (DSH) payments	DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the state and federal funds to the state.	The Omnibus Budget Reconciliation Act of 1993 placed limits on which hospitals could receive DSH payments and capped both the amount of DSH payments states could make and the amount individual hospitals could receive.
Excessive DSH payments to state mental hospitals	A large share of DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to the state treasuries.	The Balanced Budget Act of 1997 limited the proportion of a state's DSH payments that can be paid to state psychiatric hospitals.
Upper payment limit (UPL) for local government health facilities	In an effort to ensure that Medicaid payments are reasonable, federal regulations prohibit Medicaid from paying more than a reasonable estimate of the amount that would be paid under Medicare payment principles for comparable services. This UPL applies to payments aggregated across a class of facilities and not for individual facilities. As a result of the aggregate upper limit, states were able to make large supplemental payments to a few local public health facilities, such as hospitals and nursing homes. The local government health facilities then returned the bulk of the state and federal payments to the states.	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required HCFA to issue a final regulation that established a separate payment limit for each of several classes of local government health facilities. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals.

Source: GAO, Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes, GAO-04-547T (Washington, D.C., Mar. 18, 2004).

Note: Before June 2001, CMS was known as the Health Care Financing Administration (HCFA).

Many of these arrangements involve payment arrangements between the state and government-owned or government-operated providers, such as local-government-operated nursing homes. They also involved supplemental payments—payments states made to these providers separate from and in addition to those made at a state's standard Medicaid

payment rate. The supplemental payments connected with these arrangements were illusory, however, because states required these government providers to return part or all of the payments to the states.¹¹ Because government entities were involved, all or a portion of the supplemental payments could be returned to the state through an intergovernmental transfer, or IGT. Financing arrangements involving illusory payments to Medicaid providers have significant fiscal implications for the federal government and states. The exact amount of additional federal Medicaid funds generated through these arrangements is not known, but was in the billions of dollars. For example, a 2001 regulation to curtail misuse of the UPL regulation was estimated to have saved the federal government approximately \$17 billion from fiscal year 2002 through fiscal year 2006. In 2003, we designated Medicaid to be a program at high risk of mismanagement, waste, and abuse, in part due to concerns about states' use of inappropriate financing arrangements.¹²

Inappropriate Medicaid Financing Arrangements Undermine Medicaid's Fiscal Integrity

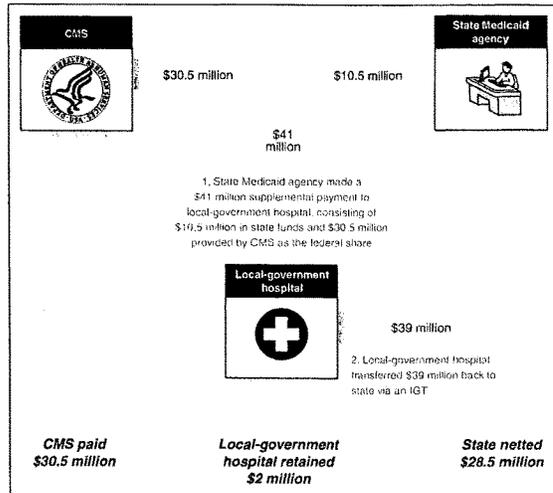
States' use of these creative financing mechanisms undermined the federal-state Medicaid partnership as well as the program's fiscal integrity in three ways. First, inappropriate state financing arrangements effectively increased the federal matching rate established under federal law by increasing federal expenditures while state contributions remained unchanged or even decreased. Figure 1 illustrates a state's arrangement in place in 2004 in which the state increased federal expenditures without a commensurate increase in state spending. In this case, the state made a \$41 million supplemental payment to a local-government hospital. Under its Medicaid matching formula, the state paid \$10.5 million and CMS paid \$30.5 million as the federal share of the supplemental payment. After

¹¹The two most common supplemental payments that involved illusory payments to government providers are upper payment limit, or UPL, payments and disproportionate share hospital, or DSH, payments. Illusory UPL payments are based on the misuse of Medicaid UPL provisions. UPLs are the federal government's way of placing a ceiling on the federal share of a state Medicaid program; they are the upper bound on the amounts the federal government will pay a state for the federal share of state spending on certain services. Some states made supplemental payments up to the UPL but then required the providers to return all or a portion of the payment. Under Medicaid law, states are required to make special hospital payments to supplement standard Medicaid payment rates and help offset costs for hospitals that serve a disproportionate share of low-income or uninsured patients; these payments came to be known as disproportionate share hospital, or DSH, payments.

¹²GAO, *Major Management Challenges and Program Risks: Department of Health and Human Services*, GAO-03-101 (Washington, D.C.: January 2003).

receiving the supplemental payment, however, the hospital transferred back to the state approximately \$39 million of the \$41 million payment, retaining just \$2 million. Creating the illusion of a \$41 million hospital payment when only \$2 million was actually retained by the provider enabled the state to obtain additional federal reimbursements without effectively contributing a nonfederal share—in this case, the state actually netted \$28.5 million as a result of the arrangement.

Figure 1: Example of How One State Increased Federal Medicaid Matching Funds without Increasing State Spending



Source: GAO analysis of one state's financing arrangement for state fiscal year 2004.

Second, CMS had no assurance that these increased federal matching payments were retained by the providers and used to pay for Medicaid services. Federal Medicaid matching funds are intended for Medicaid-covered services for the Medicaid-eligible individuals on whose behalf payments are made. Under these arrangements, however, payments for

such Medicaid-covered services were returned to the states which could then use the returned funds at their own discretion. In 2004, we examined how six states with large supplemental payment financing arrangements involving nursing homes used the federal funds they generated. As in the past, some states deposited excessive funds from financing arrangements into their general funds, which may or may not be used for Medicaid purposes. Table 2 provides further information on how states used their funds from supplemental payment arrangements, as reported by the six states we reviewed in 2004.

Table 2: Selected States' Use of Funds Generated through UPL Arrangements, as of January 2004

State	Use
Michigan	Funds generated by the state's UPL arrangement were deposited in the state's general fund but were tracked separately as a local fund source. These local funds were earmarked for future Medicaid expenses and used as the state match, effectively recycling federal UPL matching funds to generate additional federal Medicaid matching funds.
New York	Funds generated by the state's UPL arrangement were deposited into its Medical Assistance Account. Proceeds from this account were used to pay for the state share of the cost of Medicaid payments, effectively recycling federal funds to generate additional federal Medicaid matching funds.
Oregon	Funds generated by the state's UPL arrangement were used to finance education programs and other non-Medicaid health programs. UPL matching funds recouped from providers were deposited into a special UPL fund. Facing a large budget deficit, a February 2002 special session of the Oregon legislature allocated the fund balance, about \$131 million, to finance kindergarten to 12th grade education programs. According to state budget documents, the UPL funds were used to replace financing from the state's general fund.
Pennsylvania	Funds generated by the state's UPL arrangement were used for a number of Medicaid and non-Medicaid purposes, including long-term care and behavioral health services. In state fiscal years 2001–2003 the state generated \$2.4 billion in excess federal matching funds, of which 43 percent was used for Medicaid expenses (recycled to generate additional federal matching funds), 6 percent was used for non-Medicaid purposes, and 52 percent was unspent and available for non-Medicaid uses (does not total 100 percent because of rounding).
Washington	Funds generated by the state's UPL arrangement were commingled with a number of other revenue sources in a state fund. The fund was used for various state health programs, including a state-funded basic health plan, public health programs, and health benefits for home care workers. A portion of the fund was also transferred to the state's general fund. The fund was also used for selected Medicaid services and the State Children's Health Insurance Program (SCHIP), which effectively recycled the federal funds to generate additional federal Medicaid matching funds.
Wisconsin	Funds generated by the state's UPL arrangement were deposited in a state fund, which was used to pay for Medicaid-covered services in both public and private nursing homes. Because the state used these payments as the state share, the federal funds were effectively recycled to generate additional federal Medicaid matching funds.

Source: CMS and states.

Note: Information is based on work ending in January 2004. See GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228 (Washington, D.C.: Feb. 13, 2004).

Third, these state financing arrangements undermined the fiscal integrity of the Medicaid program because they enabled states to make payments to government providers that significantly exceeded their costs. In our view,

this practice was inconsistent with the statutory requirement that states adopt methods to ensure that Medicaid payments are consistent with economy and efficiency.

CMS Oversight Initiative to End State Financing Arrangements Lacked Transparency

Our March 2007 report¹³ on a recent CMS oversight initiative to end certain financing arrangements where providers did not retain the payments provides context for CMS's May rule. Responding to concerns about states' continuing use of creative financing arrangements to shift costs to the federal government, CMS has taken steps starting in August 2003 to end inappropriate state financing arrangements by closely reviewing state plan amendments on a state-by-state basis. As a result of CMS initiative, from August 2003 through August 2006, 29 states ended one or more arrangements for financing supplemental payments, because providers were not retaining the Medicaid payments for which states had received federal matching funds.

We found CMS's actions under its oversight initiative to be consistent with Medicaid payment principles—for example, that payment for services be consistent with efficiency and economy. We also found, however, that CMS's initiative to end inappropriate financing arrangements lacked transparency, in that CMS had not issued written guidance about the specific approval standards for state financing arrangements. CMS's initiative was a departure from the agency's past oversight approach, which did not focus on whether individual providers were retaining the supplemental payments they received. In contacting the 29 states that ended a financing arrangement from August 2003 through August 2006 under the initiative, only 8 states reported they had received any written guidance or clarification from CMS regarding appropriate and inappropriate financing arrangements. CMS had not used any of the means by which it typically provides information to states about the Medicaid program, such as its published state Medicaid manual, standard letters issued to all state Medicaid directors, or technical guidance manuals, to inform states about the specific standards it used for reviewing and approving states' financing arrangements. State officials told us it was not always clear what financing arrangements CMS would allow and why arrangements approved in the past would no longer be approved. Twenty-four of 29 states reported that CMS had changed its policy regarding

¹³GAO, *Medicaid Financing: Federal Oversight Initiative is Consistent with Medicaid with Medicaid Payment Principles but Needs Greater Transparency*, GAO-07-214 (Washington, D.C.: Mar. 30, 2007).

financing arrangements, and 1 state challenged CMS's disapproval of its state plan amendment, in part on the grounds that CMS changed its policy regarding payment arrangements without rule making.¹⁴ The lack of transparency in CMS's review standards raised questions about the consistency with which states had been treated in ending their financing arrangements. We consequently recommended that CMS issue guidance to clarify allowable financing arrangements.

Our recommendation for CMS to issue guidance for allowable financing arrangements paralleled a recommendation we had made in earlier work reviewing states' use of consultants on a contingency-fee basis to maximize federal Medicaid revenues.¹⁵ Our work found problematic projects where claims for federal matching funds appeared to be inconsistent with CMS's policy or with federal law, or that—as with inappropriate supplemental payment arrangements—undermined Medicaid's fiscal integrity. Several factors contributed to the risk of state projects. Many were in areas where federal requirements had been inconsistently applied, evolving, or not specific. We recommended that CMS establish or clarify and communicate its policies in these areas, including supplemental payment arrangements.¹⁶ CMS responded that clarifying guidance was under development for targeted case management, rehabilitation services, and supplemental payment arrangements.

We have recently initiated work to examine CMS's current oversight of certain types of state financing arrangements. We have not reported on CMS's May 2007 rule or other rules related to Medicaid financing issued this year. The extent to which the rule will address concerns about the

¹⁴This state formally requested that the CMS Administrator reconsider the disapproval of the state plan amendment. The Administrator upheld the disapproval, finding the state's argument that CMS was required to use notice-and-comment rule making unsupported. The United States Court of Appeals for the Eighth Circuit denied the state's appeal of this decision. *Minnesota v. Ctrs. for Medicare and Medicaid Servs.*, 495 F.3d 991 (8th Cir. 2007).

¹⁵See GAO, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, GAO-0-748 (Washington, D.C.: June 28, 2005).

¹⁶Other areas where we found federal law and policies had been inconsistently applied, evolving, or not specific included targeted case management services, rehabilitation services, and Medicaid administrative costs. We found that states' claims in some of these categories had grown substantially in dollar amounts. For example, during fiscal years 1999 through 2003, combined state and federal spending for targeted case management services increased by 76 percent, from \$1.7 billion to \$3.0 billion, across all states.

transparency of CMS's initiative and review standards will depend on how CMS implements it.

Concluding Observations

As the nation's health care safety net, the Medicaid program is of critical importance to beneficiaries and the providers that serve them. The federal government and states have a responsibility to administer the program in a manner that assures expenditures benefit those low-income people for whom benefits were intended. With annual expenditures totaling more than \$300 billion per year and growing, accountability for the significant program expenditures is critical to providing those assurances. The program's long-term fiscal sustainability is important for beneficiaries, providers, states, and the federal government.

For more than a decade, we have reported on various methods that states have used to inappropriately maximize federal Medicaid reimbursement, and we have made recommendations to end these inappropriate financing arrangements. Supplemental payments involving government providers have resulted in billions of excess federal dollars for states, yet accountability for these payments—assurances that they are retained by providers of Medicaid services to Medicaid beneficiaries—has been lacking. CMS has taken important steps in recent years to improve its financial management of Medicaid. Yet more can be done to enhance the transparency of CMS oversight. Consequently, we believe our recommendations regarding the clarification and communication of allowable financing arrangements remain valid.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Committee may have.

Contact and Acknowledgments

For future contacts regarding this testimony, please contact Marjorie Kanof at (202) 512-7114 or Kanofm@gao.gov. Katherine Iritani, Assistant Director; Ted Burik; Tim Bushfield; Tom Moscovitch; and Terry Saiki made key contributions to this statement.

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Chairman WAXMAN. Thank you very much. I want to thank all of the witnesses for your presentation. You have given us excellent, excellent information to think about as we look at this issue.

We are now going to proceed to questions by the members of the committee in 5 minute intervals. I will start with myself.

Dr. Kanof, as you know, one of the proposed rules issued by CMS would limit Medicaid payments to public hospitals to the direct cost of serving each Medicaid beneficiary. No payment would be allowed for the indirect cost that might be part of running the hospital, say, for example, the losses that the hospital might incur for emergency rooms, burn units, or trauma care. Has the GAO supported a policy of Medicaid payment for direct costs, alone?

Dr. KANOF. No. In fact, we have, though, supported a recommendation made to Congress in both 1994 and repeated in 2004 that costs should be limited to cost, but have never defined what is in that cost, what is direct or what is indirect.

Chairman WAXMAN. In 1994, though, you said Congress should enact legislation.

Dr. KANOF. We did, and, in fact, we did that because in comments that we received from HCFA at that time they indicated that they could not do this without congressional legislation, and, in fact, in 2005 the President's budget proposal actually requested legislation for this.

Chairman WAXMAN. So would it be inaccurate for CMS to imply that GAO supports the proposed cost rule?

Dr. KANOF. I think you have an interesting question you are asking me. GAO definitely recommends cost, but GAO has not commented what should be in that cost.

Chairman WAXMAN. You recommend legislation. I know that you also know a great deal about the Medicare program. Does Medicare include direct and indirect costs within its payment system?

Dr. KANOF. Yes. That is sort of a fundamental of how Medicare pays its providers.

Chairman WAXMAN. Thank you. It has been one of the fundamental ways Medicaid has paid its providers, as well.

Dr. Gardner, last week southern California suffered from a terrible disaster with devastating fires, and during this calendar year we have seen other problems such as the recent bridge collapse in Minneapolis. Communities relied on public teaching hospitals to provide critical emergency, trauma, and burn care. In the major cities of our country public hospitals provide nearly half of all level one trauma services and two-thirds of burn care beds. Are you concerned that the rules proposed by CMS will damage our communities' ability to manage the next natural disaster or public health emergency?

Dr. GARDNER. Absolutely. I cannot be more clear that we have no surge capacity. As demonstrated in Los Angeles and in the counties surrounding San Diego, dealing with a catastrophe is a problem for them. They have seen the closure of six hospitals with emergency departments in the last several years. Had this catastrophe been worse, they would not have been able to deal with those patients. And there is nowhere else for them to go.

Chairman WAXMAN. Well, one out of five hospitalized patients received care in a public hospital, one out of four babies is born in

a public hospital, and one out of five ER patients receive care at a public hospital. Given this volume of services, will other hospitals be able to fill the void if public hospitals are forced to close beds or curtail services due to the CMS regulations?

Dr. GARDNER. No, sir. The private hospitals are in much the same shape as the public hospitals. There is no bed capacity. There aren't nurses. There aren't specialists. There isn't room anywhere for any overflow of the system. There will be nowhere for these patients to go.

Chairman WAXMAN. We all know public and teaching hospitals operate emergency rooms, trauma centers, burn units, and sophisticated ICUs, but these hospitals also manage large outpatient clinics that keep community members healthy and out of the hospital. Today in our major cities over one-third of patients who need outpatient care receive it at a public hospital clinic. If CMS implements the proposed rules and public hospitals are forced to curtail these outpatient services or close these clinics, what options will these patients have to receive care?

Dr. GARDNER. Well, sir, as you know, regulations require that the emergency department stabilize and see any patients who present to our doorways, and my presumption is that those patients will show up in the emergency department and we will see them.

And if I could just take 2 seconds to dispel a common myth, there is a myth out there that our emergency departments are overrun by patients who don't need to be seen in the emergency department, but our recent research shows that 70 percent of the people who come to see us need to be seen within 2 hours, and 15.3 percent of those need to be seen within 15 minutes. So we will be adding clinic patients to an already overburdened system.

Chairman WAXMAN. Thank you.

Mr. AVILES. Mr. Chairman, I would just add, as well, that this highlights the extent to which this can be viewed as penny wise and pound foolish. To the extent that you strip out—

Chairman WAXMAN. I thank you for that, but I have one last question. You can see the red light, so my time is going to be up if I don't ask my last question of Ms. Herrmann.

The President says he wants to make sure that the low-income children are covered under Medicaid and S-CHIP. Now, Medicaid, of course, covers the poorest of the poor children. What would happen if you had the school nursing program made ineligible for treating some of these Medicaid patients?

Ms. HERRMANN. Thank you for your question. We see every day I would rather be a poor child because I am going to get Medicaid. If I am a little bit poor but not poor enough for Medicaid and I have diabetes, I have asthma, I have a broken arm, I have a bad respiratory virus, those children are not going to get seen. They are going to be delayed in treatment. What happens is that then—

Chairman WAXMAN. Well, they won't even be in Medicaid, because you would enroll them in Medicaid.

Ms. HERRMANN. No. That is right.

Chairman WAXMAN. If they are not in Medicaid and they have asthma, you can't even give them the services that they need.

Ms. HERRMANN. Exactly.

Chairman WAXMAN. Thank you very much.

Ms. HERRMANN. Exactly.

Chairman WAXMAN. I don't want to exceed the time. That red light is staring at me. But thank you very much for your answer. Maybe there will be further questions.

Mr. Davis.

Mr. DAVIS OF VIRGINIA. We will have some time later, but I want to get through this panel. Thank all of you for coming. I have to start with Dr. Retchin. He is from my State and he has been here before, and we very much appreciate your being here.

Your written testimony quotes the proposed rule in which the CMS points out that the Federal Government does not know or track which States are making GME payments, the amounts States are spending, or the total number of hospitals receiving such payments. Given that, what is the answer? Should it be paid through Medicaid? Should it be better tracked and overseen from us?

Dr. RETCHIN. Well, I think it is an excellent question. I am all for a better monitoring system, a better tracking system. I think CMS first has to realize these are legitimate costs. I mean, I think in part it could be obfuscation that if we can't track it then we can't pay it. That is illogical to me. In this case I think it is incredibly important for CMS to recognize the historical tradition of the payment itself, track it legitimately, and continue the payment for GME.

Mr. DAVIS OF VIRGINIA. What part of GME payments or what part of—if you didn't have that coming, you are an urban hospital, you have a lot of people who can't pay that are presenting themselves at the door.

Dr. RETCHIN. Well, if you combine the direct and the indirect, it is a substantial portion. I would venture to say it could be as much as 10 percent of our total revenues.

The direct payment for graduate medical education is a substantial portion of our direct payments for graduate medical education. The other portion is only Medicare.

Mr. DAVIS OF VIRGINIA. And the same would apply to New York, I am sure.

I want to get to Dr. Kanof for a couple of minutes.

How does the inappropriate maximization of Federal Medicaid reimbursement impact the financial integrity of the program? Does this have implications for Medicaid beneficiaries? Are we merely moving costs from the Federal to the State? I mean, what is your overview of that?

Dr. KANOF. Well, in fact, what we have found and what we have reported is that the supplemental payments can undermine the fiscal integrity of the Medicaid Federal-State partnership, and we have looked at this and summarized it in three ways. They clearly, effectively increase, as I spoke about the Federal matching rate established under statute. They allow States to use Federal Medicaid funds for non-Medicaid purposes. And they enable States to make payments to government providers that significantly exceed their costs.

While we have not specifically looked at the impact that this would have on Medicaid beneficiaries, a natural extension would be that if there are funds that are in the Medicaid program that are

going to the States and then being returned to the States and not used for Medicaid, this would, in fact, harm a beneficiary.

In fact, the HHS IG found that, in fact, there were Medicaid funds that were going to an institution. The institution had returned these funds to the State, and then the State Department of Health and Human Service actually put the provider in jeopardy for not providing quality care to the beneficiaries.

Mr. DAVIS OF VIRGINIA. Let me followup on my earlier question. Is the GAO aware of any examples of concerns regarding Medicaid payments for school-based administration that may speak to the need for greater accountability or oversight in that area?

Dr. KANOF. We have not examined this issue in great detail. Two years ago we looked at contingency fee payments, and in Georgia we found that, in fact, there were funds that have been directed to the State for State programs and they had specifically gone back into the State and not been used for education purposes. In reviewing that, we determined that there needed to be better guidance to ensure accountability of these funds.

Mr. DAVIS OF VIRGINIA. Dr. Gardner, as it relates to uncompensated care, will government-operated facilities still have access to the dish payments which are meant to address caring for the uninsured?

Dr. GARDNER. I am not sure that I am adequately prepared to answer that question at this time. I can get back to you.

Mr. DAVIS OF VIRGINIA. If you would try to get back to us, just for the record, that would be helpful to us.

Dr. GARDNER. All right.

[The information referred to follows:]



December 12, 2007

The Honorable Tom Davis
Ranking Member
House Committee on Oversight and
Government Reform
B-350A Rayburn House Office Building
Washington, DC 20515

Dear Congressman Davis:

On November 1, 2007, I testified on behalf of the American College of Emergency Physicians (ACEP) at the House Committee on Oversight and Government Reform's hearing entitled, "The Administration's Regulatory Actions on Medicaid: The Effects on Patients, Doctors, Hospitals, and States." During the hearing, you posed a question to me regarding the effect of the Administration's final and proposed Medicaid rules on the continued availability of Disproportionate Share Hospital (DSH) adjustment payments. The following is the response to your November 1 inquiry:

Question: "As it relates to uncompensated care, will government operated facilities still have access to the DSH payments, which are meant to address caring for the uninsured?"

Response: After reviewing the Centers for Medicare & Medicaid Services' (CMS) final rule on cost limits for providers operated by units of government and the proposed rules on health care-related taxes; Graduate Medical Education (GME); rehabilitation services; reimbursement for school administration expenditures and costs related to transportation of school-age children between home and school; and clarification of outpatient clinic and hospital facility services definition and upper payment limit; the answer to your inquiry is yes. The final rule on Medicaid cost limits does clarify that it would not apply to DSH payments.

Thank you for the opportunity to testify on these important issues. If you have any further questions, or if ACEP may be of any assistance to you or your staff, please let us know.

Sincerely,

Angela F. Gardner, MD, FACEP
Vice President

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CC: The Honorable Henry Waxman

Mr. DAVIS OF VIRGINIA. Mr. Aviles, some of the quotes in your written testimony speak to a very broad list of services that hospitals would purportedly have to discontinue under the proposed cost limit rule. I understand that you are challenging the CMS' estimate of the impact of the rule. For argument's purposes, if the impact was twice as large as CMS estimates, it still would be less than 1 percent change in Federal Medicaid spending. Can you talk to the magnitude of this change from your perspective?

Mr. AVILES. It may be 1 percent in the aggregate, Congressman, but, in fact, NAPH members constitute 2 percent of the hospitals in this country, and we cover 25 percent of the uncompensated care. These regulations are directed at the public hospitals in the country, and therefore the impact is concentrated there.

As I mentioned in my testimony, just for us the impact would be about 4 percent of our budget on the cost limit regulation alone. All three regulations together aggregate to closer to 9 percent of our budget, or in the range of \$400 to \$500 million.

Others of our members in California, for example, the estimates are in excess of \$500 million, in Florida in excess of \$900 million, and in Tennessee and North Carolina and Georgia it is a combined impact of \$800 million on an annual basis for the cost limit regulation, alone. That necessarily would devastate our ability to deliver services.

Mr. DAVIS OF VIRGINIA. Thank you.

Chairman WAXMAN. Thank you, Mr. Davis.

We are being called to the House floor for a series of three votes. We are going to take a recess and come back at 10 minutes to 12:00—I think that would be a good prediction of time—to complete the questions for this panel.

Thank you.

We stand in recess.

[Recess.]

Chairman WAXMAN. The hearing of the committee will please come back to order.

Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

First of all I want to thank all of our witnesses for your testimony. I thank you for bringing and presenting a face for the people who are affected by these proposals.

I also want to say to Ms. Miller, I want to thank you for your testimony. As a fellow Marylander, I am very, very, very proud of you. Thank you so very much for taking your story and bringing it to us. I really appreciate that, too.

Dr. Gardner, please do not ever apologize for your passion. We are talking about the lives of human beings. We are talking about life and death situations.

To all of you, I thank you for your passion.

It seems, Mr. Chairman, that we are currently engaged in a very public debate over the future of S-CHIP, which covers 6 million children and potentially will cover 4 million more. But today, after listening to this testimony, I am concerned that, while we wrangle over that program in the press, CMS has launched a systematic attack on Medicaid which serves 60 million people, 28 million of them children, behind our backs and in their suites.

Your testimonies highlight how vitally important it is that we shed a light on these ill-advised proposed regulations. Left to their own devices, it appears that CMS will leave our most vulnerable citizens—that is, the poor, the sick, the disabled, and the elderly—far, far behind, if not left out completely.

Mr. Chairman, that is not the American way. As I listened to some of this testimony, I must tell you that if I closed my eyes I had to wonder whether or not we were still in America.

America has gained its moral authority by the way it treats its people, not by military might. It may have been backed up by military might, but the way we treat every single American. This is not a matter of fiscal responsibility. I have concluded it is a matter of moral irresponsibility.

Are we so morally bankrupt that we are willing to shortchange life and death services?

That leads me to you, Mr. Parrella. I want to thank you for your testimony. You testified that you worked in Medicaid for the past 20 years. In your experience, is there any precedent for what CMS is doing with the six proposals we are discussing today? Has the Federal Medicaid agency ever proposed a set of Federal rules that would shift \$11 billion in costs from the Federal Government to the States?

Mr. PARRELLA. Thank you for that question, Mr. Cummings.

I am not aware of a regulatory initiative that would have an impact of this magnitude that we have experienced.

Mr. CUMMINGS. And I take it from your testimony that the State Medicaid directors, the managers like you who actually run the program on a day to day basis, I guess you all oppose each of these six CMS proposals we are discussing today. And is that opposition bipartisan?

Mr. PARRELLA. Our organization—

Mr. CUMMINGS. First of all, are you opposed?

Mr. PARRELLA. I am, sir.

Mr. CUMMINGS. All right. And is that the view of your organization?

Mr. PARRELLA. It is, sir.

Mr. CUMMINGS. It is a bipartisan organization?

Mr. PARRELLA. It is, sir.

Mr. CUMMINGS. Do you all have opportunities to express your concerns to the folk who sit in the suites making these decisions affecting people's lives on a day to day basis?

Mr. PARRELLA. We do.

Mr. CUMMINGS. And how do you do that? How do you go about doing that?

Mr. PARRELLA. CMS is very good about meeting with us on at least a quarterly basis. We have direct access to Mr. Smith. In terms of the regulations that are issued, we provide written comments.

Mr. CUMMINGS. I always find these hearings fascinating because we hear your stories and, having been here 11 years, the fascinating part is we will hear the story from CMS in a few minutes. They will probably say—well, Mr. Smith has already said in his written testimony, "These rules will provide for greater stability in the

Medicaid program and equity among States.” Do you agree with that statement?

Mr. PARRELLA. I do not. I am sympathetic to the task that Mr. Smith and CMS have in that it is their responsibility to maintain program integrity, and part of program integrity is to hold the States accountable for the State share that they provide for Medicaid. So to the extent that these regulations were an attempt to correct any practices historically which have shifted inappropriately responsibility to the Federal Government from the States, I understand and support what Mr. Smith is doing. However, I think what these regulations do is they go far beyond that in terms of the impact that they are having on the kind of public providers and recipients who are here who benefit from these programs. I think that is the reason why we are in opposition.

Mr. CUMMINGS. I see my time is up. Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Cummings.

Mr. Davis.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman. I want to thank you for holding this hearing. As a matter of fact, I represent a District that has more than 25 hospitals, 4 medical schools, 30 community health centers. As a matter of fact, we are, indeed, a health mecca, and so you can imagine that these proposed rules frighten me to death. As a matter of fact, every time I think about them I shake in my boots in terms of the devastating impact that they could have, because we also care for people from not only in our State but we care for many people from all over the country and, indeed, from all over the world. So I thank all of you for your testimony.

Let me just ask you, Mr. Aviles, the Senate Finance Committee recently confirmed Mr. Kerry Weems as the CMS administrator, and in response to questions submitted by the committee as it considered its nomination he made the following statement. He said, “I appreciate that Medicaid is a vitally important program that serves very vulnerable populations. I am concerned that the perception that this Medicaid rule is intended to harm public providers. In fact, I understand it to protect public providers. Governmentally operated health care providers are assured the opportunity to receive full cost reimbursement for serving Medicaid-eligible individuals instead of being pressured to return some payment to the State.”

It sounds like Administrator Weems believes that CMS is doing safety net hospitals like those in New York and like the three that I represent in my District in Chicago a favor by proposing these rules. Do you agree?

Mr. AVILES. Absolutely not, Congressman. As I have mentioned before, the cumulative impact on these regulations is a massive cut in funding to our public hospitals across the country.

The argument that it does us a favor by limiting our reimbursement to actual cost really turns a blind eye to the role that public hospitals play across the country. Those costs that we incur include the cost of running our trauma services, include the cost of running those burn beds.

As you have heard, our members in communities across this country on average provide 50 percent of the trauma services, provide two-thirds of the burn beds.

If you are in Miami and you need trauma services, the only place you are going to get those trauma services is in a public hospital. If you are in Los Angeles, CA, or Columbus, OH, the only place you are going to get specialized burn bed treatment is in a public hospital.

So those costs need to be borne, and historically have been borne through supplemental Medicaid payments that recognize that is an essential part of the mission and role of public hospitals in this country.

Mr. DAVIS OF ILLINOIS. Well, on the next panel the CMS witness, Mr. Smith, will argue that his proposed rules will not have a negative impact on providers and that if the rules were to negatively affect providers—he said, “It would be due to decisions made by State and/or local governments, not by CMS.”

If CMS implements this rule, and Federal Medicaid payments are no longer available to public hospitals for costs not directly attributable to Medicaid patients, will the State of New York and the city of New York pick up the financial slack and cover the difference on their own? And what about other States and localities?

Mr. AVILES. With all due respect, that statement is a lot like saying that if we eliminated the Federal share of Medicaid entirely the States could pick up the slack and therefore there would not necessarily be a negative impact.

We are talking about a massive de-funding of public hospitals. As I have mentioned, in New York City, alone, the combined effect of these rules would be in the neighborhood of \$400 to \$450 million. It is inconceivable that we could continue to run the public hospital system we currently have in our city with that type of defunding. Quite frankly, neither New York state or other States around the country have the wherewithal to make up that massive amount of defunding.

Mr. DAVIS OF ILLINOIS. My time is about to run out. Let me ask you, If the States and local governments can't pick it up, do you think that the private sector hospitals and health systems would now be able to pick up the slack?

Mr. AVILES. Absolutely not. We know that in many areas of the country the emergency departments are absolutely crowded. Many hospitals, certainly in the northeast and elsewhere, struggle just to stay above water. We are talking about a public hospital system that provides 1.7 million hospital discharges each year and close to 30 million outpatient visits. The private sector simply could not make that up, does not have the excess capacity to do that.

Mr. DAVIS OF ILLINOIS. Thank you very much, and thank you, Mr. Chairman.

Chairman WAXMAN. Thank you very much, Mr. Davis.

Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me begin by first thanking all of you for your testimony and for the many examples that you were able to give to highlight the fact that we are moving in the wrong direction.

Let me ask, did any of you comment on the rules? Did any of you comment on the rule?

[Panel members nodding affirmatively.]

Mr. TOWNS. You did? All of you?

[Panel members nodding affirmatively.]

Mr. TOWNS. You know, in looking at the situation, it seems to be not a single person supported this rule, so I am wondering now if comments make a difference. If nobody supported it and, of course, here we are. Of course, you expressed your concerns, which I hear you. I am hoping that the agency will also hear you, as well.

Let me ask you, Dr. Aviles, what would this do to the graduate medical education programs that we have in our hospitals?

Mr. AVILES. This would be extraordinarily destabilizing to the graduate medical education across the country. There is a very close inter-weaving of graduate medical education and public hospitals. Of NAPH members, 85 percent are teaching hospitals. In New York City, HHC has nearly 2,400 residents being trained on any day of the week. So this is a central component of the infrastructure for academic medicine, and the training of physicians in our country. With projected physician shortages going into the future as the Baby Boom generation requires more services, and as we look around the country and see physician shortages even now, it is a very dangerous proposition, indeed.

Mr. TOWNS. There is legislation being put forth by my colleague from New York, Elliott Engel. I would like to move down the line and ask you, in terms of your views, whether you support it or not, basically yes or no, starting with you, Ms. Miller, and coming all the way down the line, the Elliott Engel legislation. Are you familiar with it?

Mr. PARRELLA. I am not, sir.

Mr. TOWNS. You are not familiar with it? OK.

Mr. PARRELLA. Is it a moratorium legislation?

Mr. TOWNS. Yes. Let's go right down the line.

Mr. PARRELLA. Extend the moratorium. We would be in favor of that, sir.

Mr. TOWNS. You would be in favor. OK. Right down the line.

Ms. MILLER. Yes.

Mr. TOWNS. Yes. Yes or no, basically.

Ms. COSTIGAN. Yes.

Ms. HERRMANN. Yes.

Mr. AVILES. Yes.

Dr. RETCHIN. Yes.

Dr. GARDNER. Yes.

Dr. KANOF. I am not in a position to offer an opinion.

Mr. TOWNS. OK. All right. So that is neither yes nor no. OK. I got it.

Let me just say to you, do you think that legislation would really help the delaying it a year rather than dealing with it now?

Mr. PARRELLA. Yes, it would help. This legislation would help us.

Mr. AVILES. It would help. We obviously would welcome a more permanent solution that would not require us to come back yet again, but certainly, given the alternatives, we would welcome a further moratorium.

Mr. TOWNS. Do any others have any comments as to what this would do to your facility if these cuts go forward, as to what it would do to your facility in terms of if we do not rectify this?

Ms. COSTIGAN. We run an adoption program at Intermountain in Helena and Great Falls, MT. If this rehab rule stays the way it is, we would potentially lose that program. We have served over 100 SED kids, and we have found permanent homes for many of them, and we have kept them in permanent homes. We have a 73 percent success rate. The program would be gone.

Mr. TOWNS. Thank you.

Ms. HERRMANN. The Medicaid administrative claiming dollars that come back to school districts and programs, once that is gone the program is gone. That is it. Everything will be. So school nursing positions, social worker positions, preventive care—all of those kinds of things would be gone and we wouldn't be able to enroll or help kids with eligibility.

Mr. AVILES. These funds help to subsidize the extraordinary cost of running six trauma centers in New York City, as well as our high-level neonatal intensive care units. All of those types of services would absolutely be endangered by this level of cuts.

Dr. RETCHIN. The cuts as they stand in the proposed rules taken together would be absolutely devastating for our teaching hospital.

A few years back we were actually on the cover of the Wall Street Journal because a cancer patient from a distant part of the State could not receive chemotherapy where he was, and he traveled about 150 miles to MCB hospitals where he got chemotherapy and treatment for his cancer and actually went into remission and survived. Those are the kind of programs at a cancer center like that we would have to reconsider. These would be devastating in terms of the consequences.

Dr. GARDNER. If I am allowed, I will have a short, two-part answer. One is that Texas is 51st already in administration of Medicaid, and we have 50 percent of our children and 30 percent of our adults who are also uninsured. We have research that says that over 20 percent of the adults and 25 percent of the children reported that they needed to see a doctor in the past 2 years and could not do so. This will certainly not improve that.

Mr. TOWNS. Thank you very much, Mr. Chairman. You have been very generous with the time. Thank you. I appreciate it.

Chairman WAXMAN. Thank you, Mr. Towns.

Ms. Watson.

Ms. WATSON. I really want to thank the Chair for holding this hearing. I think this is one of the more important issues that we have brought out to the public, and I want the public to listen closely.

If all the new regulations were to be implemented, Federal Medicaid funds to States would be cut over \$11 billion over the next 5 years. This loss in funding would be detrimental to the program and its recipients and would cause States to roll back valuable services that poor and low-income families would need and otherwise would not be able to afford.

I represent the State of California. We are the first State in the Union to be a majority of minorities. We get a lot of people coming from over the Pacific Ocean, southeast Asia, over the border, and

so on, with tremendous health needs. Where do they go? They go to emergency.

We just lost one of our public hospitals because the funding was cut back, Martin Luther King down in Watts. I think all of you are aware of that. I heard someone on the panel mention the dish hospitals. Let me tell you, in the same area there is St. Francis, a Catholic hospital. They can't take another patient. The dish hospitals are under-funded.

We are going to see more cases of people dying in the emergency room. We don't have an emergency room at King Hospital, as many of you know.

I am a teacher, worked in the District, so I want to direct this question to Ms. Herrmann. I believe that you have answered most of my questions. What would happen in our schools? I think the worst thing we do in our districts—we have 1,100 of them in California—is cut out the daily nurse. We don't even see the doctors.

So in his testimony, Mr. Smith for the next panel—he is the CMS witness—will defend this proposal rule on the grounds that there has been improper billing under the Medicaid program—In California we have our own. It is called MediCal—by school districts for administrative costs and transportation services. There is no over-billing, because in a State as large as ours, the largest one in the Union, you are going to have to have an administration, you are going to have those costs.

I want to ask Ms. Herrmann, does your school district improperly bill your State's Medicaid program for the cost of your services? Or are there administrative costs? And even if there had been abuses in other school districts, is this rule a common-sense solution to the problem?

Ms. HERRMANN. No, we do not improperly bill Medicaid, and I can't imagine any school district would knowingly and intentionally try to defraud the Medicaid program.

I forgot the second part of your question. I am sorry.

Ms. WATSON. That is all right. I think you have answered it all.

Ms. HERRMANN. Thank you.

Ms. WATSON. It was a comprehensive question. But my second part was, Is this rule a solution?

Ms. HERRMANN. No, this rule is not the solution. Children will lose out and school districts will lose out because we will not be able to enroll them or assist to enroll them in Medicaid.

Ms. WATSON. And I am so pleased that I still see the green light. Mr. Chairman and Members, we are being asked again to fund a war over in Iraq. Soon it will be \$1 trillion. And we are going to cutoff health care to the poorest and most deserving children in our Nation? It doesn't make any sense, and I am going to say for all of you to hear I will not cast a vote for another penny in Iraq if this rule goes through and we cutoff the services to our children and our schools and we cutoff the services in our county hospitals and we close the county hospitals by pulling back on the funds, as has happened to us in L.A. County, the largest county in the State of California. It doesn't make sense.

If we are talking about protecting our homeland, it is not about the land, it is about the people on the land, and if we can't provide those services we ought to go out of business.

Thank you, Mr. Chairman, for the time. I yield back.

Chairman WAXMAN. Thank you, Ms. Watson.

Mr. Higgins.

Mr. HIGGINS. Thank you, Mr. Chairman. I have no questions, but more of just to thank the panel for being here. Most of the questions I had have been asked and answered. We appreciate very much your being here, because in making policy or challenging this administrative policy it is fundamentally important for us to know what the impact is going to be on the ground, whether it is graduate medical education and the impact to public hospitals and their ability to deliver services, be they at hospitals or clinics throughout the communities, are very, very important. I want to assure you that we are here to ensure that nothing is done that is going to have a detrimental impact relative to service delivery at a time when we should be providing more health care, not less, particularly to those who are most vulnerable in our community.

Your presence here and the chairman's presentation of this hearing is fundamentally important toward shaping policy moving forward, and I thank you for being here.

Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Higgins.

Mr. Murphy.

Mr. MURPHY. Thank you very much, Mr. Chairman. I would like to especially thank Mr. Parrella for joining us today. He has served incredibly ably as the director of Medicaid Services in my own State of Connecticut. I got to serve 8 years on the Public Health Committee, 4 of those years chairing it, working together on a number of issues there.

Mr. Parrella, I wanted to give you the opportunity to expand upon I think an important point in your testimony, which is that much of the rationale for these rule changes seems to be the contention from the administration that Medicaid was never supposed to cover these services in the first place. For someone that has only worked in this field for 10 years, even for me that contention seems incredibly wrong-headed. Your experience is much deeper and broader, and I would like you to just expand a little bit on the response, for those of us, when the administration tells us that the reason for these changes is simply because Medicaid was never supposed to cover it in the first place, and the corollary argument from the administration that there is other money out there to cover the services that they are cutting.

Mr. PARRELLA. Thank you, Congressman. It is a great pleasure to refer to you as Congressman Murphy in an official setting.

There are many examples you could find, but I think a best example is in the schools, in particular. I think some of the opposition comes from the sense that school business is the business appropriately of the Department of Education, that Medicaid should not cross that line. I think that we all know that Medicaid does cross that line because many of the children in schools receive services through special education.

There is a Federal mandate for special education services through the IDEA, the Federal Act for special education. IDEA does not come close to funding the full cost of the medical portion of special education services that States and cities provide. So Med-

icaid was actually directed by Congress in the Medicare Catastrophic Act back in 1988 to participate in paying for special education services that were medical in nature.

So we have had direction at various times in the past to be intimately involved in payment for services through the schools, so it does appear to be something of a retrenchment or a revisiting philosophically to say that, for the purposes of promoting program integrity, there are going to be areas like school education, like graduate medical education where Medicaid does not have a role.

On the graduate medical education issue, Medicaid does have a role because we have a great vested interest in training doctors who will continue to serve the low-income population. So if you were to take a strict constructionist view and say that education at large is not part of Medicaid, that argument might hold some ground in a pure philosophical sense, but in the real world where States are simply not going to be able to replace the kind of funds, as Mr. Aviles said, for special education or graduate medical education, to take Medicaid out of the equation without some kind of supplemental Federal program to take its place is simply not realistic.

Mr. MURPHY. Thank you very much, Mr. Parrella.

Ms. Costigan, I just want to talk to you for 1 second about foster care. One of the proposed regulations would, as I understand it, require therapeutic foster care homes to unbundle their services in how they bill for those services, creating, at least at first view, a whole new level of bureaucracy for families that are looking to take on some pretty difficult and emotionally complex children.

What do you think the effect of that proposed regulation is going to be on efforts of States that are already difficult, as it is, to try to get parents to come into the therapeutic foster home system?

Ms. COSTIGAN. I think it will be very destructive to any recruitment efforts. I also think that our agencies will not have the ability to track everything by 15-minute increments, especially when what we are talking about is giving kids back a social life, giving them skills to be able to have a friend and keep a friend and be a friend. I think this Medicaid rule will eliminate the support that therapeutic foster parents need, and if we want permanent homes for our kids, which is one of the things that Intermountain is very interested in is permanent homes for seriously emotionally disturbed kids, we deal with therapeutic adoptive care, but we fall under therapeutic foster care.

If we want these homes for these kids, we have to be willing to support them and to help them to help the child grow.

Mr. MURPHY. Thank you very much, Ms. Costigan.

Thank you, Mr. Chairman, for holding this very important hearing.

Chairman WAXMAN. Thank you very much, Mr. Murphy.

Mr. Hodes.

Mr. HODES. Thank you, Mr. Chairman.

I thank the panel for coming today. I am a co-sponsor of H.R. 3533, and I really appreciate the opportunity to have you here today to highlight this critical issue.

I want to thank Mr. Cummings for his remarks, which I associate myself with. Like Mr. Cummings, I have been gravely con-

cerned about what seems to be this administration's undeclared war on children and the poor under the Orwellian guise of a claim of fiscal responsibility. It is not what this country is about.

I am wearing a pin which says Article I on it. The Article I initiative is a new initiative by the Democratic Members of the Class of 2006 to help the people in this country understand that checks and balances are vital in our system of Government, and this oversight hearing is one prime example of a check and a balance in a system where the administration seems to believe that it makes the law and not Congress.

We will not be silent on this issue.

In my home State of New Hampshire we have one large teaching hospital, Dartmouth Hitchcock Medical Center in Lebanon, NH, in association with Dartmouth College. It really is the sole teaching hospital there.

I want to focus for a moment on the graduate medical education issues. I understand that a recent report by the Agency of Health Care Research and Quality, which is a sister agency to CMS, found that teaching hospitals have a terrible patient revenue margin. In fact, they are losing almost \$0.10 on the dollar.

Dr. Retchin, would you simply explain why this is so. Why do they lose money? And how do you make up the difference?

Dr. RETCHIN. Well, the old joke you make it up on volume probably doesn't apply here.

The teaching hospitals are at a disadvantage from the start all the way to the finish line because they have so many missions, so they are asked to be the tertiary referral centers, the cutting edge for technology and development of new research, new therapeutics. They are asked to supply tomorrow's work force for health care workers, not only physicians but nurses, physical therapists, pharmacists, occupational therapists. And then they are asked, after all of that, to be a safety net in the partnership for taking care of the disadvantaged.

So it should be no surprise that all of these missions require funding, and they all require subsidization, so the cross-funding of these is very difficult. I can tell you the safety net care generates no margins to subsidize either education or research, so all of these have to pay for themselves, and some fall by the wayside. They have to give up or compromise on one of those missions. It has to be research, education, and, as a last resort, patient care. They can't make it up. That is the answer.

Mr. HODES. Dr. Retchin, CMS says that its proposed rule eliminating Medicaid GME would "clarify that costs and payments associated with graduate medical education programs are not payments for medical assistance that are reimbursable under the Medicaid program."

Do you agree with the CMS characterization that their proposed rule is a "clarification?"

Dr. RETCHIN. Well, after 20 years of approving the State plans for GME payments, after more than two decades of not only approving State payments but actually making the payments and sharing, this has been a great Federal-State partnership. It seems unusually convenient to come to the conclusion that this is merely a clarification. It took a long time to clarify.

I think that everybody has skin in the game. We all have to train the work force of tomorrow. Here you have a Federal-State partnership, so it seems unusual, as one way to cut this, to make it merely a technical clarification.

Mr. HODES. Well, if the rule goes through, why can't the States simply step in and pick up the slack? And if they can't, what will happen if they don't? What will happen to training the Nation's doctors? What will happen, for instance, in your hospital on emergency care and disaster preparedness?

Dr. RETCHIN. All of these have to be compromised. You know, it is sort of funny about this, because if you look at the 47 States that actually have GME payments through Medicaid, most of those States, if not all, have balanced budget amendments. They are the ones that have to ride out the business cycles and yet continue year after year to make these payments and make a commitment to funding the most disadvantaged in our society.

You would think actually it would be the Federal Government that would actually be saying to the States, You need to make these payments because we are concerned about the work force. It is just odd that it is the other way around.

So the States will not be able to make this up. I hope some of the States would continue their portion, because, like I said, they both have skin in the game, but they won't be able to make up the defunding of the Federal portion. Can't happen.

Mr. HODES. Thank you.

I yield back.

Chairman WAXMAN. Thank you, Mr. Hodes.

Mr. SHAYS.

Mr. SHAYS. Thank you, Mr. Chairman. Again, thank you for having this hearing.

I sometimes find, when everything is weighted one way, I want to bring some balance, even if I may not feel as strongly about that as I do. But in this case I am looking at administrative changes that change not 10 percent, not 1 percent, but 9/10ths of 1 percent, so I am hard-pressed to know how terrible things are going to happen.

We are talking about one thousand two hundred billion [sic] dollars of money spent and \$11 billion in alterations over 5 years. That is tiny times 10, so I don't want to blow this whole hearing out of proportion.

With regard to the GAO, GAO has looked at a number of financing arrangements with Medicaid. In your experience, how does the joint nature of Medicaid program, joint Federal-State, 50/50, incentivize inappropriate financing arrangements?

Dr. KANOF. Well, it does it in several ways. Clearly, one way is as was mentioned this morning, earlier today, through the supplemental payments that can be excessively large and then can be transferred back from a provider to the State because there is an inter-government transfer allowed and there is an excessive amount of money now returned to the State. It allows this in that the payments are now not to the providers, because they have not rendered these services for this payment, and it creates tension in that it increases the Federal match to the State.

Mr. SHAYS. In other words, what we have found in my 20 years here, and that is why we looked at this issue in 1997, what we did in the late 1990's was, with President Clinton's support, we balanced the Federal budget. We pretty much allowed discretionary spending to go up 1 percent, slowed entitlements for 1 year alone by a few percentage points—not 9/10ths of 1 percent—and we balanced the budget. That is what we did, Democrats and Republicans.

Here we are talking about an \$11 billion savings over \$1.2 trillion, and it is clear—all of us know this on this side, not there—that a smart State looks to take 100 percent of its costs, and if it can transfer it to Medicaid it now only has 50 percent and now the Federal Government picks up the other 50 percent. That is the incentive, isn't that true?

Dr. KANOF. Without appropriate safeguards, those are the incentives.

Mr. SHAYS. Absolutely. Now, I am very proud of how our State operates. I am also proud of our State's ingenuity. Mr. Parrella, I think that you get rewarded if you find ways to increase programs and reduce the State's costs, and if I were Governor I would want to make sure you did that every time. And if I was on that side of the table I would be arguing for it every time.

But I am not on that side of the table. Medicare is going up \$16 billion from last year to this year's budget, \$17 billion next, \$18 billion the year after, \$19 billion the year after, \$21 billion the year after. It is not like the Federal Government isn't invested in this program, isn't that clear?

Mr. PARRELLA. That is true, Congressman.

Mr. SHAYS. So let me ask you, to the degree that some States use creative financing mechanisms, does that put States who choose to follow both the letter and spirit of the law and regulations at an unfair disadvantage by, frankly, undermining the overall financial integrity of the Medicaid program? In other words, if some States are using creative financing and you are a State that is pretty much playing by the letter and spirit of the law, doesn't that put you at a bit of a disadvantage?

Mr. PARRELLA. I think the danger of creative financing, the way it has been described, is that it can undermine the relationship between the States and the Federal Government, which is based on a partnership. It is. We have to have integrity in what we represent to the Federal Government when we want to talk to them about matching funds for programs that we are trying to do to cover the uninsured. There has to be some integrity behind that so that they believe that we are really going to spend money on services that are really going to go to providers. That is part and parcel of what we do.

I guess I would concede that if there are attempts to recycle funds or divert funds from that purpose, it undermines the credibility of every State.

Mr. SHAYS. Well, Mr. Murphy and I both served at the State level, and when we were at the State level we thought like State legislators and we were eager to have you get every penny you could from the Federal Government. But I hope there is no disrespect on my side here. Please understand, I feel my job is to

make sure it is fair for all States so that one State doesn't gain the system, and that we have a system that we can afford both on the State and Federal level.

I thank all our witnesses again.

Thank you, Mr. Chairman, for this hearing.

Chairman WAXMAN. Thank you, Mr. Shays.

Just for the record, Dr. Kanof, the GAO has recommended both improved accountability and transparency in many of these areas that are the subject of these proposed regulations. Has GAO ever recommended prohibiting Medicaid payment for school administrative services?

Dr. KANOF. Based on my own knowledge of the reports that GAO has done, the answer to that would be no.

Chairman WAXMAN. How about school transportation services?

Dr. KANOF. No.

Chairman WAXMAN. Therapeutic foster care services?

Dr. KANOF. Not that I am aware of. No.

Chairman WAXMAN. Rehabilitation services?

Dr. KANOF. No.

Chairman WAXMAN. Indirect hospital costs?

Dr. KANOF. I don't think so.

Chairman WAXMAN. OK. Graduate medical education costs?

Dr. KANOF. No.

Chairman WAXMAN. And assertive community treatment?

Dr. KANOF. No.

Chairman WAXMAN. Thank you.

Let me thank all of you for your testimony.

Mr. SHAYS. May I ask a question in regards to the question you asked?

Chairman WAXMAN. Certainly.

Mr. SHAYS. Have you looked at each one of these issues?

Dr. KANOF. No. And what we have looked at is indications of more how is the State using some of these funds, but we have not looked at these issues.

Chairman WAXMAN. If the gentleman would permit, these proposed regulations would impact each of those areas. We are not just talking about mechanisms for drawing more money. As I understand it, these are services that would no longer be available.

I thank you all very much for your presentation. I think this is very, very helpful. It is a record that we are going to be able to share with our colleagues. Thank you so much.

[Recess.]

Chairman WAXMAN. The committee will come back to order.

Mr. Smith, I am going to ask you to come forward.

Dennis Smith is the Director of the Center on Medicaid and State Operations at the Centers for Medicare and Medicaid Services, Department of Health and Human Services.

We are pleased to have you here today. As I indicated, it is the practice of this committee that all witnesses answer questions under oath, so please rise.

[Witness sworn.]

Chairman WAXMAN. Do you have a prepared statement? We would like to recognize you for comments you might wish to make.

STATEMENT OF DENNIS SMITH, DIRECTOR, CENTER ON MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. SMITH. Thank you very much, Mr. Chairman. I will make my remarks brief and try to respond really to some of the issues that were raised from the previous panel and questions from the Members, themselves. Hopefully we will be helpful to help to understand the context of the rules, the impact across the program, and really how the rules do work, because I think that in some respects the interpretation of rules get interpreted and reinterpreted and stretched a little further than what the rules actually say.

I think I first also want to thank David Parrella for his very kind remarks. We do work very closely together with the Medicaid directors and we have a great deal of respect for David personally and for Martha Rorety, who runs the Medicaid Directors, and we do have a great deal of exchange. We talk a lot about these regulations before they ever become regulations and what is going on out there in the States.

The Medicaid program speaks through State plan amendments, so while you work within the confines of the statute, itself, in title 19, the States change their program, update their program, etc., through State plan amendments. And we do learn new things over time.

We have learned new things through the submission of State plan amendments. I think I have done what my predecessors have done. In the area of school-based services, for example, and the discussion that we heard on the previous panel about the school nurse, some of the things that she was describing would not have been allowed under the guidance of the previous administration. Direct services that you are doing for routine medical care falls under the free care rule, and the rationale that no other payer is paying for it so it should not be billed to Medicaid. So some of the activities that she was describing would not have been allowed under the previous administration, as well.

The previous administration became increasingly concerned about what is called bundling, to where schools would bundle payments together. They came out with guidance saying no, we are not going to recognize bundling any longer.

In terms of provider taxes, the previous administration, again, was very concerned, took a disallowance against five States in excess of \$1 billion. In many respects, the cost associated with Medicaid was not being shared by the State but, in fact, being passed off onto the providers, themselves. The previous administration stepped in and acted.

We also provided a table as an attachment to my testimony that shows the history of deferrals and disallowances that we have taken as a result of our financial management activities, and I think in looking at the chart I think that we are very much in line with our predecessors.

In terms of there was a lot of discussion about the cost rule, in particular, and again I have talked to a lot of groups, a lot of hospitals, and tried to explain what has been going on in Medicaid is

the States have been passing their obligations on to providers. When we have stepped in, their providers have benefited from that.

In California, for example, we have worked with California in their hospital financing. Revenues to California public hospitals went up. They went up by 12 percent, according to their own Public Hospital Association.

Provider taxes, again, to sort of reveal what is below the surface, when is the last time someone came in and asked to be taxed? Provider taxes are related then to payments, because the provider is willingly paying a tax knowing that there is going to be a return on that through increased payments. So, again, the financing is left to the Federal Government because the provider is not really paying the tax. The State is not really paying its share, but it is the Federal Government who is funding.

I think these things really can be summed up in terms of what we are funding and what we are for in these rules.

Is it a medically necessary service? Is it for a Medicaid beneficiary? Is the matching requirement under the Federal-State partnership intact? If, the answer is yes to all of those, we pay. Federal dollars follow State dollars. They are the ones who are determining the services. They are the ones who are determining the reimbursement rate to providers. They are the ones who are determining the scope of services when you get to an issue like rehabilitative services. We are not talking about a disagreement about is physical therapy covered as a rehab service. Of course it is. There is no disagreement about is speech therapy in a school covered. Of course it is. That is not what the disagreement is about. The disagreement is about pushing the edges of the envelopes even further to see where an activity or a program of the State is being funded with State-only dollars. If you can get Medicaid money out of the Federal Government by calling it Medicaid, then you are ahead of the game.

That is where the issues of the discussions are about when we are talking about rehab services. We, again, learned a great deal in our conversations as States submit State plan amendments, on things like therapeutic foster care. There is not a definition of therapeutic foster care in the Medicaid statute. There are many different definitions of therapeutic foster care when you go out and ask the States, themselves, what do you mean by therapeutic foster care.

Again, when you are talking about that, in itself, are these a component of services for people with mental illness? We will pay. Is this for a mental health counselor? We pay. Is this for the prescription drugs that someone needs? Of course we will pay.

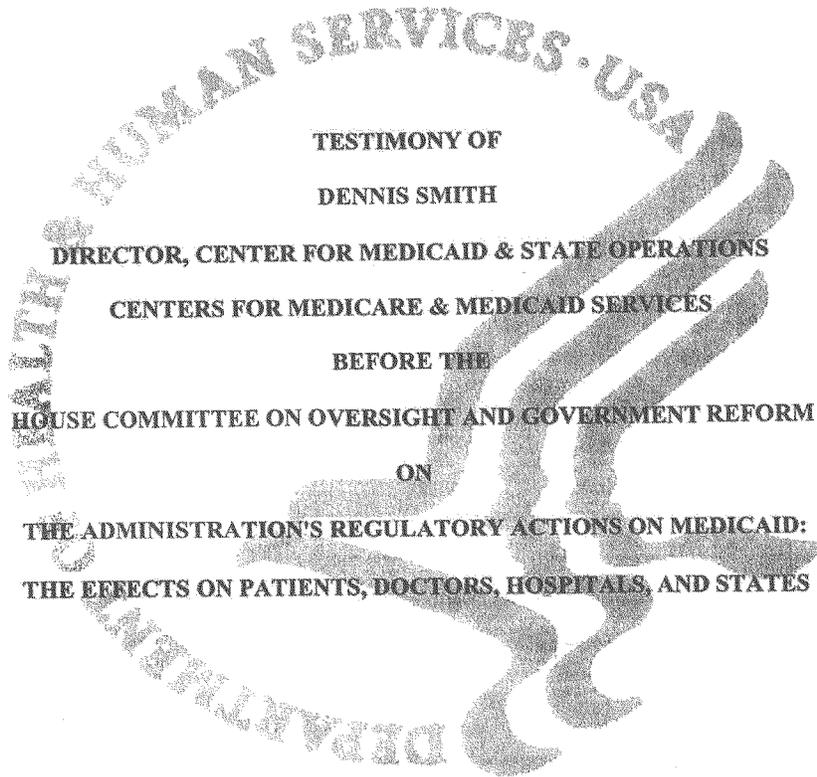
This is about pushing the envelope to the outer boundaries to where is therapeutic foster care a juvenile justice wilderness camp. Then I think you do expect me to push back on the States and say no, that is outside the bounds.

David Parrella's quote about the creativity of the States I thought had great double meaning to it. The creativity of the States, new things out there on the horizons. States contemplating, talking openly about four elderly prisoners in our penal system, in our correction system, can we somehow get them into a nursing home and have Medicaid start picking up the cost for them?

These are things that have been pushed to the edge, beyond the edge, and, in our opinion, yes, beyond the edge when we ask you what do you mean by therapy and we get the answer is we are going to pay for small engine repair. We think that is our obligation to be saying what are we really paying for here. Is the Federal-State partnership intact?

Again, if the State is paying its share, if it is for a medically necessary service, we are going to be there with you, as we have matched and we have matched over the years.

[The prepared statement of Mr. Smith follows:]



TESTIMONY OF
DENNIS SMITH
DIRECTOR, CENTER FOR MEDICAID & STATE OPERATIONS
CENTERS FOR MEDICARE & MEDICAID SERVICES
BEFORE THE
HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
ON
THE ADMINISTRATION'S REGULATORY ACTIONS ON MEDICAID:
THE EFFECTS ON PATIENTS, DOCTORS, HOSPITALS, AND STATES

November 1, 2007



Testimony of Dennis G. Smith
Director of the Center for Medicaid and State Operations at the
Centers for Medicare & Medicaid Services
On
“The Administration's Regulatory Actions on Medicaid:
The Effects on Patients, Doctors, Hospitals, and States”
Before the
House Committee on Oversight and Government Reform
November 1, 2007

Thank you for inviting me to discuss regulatory activities in 2007 by the Centers for Medicare & Medicaid Services (CMS) on a variety of Medicaid regulations, specifically our final rule on Cost Limits for Providers Operated by Units of Government, as well as Notices of Proposed Rulemaking on Health Care-Related Taxes; Graduate Medical Education; Rehabilitative Services; Medicaid Reimbursement for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School; and Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit.

Each of these rules is vitally important to ensure the integrity of the Medicaid program, that Medicaid beneficiaries are receiving the services for which Medicaid is paying, that those services are effective in improving the health outcomes of individuals with Medicaid, and that taxpayers are receiving the full value of their dollars that are spent through Medicaid.

Medicaid: A Partnership with States

Medicaid is a means-tested health care program for low-income Americans, administered by the States within a Federally defined framework. CMS provides matching payments to States and Territories to cover Medicaid services and related administrative costs.

State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. The Federal government's share of a State's Medicaid expenditures is called the Federal Medical Assistance Percentage (FMAP), which currently ranges between 50 percent and 76.9 percent.

States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments. Accordingly, there is variation among the States in eligibility, services, and reimbursement rates to providers and health plans. In short, Federal dollars follow State dollars. Spending also reflects State demographics regarding age and the wellness of the State population. For example, a State with a "younger" population would generally spend less on Medicaid than a State with an "older" population. In 2005, the average per capita spending on a child in the Medicaid program was \$1,608, while the average spending for a senior in the Medicaid program was \$11,898. In FY 2005, 87 percent of children consumed less than \$2,500 in services while 54 percent of seniors required Medicaid benefits in excess of \$2,500.¹

In Fiscal Year (FY) 2008, CMS estimates that approximately 50 million individuals in States and Territories across the country will be covered by the Medicaid program. However, I want to point out that Medicaid is actually at least four distinct programs. First, it functions as a health insurance program for an estimated generally healthy 35.3 million indigent children and their parents or caretaker relatives. Approximately 30 percent of Medicaid expenditures goes to this population. Second, Medicaid provides "Medi-Gap" and long-term care insurance benefits for over 5 million senior citizens. Approximately one-third of Medicaid spending is attributed to long-term care services and supports. Medicaid is estimated to spend over \$11 billion in FY 2008 paying for Medicare premiums and cost sharing on behalf of low-income seniors and people with disabilities who qualify for Medicare. Approximately 20 percent of Medicaid payments

¹ These calculations are based on Medicaid Statistical Information System data for the year 2005. The denominator includes individuals enrolled in Medicaid at any point in the year.

are made on behalf of low-income seniors. Third, an estimated 8.6 million individuals with disabilities rely on the Medicaid program for both acute medical needs and long-term care services and supports, which together will account for about 45 percent of Medicaid expenditures in FY 2008. For individuals with disabilities, Medicaid is not just about access to medical care, but also provides supportive services that enable individuals with disabilities to live in their community as they choose. Finally, through the Disproportionate Share Hospital (DSH) payment program, Medicaid is expected to contribute approximately \$17.3 billion in FY 2008 to hospitals to reimburse them for indigent care as well as to supplement Medicaid payment rates.

According to the most recent unadjusted State estimates, medical assistance payments, Federal, State, and local combined, are projected to total \$345.6 billion in FY 2008, of which \$196 billion will be provided by the Federal government. This is an increase of approximately six percent above spending for FY 2007.

For much of the program, Medicaid looks like a typical third-party payer as it reimburses for inpatient and outpatient hospital services, physician services, laboratory and radiological services and prescription drugs. But Medicaid has also been given unique roles for the special populations who depend on the program. Medicaid is the largest single source of direct payment for nursing home services at a projected cost of \$50 billion in FY 2008. Medicaid is the largest single source of direct payment for mental health services. States project spending nearly \$11 billion on “personal care” services, another \$13.8 billion for intermediate care facilities for the mentally retarded, and \$31.4 billion for home and community-based services for individuals at risk of institutional care. CMS classifies 28 distinct service categories of spending in our budget reporting forms that States are required to submit each quarter. In addition, there is a “catch-all” spending category of “All Other.” In FY 2008, “All Other” will represent \$13.2 billion in spending on other care services that may include non-emergency transportation, physical and occupational therapy, dentures, eyeglasses, and other diagnostic, screening, rehabilitative, and preventative services and emergency hospital services. Notably, this does not include the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit.

States are instructed specifically to report screenings for children under EPSDT as a separate category.

In addition, another \$18.6 billion will be spent on administrative costs, of which the Federal government will provide approximately \$10 billion. Administrative costs are broken down by categories including computer systems, skilled professional medical personnel, external quality reviews, Immigration Status Verification System, and out stationed eligibility workers. Eligibility workers and State and local personnel managing the program make up the bulk of these costs. But we also know that some States also include expenditures for school-based administrative costs, non-emergency transportation, and targeted case management into this item.

My purpose for providing this detail of Medicaid expenditures is to provide a backdrop for the specific regulatory actions we are discussing today. I hope it is helpful for the Committee to understand that there are many different rooms in the Medicaid program and it is often a challenge for CMS to track what may be occurring among the States. Also, to give the Committee appropriate context for today's discussion, I want to clarify that the combined total of these CMS regulatory actions represent approximately one percent of annual Federal spending on Medicaid.

Preserving the Medicaid Partnership

Unfortunately, there is a long and complicated history that is marked by States seeking to shift funding of the Medicaid program to the Federal government; Federal recognition of this occurrence dates back to at least 1991 when Congress enacted prohibitions on provider taxes and donations. Each of the regulations that are the subject of today's hearing has previously been the subject of Congressional scrutiny over the years. Many of the policies that are reflected in these regulations have been advocated or supported by the Government Accountability Office (GAO) in the past or at least acknowledged by GAO as a source of potential Federal fiscal vulnerability.

The essence of these regulations is that Medicaid is a financial partnership and that it is inappropriate for States to shift their matching responsibilities to either the Federal government or to providers.

While we work to protect the integrity of Medicaid as a matching program, we have worked cooperatively with States to resolve funding disputes through a deliberative approach in order to avoid major disruption of State budgets. CMS was successful in ending impermissible funding arrangements in 30 States without creating major funding problems for those States.

The recent financial management actions taken by CMS are in line with the previous Administration. Between FY 1993 and 2000, the previous Administration took 990 deferrals totaling \$3.1 billion and 162 disallowances totaling \$2.2 billion (table attached). Between FY 2001 and 2007, CMS has taken 757 deferrals totaling \$4.7 billion and 189 disallowances totaling \$2.9 billion. There are two caveats to these figures. First, our increased dollar amounts are also on a significantly larger Medicaid program than was the case in the period of FY 1993-2000. Additionally, the \$1.6 billion amount attributed to FY 2001 was in large part due to actions taken by my predecessor against five States related to provider taxes that the Agency eventually lost at the Departmental Appeals Board.

Thus, our actions have caused no major disruptions on State budgets or in the delivery of services to Medicaid recipients. CMS' actions are geared to identifying and preventing the spread of new loopholes that could be used by States to inappropriately shift costs to the Federal government. Medicaid is already an open-ended Federal commitment for Medicaid services for Medicaid recipients; it should not become a limitless Federal account for State and local programs and agencies. To this end, the GAO has provided Congress with numerous reports on how consultants in various areas assist States in maximizing Federal revenues.

Final Medicaid Cost Rule

CMS issued the final rule regarding the Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership (Cost Rule) on May 25, 2007 with a July 30, 2007 effective date. The final rule implements the President's FY 2007 Budget proposal to strengthen the fiscal integrity of the Medicaid program by: (1) limiting governmentally-operated health care providers to reimbursement that does not exceed the cost of providing Medicaid covered services to Medicaid individuals; (2) reiterating that only units of government are able to participate in the financing of the non-Federal share of Medicaid payments; (3) establishing specific cost reporting requirements that build upon existing requirements for documenting cost when using a certified public expenditure; and (4) reaffirming that all health care providers receive and retain the total computable amount of their Medicaid payments.

Over the last few years, CMS has been closely examining Medicaid institutional and non-institutional reimbursement State plan amendments (SPAs) and their associated funding arrangements due to agency concerns about questionable methods of State Medicaid financing. The GAO and the Office of the Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) have expressed similar concerns about Medicaid financing practices. In fact, in 2003 GAO placed Medicaid on its list of "high risk" programs for the first time in the Medicaid program's history in part due to these questionable methods of State financing. Additionally, GAO cited in a recent report, "For more than a decade, we have reported concerns relating to actions by some states that result in excessive federal reimbursement. We have also reported concerns that CMS's oversight of states' claims for reimbursement and CMS's efforts to detect and reduce improper payments in the Medicaid program."²

Prior to the effective date of the Cost Rule, payments to individual State and local governmentally-operated health care providers were not limited to the amount it actually costs to provide these services. Instead, regulations defining the Medicaid Upper

² GAO, *Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts*. GAO-06-705, June 22, 2006, page 1.

Payment Limit (UPL) established aggregate limits on what Medicaid will pay to a group of facilities based on estimates of the amounts that would be paid for similar services using Medicare payment rules. The result of such an aggregate limit would permit a particular governmentally-operated health care provider to receive Medicaid revenue in excess of its Medicaid costs.

By requiring that Medicaid payments to governmentally-operated health care providers not exceed an individual provider's cost, the Cost Rule will ensure that the Federal government pays only its share for Medicaid services delivered by that provider. This reform is critical to strengthening program accountability, consistent with GAO and OIG recommendations.

Some have criticized this rule for potentially having a negative impact on providers. If such an impact were to negatively affect providers, it would be due to decisions made by State and/or local governments, not by CMS. State responsibility for funding has in the past been pushed onto providers. CMS does not believe such maneuvers are appropriate, nor do they meet the matching requirements of the Medicaid program. It is also important to note that non-governmentally operated health care providers, including many of the "public" safety net providers, are not affected by the cost limit provision and therefore, may continue to receive Medicaid payments in excess of the cost of providing services to Medicaid individuals, within existing Federal requirements.

Clarification of Outpatient and Clinic Upper Payment Limit

The proposed regulation intends to clarify the current vague regulatory language in order to define the scope of Medicaid outpatient hospital services and the UPL for those services. Clarifications were made to regulatory language at 42 CFR 440.20 and 42 CFR 447.321. The rule recognizes services paid under the Medicare outpatient prospective payment system or paid by Medicare as an outpatient hospital service under an alternative payment methodology as Medicaid outpatient hospital services. The scope of Medicaid outpatient hospital services may not include a service reimbursed under a distinct State plan payment methodology for another Medicaid covered service. The rule

also limits the facilities that may provide outpatient hospital services to hospitals and departments of an outpatient hospital as defined at 42 CFR 413.65.

In addition, the rule would codify HHS policy regarding the UPL for Medicaid outpatient hospital services in private facilities by referencing accurate data sources and the formula to calculate a reasonable estimate of the amount that would be paid for outpatient hospital service furnished by hospitals and outpatient departments of hospitals under Medicare payment principles.

The regulation intends to prevent an overlap between outpatient hospital services and other covered benefits. The potential overlap could result in circumstances in which payment for services is made at the high levels customary for outpatient hospital services instead of the levels associated with the same services under other covered benefits.

By clarifying the UPL definition, CMS seeks to provide additional guidance on accurate data resources and formulas to help States demonstrate compliance with 42 CFR 447.321. CMS has issued this guidance informally to States in the past. However, a number of States have requested the guidance be issued through regulation. Further, CMS does not anticipate a major impact on providers or beneficiaries under this regulation as we do not believe attempts to inflate UPLs through this manner are widely used currently, but we do believe it is important to clarify this policy.

Elimination of Reimbursement for Administrative Claiming and Transportation Costs for School-Based Services

CMS issued a proposed regulation, published in the Federal Register on September 7, 2007, clarifying that administrative activities performed by schools are not necessary for the proper and efficient administration of the State Medicaid plan. The proposed rule also specifies that transportation of students from home to school and back is not within the scope of allowable Medicaid-related transportation recognized by the Secretary. Therefore, under the proposed rule, funding for the costs of these activities or services performed would no longer be available under the Medicaid program.

I want to strongly emphasize, as there has been some misunderstanding about the proposed rule, that this rule is not a limitation on medical services provided by schools. States will continue to receive reimbursement under the Medicaid program for school-based Medicaid service costs under their approved State plans under current law. For example, if a child is Medicaid-eligible and receives physical therapy, this rule does not change the benefit or the level of reimbursement.

CMS has had long-standing concerns about improper billing under the Medicaid program by school districts for administrative costs and transportation services. Both HHS' OIG and the GAO have identified these categories of expenses as susceptible to fraud and abuse. Congress has also expressed concern over the dramatic increase in Medicaid claims for school-based administrative costs and transportation services, which were the subject of two U.S. Senate Finance Committee hearings.

States reported a total of \$849 million of expenditures for administration and training in FY 2006, of which the Federal share was \$428 million. Most of this spending was concentrated on a handful of States. Specifically, two States accounted for 40 percent of the entire claims submitted for administration and training. Eight States accounted for 80 percent of the claims. Between FY 2002 and FY 2006, two States went from \$0 in claims to more than \$30 million in claims. Conversely, another State went from \$84 million in claims to \$3.5 million in claims during the same period. Some States have made larger claims for administration and training costs than they claimed for actual medical assistance services.

In an audit of one county, the OIG determined that \$5.8 million out of \$12.5 million claimed for administrative costs were in fact not allowable. Medicaid was improperly charged for nearly \$4 million in capital expenditures.

Rehabilitative Services

CMS issued a proposed regulation, published in the Federal Register on August 13, 2007, that clearly defines allowable services that may be claimed as "rehabilitative services."

Rehabilitation services are optional Medicaid services typically offered to individuals with special needs or disabilities to help restore a lost function and improve their health and quality of life. In recent years, Medicaid rehabilitation services have increasingly become prone to inappropriate claiming and cost-sharing from other programs, because these services are so broadly defined as to become simply a “catch all” phrase.

“Rehabilitative services” have become so broad that it has become meaningless and States have taken advantage of the ambiguity and confusion to bill Medicaid for a wide variety of services outside the scope of medical assistance.

CMS believes our regulation will improve the quality of care provided to the individuals who need these rehabilitative services. Our proposed rule is clinically based, and is patient centered.

CMS’ recent history in dealing with SPAs reveals that States themselves often have difficulty in identifying what is actually meant by rehabilitative services and what their reimbursement rates are based upon. Medicaid will benefit from greater clarity and should not be left open to other programs, no matter how important, in search of a funding source.

Proposed Rule on Graduate Medical Education

For several years, many States have developed a pattern of using Medicaid to subsidize the costs of physician training programs. We believe that paying for Graduate Medical Education (GME) is outside the scope of Medicaid’s role, which is to provide medical care to low-income populations. There is no explicit authorization under the Medicaid statute to subsidize the training of physicians. In a time of limited Federal and State resources, it is important to prioritize Medicaid spending and target it to its primary purpose.

Proposed Rule on Provider Taxes

The President’s FY 2007 Budget Request proposed to reduce the reliance on health care related taxes as a source of the State’s share of financing the Medicaid program. The

Administration proposed to reduce the amount of tax collected from health care providers from 6 percent of net patient services revenue to 3 percent. However, before the Administration could proceed with the proposal, Congress took action through the Tax Relief and Health Care Act of 2006 to temporarily reduce the allowable amount from 6 to 5.5 percent of net patient service revenue, effective January 1, 2008 through September 30, 2011.

On March 23, 2007, CMS published a notice of proposed rulemaking (NPRM) to implement the Congress' direction regarding the allowable amount of health care related tax collections. The NPRM also did the following: (1) Clarified the standard for determining the existence of a hold harmless arrangement; (2) Clarified the definition of a managed care organization (MCO) as a permissible class of health care service as enacted by the Deficit Reduction Act of 2005; (3) Proposed to remove language related to "similar services furnished by community-based residences for the mentally retarded under a waiver of section 1915(c) of the Act, in which, as of December 24, 1992, at least 85 percent of such facilities were classified as intermediate care facilities for persons with mental retardation (ICF/MRs) prior to the grant of the waiver" associated with the permissible class of service listed in statute as services of ICF/MRs; and (4) Removed obsolete transition period regulatory language.

Conclusion

We believe these rules reflect the long-standing work of CMS and others such as GAO and the OIG to restore greater accountability to the Medicaid program while safeguarding limited resources for actual services to those individuals who rely on the Medicaid program. CMS understands that Medicaid is one of the largest programs in State budgets, generally accounting for more than 20 percent of a State's total spending. When the Federal government presents a significant disallowance against a State, the effects ripple through State government. Nevertheless, Medicaid is fundamentally a partnership that relies on both sides to contribute their share to the cost of the program.

As Medicaid competes for resources at the State level against all the other demands that are present, an erosion in the confidence in the integrity of the Medicaid program ultimately is not good for Medicaid nor for the people who rely on it. These rules will provide for greater stability in the program and equity among the States.

Medicaid Financial Management Activity - FYs 1993-2007

Year	Deferrals Taken			Disallowances Taken		
	Count	Adm. Exp.	Total	Count	Adm. Exp.	Total
1993	107	\$8,071,237	\$387,948,189	44	\$316,997,995	\$316,997,995
1994	160	\$374,669,404	\$462,695,169	28	\$239,798,011	\$239,798,011
1995	155	\$202,314,112	\$1,096,527,593	31	\$706,604,156	\$706,604,156
1996	118	\$116,328,864	\$297,941,051	32	\$723,666,946	\$723,666,946
1997	109	\$55,003,803	\$115,590,773	10	\$13,269,819	\$13,269,819
1998	125	\$42,175,540	\$148,332,770	8	\$40,506,729	\$40,506,729
1999	126	\$105,424,160	\$135,127,527	3	\$1,664,251	\$1,664,251
2000	90	\$219,977,710	\$180,545,634	6	\$114,612,193	\$114,612,193
Total	990	\$240,551,687	\$2,824,708,706	162	\$2,157,120,100	\$2,157,120,100
2001	92	\$225,493,003	\$302,394,015	22*	\$1,625,258,650	\$1,625,258,650
2002	95	\$42,604,723	\$1,036,763,709	13	\$272,808,879	\$272,808,879
2003	146	\$48,970,624	\$1,292,657,243	14	\$60,229,051	\$60,229,051
2004	101	\$24,760,441	\$364,385,047	38	\$213,982,813	\$213,982,813
2005	98	\$63,038,290	\$304,224,182	28	\$216,094,464	\$216,094,464
2006	148	\$64,764,445	\$555,926,543	25	\$121,107,073	\$121,107,073
2007*	77	\$21,791,205	\$338,944,114	49	\$453,117,461	\$453,117,461
Total	757	\$491,422,731	\$4,195,294,853	167	\$2,962,598,391	\$2,962,598,391

* Only quarters 1 through 3

*portion of FY2001 amount includes disallowances taken between 10/1/00 - 1/19/01, including 5 health care related tax disallowances totaling \$950 million.

Chairman WAXMAN. Thank you, Mr. Smith. Your prepared statement is all going to be in the record.

I want to start the questions, if I might.

Over the past 10 months, CMS has issued six proposed Medicaid rules that would reduce Federal Medicaid payments to States by over \$11 billion. There are persistent rumors that CMS is considering issuing more proposals that will cut Federal Medicaid payments to States even more. Members of this committee, the States, providers, and beneficiaries would all be very interested in knowing whether these rumors are true, so I want to ask you, between today and the end of this administration does CMS plan to propose regulations that would cut Federal Medicaid payments to States for targeted case management services? And if so, when will these proposed rules be published and how much do you estimate they will cut Federal payments to the States?

Mr. SMITH. We are to publish a rule on targeted case management. This is implementing the changes made under the Deficit Reduction Act of 2005, so we will be publishing final rules on that. The estimated savings I think is in the neighborhood of \$4 billion.

Chairman WAXMAN. And these proposed rules are where?

Mr. SMITH. These are under review. I believe they are in the final stages of review. They have been with OMB, so other agencies are looking and commenting, as well, so it is near the end of the process.

Chairman WAXMAN. In the next 15 months, does CMS plan to propose regulations that would restrict the flexibility that States now have to use their own methods for counting income, flexibility that enables States to give Medicaid beneficiaries incentives to work or to recognize the unique expenses many disabled individuals face in their efforts to remain independent? And if so, when will these proposed rules be published and how much do you estimate they will cut Federal payments to the States?

Mr. SMITH. Are you referring to changes in how States do income disregards for eligibility, Mr. Waxman?

Chairman WAXMAN. Yes.

Mr. SMITH. That is an issue that is under consideration. The S-CHIP debate was referenced earlier, and in some respects reflective of that, of how, in discussions about what is the upper limit for income eligibility for Medicaid or S-CHIP, through the use of income disregards going to actually even higher levels than that—

Chairman WAXMAN. So you are looking at this area, as well, for—

Mr. SMITH. It is under consideration. Yes, Mr. Chairman.

Chairman WAXMAN. OK. Let me ask you this: in the next 15 months, does CMS plan to propose any other regulations that would reduce State flexibility or reduce Federal Medicaid payments to the States? If so, what are these proposals, when will they be published, and how much will they cut Federal payments to the States?

Mr. SMITH. Mr. Chairman, we are in the formulation of next year's budget. Decisions have not been made in terms of whether any further regulations, to my knowledge, any further regulations in Medicaid will be proposed. But, as I said, that is the normal

pass-back between agencies and OMB, and final decisions are still generally a month away, month and a half away.

Chairman WAXMAN. Well, we want to know if there are proposals, so we would like to have you inform us of that.

Mr. SMITH. Doing that prior to the release of the President's budget is usually an issue of some sensitivity.

Chairman WAXMAN. The Federal Government spends about \$200 billion to help the States cover over 60 million low-income Americans. Because of the program's size, changes in Federal Medicaid policy could have major impact on States, on counties, on hospitals, on other providers, and, of course, on beneficiaries, who, by definition, are the most vulnerable among us. They have to be very, very poor to get covered under Medicaid.

Each of the proposed rules we are discussing today would make major changes in Federal Medicaid policy. As we heard from the witnesses on the first panel, many of these changes could well cause great harm. Yet, with one minor exception, each of these proposed rules have no statutory authorization, much less a statutory directive. Congress has made no change in the Medicaid statute relating directly to limits on payments to public providers for Medicaid patients since 1997. In fact, the administration in its fiscal year 2005 and 2006 budgets proposed such a statutory change and Congress rejected the proposal.

Congress has made no change in the Medicaid statute relating directly to payments to teaching hospitals for GME since the program's enactment in 1965.

Congress has made no change in the Medicaid statute relating directly to outpatient hospital services since 1967.

Congress has made no change in the Medicaid statute relating directly to payments for rehabilitation services since 1989.

Congress has made no change in the Medicaid statute relating directly to payments for school administrative and transportation costs since 1989.

In only one instance provider taxes has Congress made a change in the Medicaid statute in this past decade, and that change does not support the harmful changes you propose in your March 23rd rule.

In that red folder is a compilation of Social Security Act in the red cover. The Medicaid statute begins at page 1677, where there is a yellow sticker. Could you show us where in the Medicaid Act Congress has specifically directed CMS to issue the rules you propose that we are discussing this morning, other than the provider tax rule?

Mr. SMITH. Well, I think the Medicaid statute, itself, has a number of provisions that instruct the agency to assure that there is a match rate that Congress has established by statute that is updated every year. There is a provision in the Medicaid statute that specifically excludes payments under Medicaid for things that are not Medicaid services. So there are provisions in the Secretary's authority to review State plans, to whether or not those State plans are consistent with the efficiency and economy of Federal reimbursement. So there are a number of provisions in the statute to give us the authority to do what we have done.

Chairman WAXMAN. I just must disagree with you very strongly. I don't see anything in the statute that allows you to decide what is Medicaid eligible and what is not Medicaid eligible. I see nothing that allows you to withdraw \$11 billion in Federal Medicaid funds from the States.

It looks to me like you have just decided to take matters into your own hands. It is a blatant disregard of the prerogative of Congress to make major changes in Federal Medicaid policy. If you want changes, you should propose them. If you propose them and Congress doesn't agree with them, you don't have the ability, in my view, to just come in and propose them by way of rulemaking. I regret sincerely that matters have come to this point, and I strongly urge you to reconsider your course.

Mr. SMITH. Mr. Chairman, if I may, in particular, be able to give you the exact cite, in terms of the cost rule that we have discussed this morning and the impact on the hospitals and the States, etc., again, through State plan amendments, which we have the obligation to review, 1902(a)(2) specifically says that the State match must be assured by the State, that it requires "Federal participation by the State equal to all of such non-Federal share, or provide for the distribution of funds, et cetera."

That does tell me when a State submits a State plan amendment to increase reimbursement for a hospital, that it is my obligation to say I am willing to commit the Federal dollar, but show me your State dollar. That has been the genesis of the problems that we have been talking about in terms of recycling where providers are being required by the State or county government to return money that was meant to pay them for services provided to a Medicaid recipient.

Chairman WAXMAN. I have to move on to other Members, but Mr. Parrella testified that we have had an ongoing working relationship between the Federal Government and the States, a partnership to provide care for the poorest among us for two decades, and some of these State plans are routine. You are taking routine State plans and then trying to jam through changes that Congress never intended, and I don't think you have the authority to do it.

Mr. Davis.

Mr. DAVIS OF VIRGINIA. Thank you very much.

Mr. Smith, if you wait for Congress to act on this, it is an airplane flying into the mountain. It is the fastest-growing part of the Federal budget. It is the fastest-growing part of State budgets. It is annual appropriations \$300 billion a year. That is more than the Defense budget. And we don't vote on it or touch it at this point in Congress. So I think you have a responsibility to make sure that the dollars are spent wisely, and I don't have a comment on these six proposals that you have made, but I think you have every right to get out there and put them out for comment and to see where the public is, who is going to get hurt.

It is not really a question of dollars; it is a question of services and, as you say, making sure that the taxpayers are getting their benefit on this.

It is a difficult job, but if you wait for Congress to act on this there won't be any money left in the budget. This is the single fastest growing part of the Federal budget.

The cuts that they talk about, too, we are not talking about cutting Medicaid payments? The payments go up, don't they, every year? This is just a cut in anticipated growth; is that fair to say?

Mr. SMITH. You are correct, Mr. Davis. This is slowing the rate of growth. As Mr. Shays pointed out, we are talking about \$11 billion over five of which Federal spending will be over \$1 trillion in that time period.

Mr. DAVIS OF VIRGINIA. My understanding is that the Federal portion right now is set to go up \$16 billion in 2008, \$17 billion in 2009, \$21 billion in 2012. That is a lot of money as we go forward.

Health care is a complicated issue and we want to try to make sure that everybody gets served one way or another, but ultimately it is going to be a congressional responsibility to try to sort that out.

I am as frustrated as you are by Congress' inability to act or give you appropriate direction. A blank check isn't the way to solve it.

Let me ask you this: it is projected that the cost of the Medicaid program will double in the next 10 years. To the degree that States are inappropriately shifting costs to the Medicaid program because of the open-ended entitlement structure, what pressure does this add to the Medicaid program and its ability to fulfill its mission to provide medical services to those that are most in need?

Mr. SMITH. Well, Mr. Davis, I think, again, part of it is overall health care and Medicaid's role in that. Clearly, health care in itself is increasing and continues to grow. That is part of that. Medicaid is a component of that larger system. To some extent it causes the increase, even in the private sector. Governor Schwarzenegger, for example, has talked about the increased pressure on the private sector because MediCal under-pays its providers. So there are relationships throughout the system.

It does put greater pressure on everyone. Some changes we have applauded and helped to lead.

Mr. DAVIS OF VIRGINIA. I mean, pressure is everywhere. The providers that were here today, I think we all understand their frustration, as well. I hear from the providers, whether it is doctors or whether it is hospitals, in our area. Everybody is pressured under this current system.

One thing that was noted, they talked about hospital closing in one of the Members' District. Five hospitals were closed in San Diego County over the last 3 years just because of people coming across the border and presenting themselves at the emergency room.

This is a complicated issue.

Let me ask a couple questions. For the purposes of clarifying the impact of harmonizing Medicaid's definition of outpatient services with that of Medicare, will those services that are no longer considered outpatient services no longer be reimbursed by Medicaid?

Mr. SMITH. No, sir. The issue is not whether or not a service will be paid for. Again, there are lots of services provided in an outpatient setting. We would continue to pay for those services.

The issue, though, again, as we saw in State plan amendments in asking States about what they were going to include in, what they were trying to do was basically inflate their upper payment limit for their outpatient hospital service. So it is not an issue

whether or not you are going to pay for a clinic service; it is how it can be used to count toward potentially supplemental payments.

Mr. DAVIS OF VIRGINIA. To clarify the impact on transportation services and Medicaid, could you try to explain how the proposed rule affects the following: First, transportation to school and back for non-school-aged children to receive medical services.

Mr. SMITH. For non-school-age, if they were receiving a medical service at the school, we would pay in that respect. Yes, sir.

Mr. DAVIS OF VIRGINIA. Transportation from school to a community-based provider and back for medical services?

Mr. SMITH. We would pay for that, Mr. Davis.

Mr. DAVIS OF VIRGINIA. OK. Coverage of medical equipment necessary for a disabled student, like a breathing apparatus or wheelchair, to be transported to and from the school?

Mr. SMITH. In that respect, an individual is going to have their own. A child who is on a respirator has the need for a respirator before school, during school—

Mr. DAVIS OF VIRGINIA. Do you cover the equipment, though?

Mr. SMITH. Yes, sir.

Mr. DAVIS OF VIRGINIA. Some of that equipment would be covered by you, and that would continue to be covered?

Mr. SMITH. That would already have been paid for by Medicaid.

Mr. DAVIS OF VIRGINIA. Do you think that some of the services included in therapeutic foster care, when unbundled, will continue to be covered by Medicaid?

Mr. SMITH. Again, Mr. Davis, that is the issue in terms of when we are asking the States what are the components of what they mean. Therapeutic foster care is kind of a catch-all term, and different States are giving it different meanings. But in terms of services, and particularly for individuals that are mental health services, etc., those are all covered services. It is the components that, as I suggested, pushing the corners of the envelope—

Mr. DAVIS OF VIRGINIA. My time is up. Real quick, conceptually what would be covered and what wouldn't be covered? Do you have any concept of what you would be likely to approve and what you wouldn't in an unbundled—

Mr. SMITH. Again, when you are providing mental health counseling, when you are providing intensive mental health services, but when you are going and pushing to say therapeutic foster care also means child care or some other type of more of a social service, we would push back.

Chairman WAXMAN. Thank you, Mr. Davis.

Mr. Davis.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman. Thank you, Mr. Smith.

Mr. Smith, in recent speeches the President has repeatedly said that the administration has a clear principle; that is, put poor children first. Medicaid is the program that insures the poorest children in America. Could you tell me how prohibiting public school nurses from enrolling kids in Medicaid is putting that principle of putting poor children first?

Mr. SMITH. Happy to respond, Mr. Davis.

One of the issues that we face is in the administration and training side of what is being claimed. It is very difficult to actually es-

establish what is happening when we pay that. School-based administration really is concentrated on only a handful of States. Whether or not what they are doing with those funds is widely discussed, GAO has done studies and acknowledged that there were abuses in that setting.

Through audits we are finding Medicaid paying for capital costs of schools because it is being hidden under administration, and Medicaid is being billed for indirect costs.

We obviously want every child who is eligible to be signed up. I have had discussions with California, one of those States. Illinois uses school-based administration. Those two States combined account for 40 percent of all of the school administrative costs that Medicaid is being paid for.

But if you want to sign a child up at school, which I have suggested to California, have the social workers take their laptop down to school on Tuesday afternoons and enroll people.

Mr. DAVIS OF ILLINOIS. You express a number of allegations in your response. Could you tell me what sources of data CMS relied on to develop this proposed rule with respect to both school-based administrative claiming and transportation services?

Mr. SMITH. In terms of what data we have?

Mr. DAVIS OF ILLINOIS. Yes.

Mr. SMITH. The data reporting is uneven because there are different line items in the Medicaid service categories and in administrative costs. There is not a school-based, per se, so we are, to a large extent, relying on the States on how they are reporting what they are doing. But in terms of informing our decision, going forward our Inspector General reports, our own financial management reviews, prior GAO reports. I know Marjorie was here previously and wasn't aware of whether GAO had spoken to school administration, but they did do a report in 2000.

Mr. DAVIS OF ILLINOIS. Well, in this 2000 GAO report on school-based Medicaid services, it was indicated that what was then, of course, HCFA was providing confusing and inconsistent guidance across regions and had failed to prevent improper practices and claims in some States. I guess my question becomes: what activities has CMS engaged in to improve such oversight of school-based administrative claiming in response to this GAO report.

Mr. SMITH. Again, the way States typically talk to us is through their State plan amendments. As State plan amendments come in to us, we discuss those with the States, what is being covered, what is not.

We did release a school-based administration claiming guide in 2003 to clarify, for example, on the match rate on skilled medical personnel.

We have States out there claiming without State plan amendments. We have States out there claiming, saying that the non-Federal share is being paid for with certified public expenditures. We ask where are the certified public expenditures to show that, in fact, the cost has been incurred in the first place, that there was a non-Federal share. Quite frankly, States are often in difficulty producing such documentation.

So we have been increasingly uncomfortable that this is an area that Medicaid is being appropriately making payments, whether or

not there is sufficient accountability. That is my concern, that there is not.

Mr. DAVIS OF ILLINOIS. So you can trust the Medicaid employees but not the school employees?

Mr. SMITH. Mr. Davis, I think that there are a number of examples to where schools and the Medicaid agency, even at the State level, don't see eye to eye.

Mr. DAVIS OF ILLINOIS. Thank you very much.

Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Davis.

Mr. Murphy.

Mr. MURPHY. Thank you very much, Mr. Chairman.

I guess I want to talk about what is happening in the real world out there, which is that you simply can't take a look at the cuts that are being made in Medicaid and make statements such as the one that you have made, or at least that the agency has made, that special education funds should be taken care of by the Education Department or that services for people with mental illness should be the purview of SAMHSA and disease prevention should be in public health without figuring out that the Federal funds flowing to those programs are receiving the same, if not worse, cuts than you are seeing under the ones proposed by these regulations.

It would be one thing if the cuts you were proposing now were being made up in increased or even stable funding in burn grant funding, juvenile justice funding, in IDEA funding, in maternal and child health block grant funding. But the fact is that at the same time that these regulations are being proposed, the very Federal funds that might assist States in trying to find other avenues of funding have been cut, as well, even with more Draconian cuts.

So I guess the question is this: when you are taking a look at these cuts and making claims that these services should be picked up by other State programs, is there any effort to take a look at the other Federal programs that fund those services? And is there any recognition of the fact that those funds coming from the Federal Government that could potentially supplement States in order to make up for your cuts are experiencing even more drastic cuts? I mean, is there any view toward that big a picture?

Mr. SMITH. Thank you, Mr. Murphy. Again, in terms of service, Medicaid services that Medicaid covers that is a medically necessary service, again, we are saying yes to bill Medicaid for that individual and we will pay for it. Oftentimes, as I said, we are being stretched beyond that.

I think, to some extent, again, because there are differences among States and local agencies where these services, programs vary across the country, what we often find it is it started at the local or State level and there is—again, if you have a successful program that you believe is working, that is effective, that is helpful in that individual's life, you support that program.

Medicaid usually comes later, because then they are saying now we have this program but we are paying for it with our own dollars, but if we call it Medicaid—and, Mr. Murphy, there are agencies, there are companies out there, that is their business, for helping States to maximize Federal revenue and helping States to say

call it Medicaid. Now what was 100 percent State or local funded, we can now cut it in half because we have called it Medicaid.

Mr. MURPHY. With all due respect, sir, I don't think that is what is happening, at least in Connecticut and many other States, that there are these rampant abuses happening of things just being called Medicaid. There are, in Connecticut's case, legitimate rehabilitative services that were covered fully with State dollars for years and now there is a choice being made to take advantage of what has, for a very long time, been an available Medicaid match.

I guess you continue to provide testimony this afternoon regarding all these abuses. The solution then seems to be to cut out eligibility of those services rather than to spend some effort and finances and resources to root out the abuses that are happening and make sure that we do not reimburse for those.

So it is a little hard to understand why we aren't here talking about ratcheting up the ability of CMS to root out abuse and fraudulent billing, rather than simply saying it is too hard to figure out whether these administrative costs are really being used for signing up kids or whether they are being used to build walls, and so we are just not going to cover it any more. Why don't we spend more time actually finding out who is abusing the system and allow those who are doing it right to still gain the benefit of the Medicaid match.

Mr. SMITH. Yes, sir. And we are trying to do both. I mean, we certainly want, through management reviews, through OIG audits, want to get the abusing also, but it is also everybody does want to know what the rules are and make sure all the rules apply to everyone. If in region one the Federal Government shouldn't be saying yes that is a rehabilitative service in region one, but in region nine it is not. That shouldn't happen, and that is, again, part of the rationale for rulemaking in the first place, to make certain everybody does have the same understanding.

Mr. MURPHY. And I think that this committee and this Congress would look forward to engaging in a process by which we standardize some of those understandings rather than using the non-standardization as an excuse to simply cutoff funding.

The last thing I will say, Mr. Chairman, is that I do think that there needs to be a little bit more real-world experience put into these rules, whether it is the reality of what these new foster care guidelines will mean for families that are now going to have to maintain very detailed and complicated billing standards, whether it is the statement that you made that you should settle this question for California by simply sending a social worker down with a laptop. Well, in my State we don't have enough money to give laptops to all of our social workers, and the fact that they have more and more to do means that they have less and less time to go down to the school.

The reality on the ground is that these school districts, these social service departments are stretched so thin, these parents who are taking on these very complex children with very complex illnesses are stretched so thin, both emotionally and logistically, that this is going to be very, very hard to implement, and I think very, very hard to understand for people that have less and less resources to do it with.

I yield back the balance of my time.
Chairman WAXMAN. Thank you, Mr. Murphy.
Mr. Shays.

Mr. SHAYS. Thank you. Again, Mr. Chairman, thank you for having this hearing.

The sky isn't falling in. We are talking about \$11 billion savings in the increase over 5 years. We will spend a grand total in the next 5 years of \$1,258 billion, and it would be \$11 billion more if you didn't make these savings. So there is a part of me that wants to know why you aren't doing a better job of getting savings, not to blame you for finding 9/10ths of 1 percent in a budget.

There is no undeclared war on the part of the Bush administration. I voted for the health care bill, CHIPs bill for young people, but the President had legitimate arguments. He said it shouldn't go to illegal aliens, he said it shouldn't go to adults, and he said we should be trying to get those children who are the poorest of the poor that are still part of the program. So I think the President's position, while it is not one that I voted for because I want to expand the program, is not one that says we are declaring war against kids.

Let me ask you, with regard to inter-government transfers, can you speak to what challenges the inter-governmental transfers involving public, non-governmental hospitals raises for CMS, both from a fiscal integrity of the Medicaid program point of view and from conducting oversight of the use of Medicaid funds?

Mr. SMITH. Yes, Mr. Shays.

Again, let me hasten to say there is an inter-governmental transfer recognized in the Medicaid statute that is permissible. What it means by that is the State can share its cost with local government. That is perfectly fine. We are not challenging that. But what has been termed inter-governmental transfer, we have generally been referring to it as recycling. With a provider in 1903, I believe, Congress put a limitation that says non-governmental entities cannot pay the State's share. I am simplifying it, but basically the taxes and donations provision.

What was happening with non-governmental entities were payments were being made and then payments were being returned. We are looking at that as recycling, because we are saying what should we match. If the bill was presented to us for \$100, that a service was provided for \$100 and in a 50/50 State like Connecticut State paid \$50, we paid \$50, but we find out on the back end that the hospital or the nursing home returned, after they got paid, returned \$25 back to the county or the State government.

Mr. SHAYS. So in essence the Federal Government was paying more of the cost than 50 percent?

Mr. SMITH. Correct.

Mr. SHAYS. Let me ask you another question. With regard to rehabilitation services, school transportation, school administrative costs, hospital outpatient services, and graduate medical education, the chairman said, if I heard him correctly, that these programs were going to be discontinued. Is Medicaid eliminating these services for eligible beneficiaries?

Mr. SMITH. No, sir. Medical services that are medically necessary will continue to be covered.

Mr. SHAYS. And does CMS anticipate that these changes will result in the denial of services?

Mr. SMITH. There should not be being denied services because we clearly are saying we will pay our share for those services.

Mr. SHAYS. Let me ask you another question. On the first panel we heard from Ms. Barbara Miller about how important Medicaid rehabilitation services were to bringing her to where she is today. Can you speak to how, either under this proposed rule or under other aspects of the Medicaid program, maybe through waiver authorities, such services as psychiatric rehabilitation will still be covered?

Mr. SMITH. Yes, sir. It will take a little bit of an explanation, if you will forgive me. Rehabilitative services in terms of what she spoke so eloquently about, what is called assertive community treatment—and I have stated publicly and to all types of audiences that assertive community treatment is a model of care and it is a model of care that we do presently support, and we have said we are willing to support. We recently released a State Medicaid director letter again that is very pertinent to people with mental illness on peers of saying that Medicaid reimbursement is available for peer counseling.

So, again, there are models of care that we currently support, that we believe we will continue to support under the rehabilitative services issue.

The habilitation side to where you are getting into—it is not rehabilitation, but habilitation, such as an adult day center, that really belongs to the other side of the Medicaid program of home and community-based waivers, which really is more of a social support mechanism to pay for those things to help people stay in the community, but they are not rehabilitative services. They are not medical services.

So States have that option, as well, for individuals to do adult—if you have a program for adult day program, that belongs on over on the home and community-based services side of the program and we would continue to support that if that is what the State chose to do.

Mr. SHAYS. Thank you, Mr. Chairman.

Mr. SMITH. Yes, sir.

Chairman WAXMAN. Thank you, Mr. Shays. We give a lot of options to States and everybody else to come up with money that the Federal Government won't buy. Or States also have the option of saying no, they don't have the money.

Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman. And thanks to all the witnesses on both panels.

I think the only thing we all can agree on is that no one would want Dennis Smith's job. It is a tough one.

Everybody here knows that this is not just a hearing on whether we have illegally aggressive regulations being promulgated. The hearing is really about the collapse of the U.S. health care system, and this is just evidence of it. Rather than focus on the negative, I think it is important to recognize that we all have a responsibility in this collapse.

I was struck by the testimony on the earlier panel of Drs. Gardner and Retchin, particularly the emergency room story, but Congress passed the law years ago and made it an unfunded Federal mandate. We require hospitals to see most all comers—you can go on diversion—and we didn't pay them for it. We are surprised that the number of ERs in America have gone down relative to the needy population?

There are so many other aspects of this problem. We really need hearings like this every day for years to try to get to the bottom of it.

I am from a State that has been guilty of gaming the Medicaid system. I am embarrassed by that. As we took our legitimate 65 to 67 percent match, in some years we made it 92 percent. Why? Because we wanted to and we could get away with it. That doesn't make it right.

These six regulations, I don't think nobody here is defending them. You still have to because you work for the administration, but it is amazing that in such a giant program that only \$11 billion of savings was found.

I am not suggesting that these are the best ways, but this is such a fly speck of a larger problem. It is almost embarrassing.

The Comptroller General of the United States, David Walker, has written that we face \$50 trillion in outstanding obligations, mainly health care. Today we have no idea how to fund those.

And not a penny of that \$50 trillion is Medicaid, because we don't even have the analytical tools to describe the hole that we are in in Medicaid. Some analysts, like Hal Jackson of Harvard, say that these problems are getting worse to the rate of \$3 trillion or \$4 trillion a year. Of course, the President denies that because he doesn't want the broader measure of our deficit problems.

But that means that any reform proposal that would gain ground on this problem would have to save more than \$3 trillion or \$4 trillion a year. That is unimaginable. I don't know of any group in this country who has come up with a reform proposal of that scale.

Meanwhile, we are like the blind men of Hindustan. You know, we see a portion of the problem and each complain fiercely it looks like a snake to one, a tree trunk to another, a wall to another, and in fact it is an elephant. And we can get mad at each other and finger point and complain and all that, but meanwhile we are confronted by an elephant, and I don't see many people in Congress or outside of Congress that are doing much about it. We need comprehensive health care reform that looks at all aspects of the problem, because Medicaid is one of our most important programs.

The chairman of this committee helped build this program. Committee staff helped build this program. It is painful for them to see it dismantled piecemeal, because piecemeal solutions don't work for anybody—patients, doctors, lawmakers, families.

So it is hard to get at all these issues, and I know I just have a short period of time, but one of the unspoken issues in this hearing is federalism. Under Medicaid we give States so much leeway. I can't help but know the irony that there is Dr. Retchin sitting behind you and he used to run Virginia Medicaid. Dr. Gardner has her former Governor, now President of the United States, from Texas, and Texas is one of the States that has pioneered specialty

hospitals that have no emergency rooms. The national case recently of the person who was dying in a Texas specialty hospital, had to call 9-1-1 because there was no emergency treatment in a Texas hospital because Texas law allows that to happen, why is that?

Now, do we need to override State flexibility? That is an outrage. Yet, it is happening more and more across our country. And that is not technically a U.S. responsibility. The State did it.

Texas has more uninsured children, I think, than almost any other State in America, 25 percent. What an embarrassment. Texas is not a poor State, but they are not taking care of their own kids. Is that our fault?

So there are all these problems we are not beginning to deal with as a Nation, and I just have 5 minutes to make a quick statement, but, for the written record, I would like from you the policy choices that you could have made instead of these six regs, because there have to be other better ways to save money in the Medicaid program. We spend \$2 trillion on health care in America, yet no one wants to give up a penny of what they are receiving, and yet we don't have the best health care in the world. So I would just like to know, from the menu of choices, why you all came up with this \$11 billion and which choices you rejected.

I see that my time has expired, Mr. Chairman. Thank you.

Chairman WAXMAN. Thank you, Mr. Cooper.

Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Mr. Smith, it is good to see you again.

Mr. SMITH. Yes, sir.

Mr. CUMMINGS. As you know, on October 18, 2007, President Bush issued the Homeland Security Presidential Directive No. 21. You are familiar with that, are you not?

Mr. SMITH. [No audible response.]

Mr. CUMMINGS. Well, let me tell you what it says. You look a bit confused. This directive is intended to establish a national strategy for public health and medical preparedness that will "transform our national approach to protecting the health of the American people against all disasters."

Directive 21 instructs the Secretary of Health and Human Services to undertake several critical tasks. Among these are two of particular relevance to our hearing today. The first deals with medical surge capacity that we have heard a bit about during the first panel. Of course, that is the ability of the hospitals and the public health systems to treat large numbers of casualties in a short span of time.

The second instructs the Secretary to "identify any legal, regulatory, or other barriers to public health and medical preparedness in response from Federal, State, or local government or private sector sources that can be eliminated by appropriate regulatory or legislative action."

Based on what we heard from the physicians on the first panel, it seems clear that your proposed regulations constitute a significant legal and regulatory barrier to public health and medical preparedness and response, and, as such, they appear to violate the President's own directive.

How do you respond to those concerns?

Mr. SMITH. Mr. Cummings, in terms of the cost regulation that we have proposed, as I have tried to explain, our policy says the hospital or nursing home or whomever is actually providing the service should get paid and get to keep the money for the service they provided. I don't see that as a conflict with what you have just described.

Mr. CUMMINGS. Did you hear I think it was Dr. Gardner's testimony when she talked about—

Mr. SMITH. I did, sir. Yes.

Mr. CUMMINGS. How does that strike you that anybody sitting in this room—we have, I guess, about 100 people in here—anybody could get sick down there in Texas, I think it is, and be in a position where the patient that she talked about, not even able to get a bed. Does that bother you? I mean, when you hear things like that, does it make you think about that when you go to bed at night and put your family to bed? Do you say to yourself, Boy, it is kind of hard for me to sleep thinking that there are people in the United States, some of them my own neighbors, who might be placed in that position?

Mr. SMITH. Mr. Cummings, I have devoted most of my career to public service. I do it precisely for people who need the support and help of their neighbors.

Mr. CUMMINGS. And so you sleep well at night?

Mr. SMITH. Yes, sir, I do.

Mr. CUMMINGS. I see. So you feel, as far as these directives are concerned, when it comes to the graduates, the graduate schools, does that concern you that we may have some problems there? You heard the testimony about them?

Mr. SMITH. Health care has many different parts to it, and I absolutely want to make certain Medicaid does its part, but to take on the responsibility of other functions, programs, etc., there are lots of different choices on how to address the graduate medical situation and the hospitals, themselves, that participate in it.

For example, in New York, as New York was one of the previous witnesses, New York has a \$3 billion disproportionate share hospital system. They could use that entire amount for indigent care, but that is a choice that New York makes in the Federal-State partnership.

Mr. CUMMINGS. Well, I am going to conclude because I see we are running out of time and I see that Mr. Kucinich is here, but it seems clear that your agency's rulemaking will harm disaster preparedness in many of our Nation's cities and undermine Federal efforts to strengthen medical surge capacity for pandemic flu, bioterrorism, and other public health threats. At a time when the Congress is providing the Department of HHS billions to enhance emergency preparedness, your agency, in my opinion, is undermining key elements of our Nation's preparedness infrastructure.

I have often said that when we come to positions that we should make them better. I know that you are going to leave here saying that you are going to probably make it better, but I am telling you, after your tenure I think it will be worse. I hate to say that. And I do pray for you as you sleep in peace.

Chairman WAXMAN. Thank you, Mr. Cummings.

Mr. Kucinich.

Mr. KUCINICH. Thank you. I want to thank my colleague, Mr. Cummings. I would ask him if he has a moment if he can stay, because these questions relate to something you and I have worked on together.

Mr. Smith, in May you appeared before the Domestic Policy Subcommittee of this committee, which I am the Chair of the subcommittee, at a hearing on the serious failures to provide dental services to children in Medicaid in general and the resultant death of a child in Maryland, Deamonte Driver. At the time you said you would check on the actual services available in Maryland. Since that time, the subcommittee did its own research, including an audit of United Health Group's claims records in the county where Deamonte Driver lived and died.

Here is what my subcommittee found: that Deamonte Driver was 1 of over 10,780 Medicaid eligible children in Maryland who are enrolled in United Health's Medicaid Managed Care Organization and who had not seen a dentist in 4 or more consecutive years. Only seven dentists provided 55 percent of total service to United beneficiaries in Prince George's County, MD. Nineteen dentists listed in United's dental network provided zero services to eligible children in Prince George's County, MD.

Twenty-two dentists listed by United provided services to only one child merely a single time, and 45 dentists care for eligible children less than 10 times in Prince George's County, MD, and 7 dentists were unreachable by phone.

These findings are appalling, but at least one thing has changed: United Health no longer denies the truth about the inadequacies of their provider network in Prince George's County, MD. On October 18th, they wrote a letter to me in which they conceded that my subcommittee's findings were accurate. They said, "We concur with the majority staff's findings."

My question for you, Mr. Smith, is, would you please tell this committee if CMS had conducted an audit of United Health and was aware of the specific inadequacies of United's dental provider network prior to our subcommittee hearing?

Mr. SMITH. Prior to your hearing we had not looked at the individual records.

Mr. KUCINICH. Since the hearing has CMS conducted an audit?

Mr. SMITH. I spoke with counsel beforehand. I would be happy to speak with you off the record, if that would be fine.

Mr. KUCINICH. You took an oath.

Mr. SMITH. I did take an oath.

Mr. KUCINICH. Has CMS conducted an audit?

Mr. SMITH. We are taking additional steps, Mr. Kucinich.

Mr. KUCINICH. What about the findings?

Mr. SMITH. The findings, sir, are not in at this point. We have not made a final determination.

Mr. KUCINICH. Will you provide this committee all documents and findings within 2 weeks?

Mr. SMITH. I don't expect it will be completed by then, Mr. Kucinich, but when we are completed we will be happy to share the information we have with the subcommittee, with the full committee.

Mr. KUCINICH. Will you provide them in 4 weeks?

Mr. SMITH. [No audible response.]

Mr. KUCINICH. Six weeks? Eight weeks? Three months? Four months? When will you provide this committee with the information that you claim you are trying to get that reflects upon the death of a young man? When will you provide us with the information?

Mr. SMITH. I will furnish it as soon as it is completed. I will furnish you all the records that we have. I am not certain when this will be conducted. I expect it will be done before the end of the year.

Mr. KUCINICH. Mr. Chairman and Mr. Smith, Mr. Smith, we know how bad the problem is in the State of Maryland and we know where you were before our committee hearing. We are wondering what a national audit would show. Has CMS undertaken a national audit in this regard?

Mr. SMITH. We are looking at other States, Mr. Kucinich.

Mr. KUCINICH. Will you provide this committee all documents and findings on those audits?

Mr. SMITH. I am happy to provide what we find.

Mr. KUCINICH. How many other States, sir?

Mr. SMITH. We have just started another State. We are looking at States to look beyond that in terms of where to go after that.

Mr. KUCINICH. Mr. Chairman, I ask unanimous consent to have another minute.

Chairman WAXMAN. OK.

Mr. KUCINICH. I would just say that our subcommittee is going to be relentless on this, Mr. Smith. You are not going to be able to avoid—unanimous consent, Mr. Chairman, for another minute. My time has expired.

Chairman WAXMAN. I am sorry. The problem we have now is we have a vote.

Mr. KUCINICH. I just want to conclude then by saying that you are not going to be able to avoid the scrutiny of our subcommittee or, I am sure, of this full committee. There is a little boy in Maryland who died. We are not going to have any more children dying because CMS has not done effective oversight of these people who are providing care in the name of the Government of the United States, period.

Mr. SMITH. Mr. Kucinich, if I may, Mr. Chairman, I think the work of the subcommittee was extremely helpful and important, and I hope that you would view us as working together on the problem rather than seeing us as an adversary on this issue, because I do not feel that way. I think that we share the same interest.

Mr. KUCINICH. I agree. We are going to work together.

Chairman WAXMAN. Mr. Engel, do you have some questions you want to ask in the short time we have left?

Mr. ENGEL. Yes, thank you. Thank you, Mr. Chairman. Let me thank you for allowing me to participate. I know there is a vote on, so rather than ask all the questions I just want to make a very brief statement.

I want to thank you for your leadership. Obviously, I have also been very troubled by the recent rules proposed by CMS and from what I consider their absolute disregard for Congress. Major Medic-

aid reforms require a congressional role, and by rushing to publish these regulations CMS, in my opinion, has disregarded congressional opposition and attempted to usurp Congress' role and, more importantly, CMS appears to have no regard for our safety net providers and the low income people whose health care would be decimated if these rules were allowed to come to be inactive.

As you discussed today, CMS issued a proposed Medicaid regulation that, in my opinion, threatens public hospitals' ability to deliver vital services and stand ready in the case of a natural disaster or public emergency. This regulation would cut at least \$4 billion in Medicaid funding to safety net hospitals nationwide over 5 years, and CMS subsequently added and issued an additional regulation that would force billions of dollars in Medicaid payment reductions to teaching hospitals, many of whom are public hospitals, which hampers the ability of these providers to provide essential services, including the education of the next generation of medical professionals, despite a shortage of medical professionals.

While we have a 1-year moratorium in place until next May on staying these regulations, if we don't act soon, States, hospitals, and safety net providers are going to have to prepare for the worse, which is catastrophic draft and funding. That is why I introduced H.R. 3533, which has been mentioned several times here today, the Public and Teaching Hospitals Preservation Act, which I am proud to say has 143 bipartisan co-sponsors. You, Mr. Chairman, have been instrumental.

Mr. Smith, I am just wondering if you could please submit to me for the record. It is not possible—some of our colleagues said it before—with the financial pressure these institutions face, these public hospital systems, to sustain these kinds of sweeping cuts, so I would like you to, in writing, tell me how you expect safety net providers that provide essential care to hundreds of thousands of patients that walk through their doors to continue delivering this care. It is just not possible. It is not possible.

And the second question is: the teaching hospitals in my home State of New York currently receive \$1.2 billion in Medicaid GME, graduate medical education, payments annually. If your proposal to eliminate Medicaid GME payments is implemented, you will be essentially cutting medical education payments to New York by 40 percent. We have 15 percent of the teaching hospitals in the country, so it is simply a devastating cut to the teaching hospitals in New York; indeed, to the country, and hospitals across the State. So I do not understand why the administration is pulling support away from training America's future doctors, particularly at a time when there was a well-documented physicians' shortage looming.

If each payer isn't expected to contribute its fair share, who is expected to make up the difference?

I will take it in writing, but I just think these are unconscionable.

Mr. SMITH. We will be happy to respond, sir.

Chairman WAXMAN. Thank you, Mr. Engel.

Mr. Smith, as we conclude, your proposals would have the impact of reducing payment to the States by \$11 billion over the next 5 years. The costs that these Federal dollars now pay for will not magically disappear. People with mental illness will still need re-

habilitation services, school-age children will still need health care. But under your proposed rules, the Federal Government will no longer pay for many of these costs. In other words, what is being proposed is a massive cost shift from the Federal Government to the States, the largest Medicaid regulatory cost shift in memory, and Medicaid has always been a Federal-State partnership.

Second, these proposed rules will result in major disruptions in the State Medicaid programs. Some of these rules threaten key elements of our Nation's health care infrastructure and could harm emergency preparedness. These effects are not well understood because CMS has not done any State by State specific analysis of the impact of its regulation. Perhaps this is because CMS does not have the necessary information, perhaps it is because CMS doesn't want to know. In either case, it is very troubling.

I hope, Mr. Smith, that you or Secretary Leavitt will be moved by what we have learned today and direct CMS to withdraw these proposed rules. If it does not, it will be up to the Congress to take the necessary measures to protect States, hospitals, physicians, and Medicaid beneficiaries from these reckless proposals.

I think you understand where we are coming from, what we feel about this. There is a great deal of intensity. I have to tell you, I don't recall your being elected to any office to write the laws. We were. If you are acting improperly, we will have to take appropriate measures to make sure the laws are enforced, not denigrated.

Thank you for being here. Thanks to the first panel, as well. That concludes our hearing. The meeting stands adjourned.

[Whereupon, at 2:05 p.m., the committee was adjourned.]

[The prepared statements of Hon. Edolphus Towns, Hon. Danny K. Davis, Hon. Diane E. Watson, and Hon. Bruce L. Braley, and additional information submitted for the hearing record follow:]

HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HEARING: "THE ADMINISTRATION'S REGULATORY ACTIONS ON MEDICAID: THE EFFECTS ON PATIENTS, DOCTORS, HOSPITALS, AND STATES"

THURSDAY, NOVEMBER 1, 2007 AT 10:00 A.M. IN ROOM 2154 RAYBURN HOB

STATEMENT OF THE HON. EDOLPHUS TOWNS (D NY-10TH)

THANK YOU, MR. CHAIRMAN FOR HOLDING THIS VERY IMPORTANT HEARING ON, "THE ADMINISTRATION'S REGULATORY ACTIONS ON MEDICAID AND ITS EFFECTS ON OUR PUBLIC HEALTH SYSTEM".

AS A FORMER HOSPITAL ADMINISTRATOR, I APPRECIATE THAT ALAN AVILES, PRESIDENT OF THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, IS HERE TODAY TO TESTIFY CONCERNING RECENT FEDERAL ACTIONS THAT FURTHER THREATEN TO FRAY OUR ALREADY BATTERED PUBLIC HEALTH SYSTEM.

THREE RECENT RULINGS THIS YEAR BY THE ADMINISTRATION ELIMINATE BILLIONS OF DOLLARS IN FEDERAL MEDICAID FUNDING TO OUR PUBLIC HOSPITALS. SOMETHING IS VERY WRONG WITH OUR NATIONAL PRIORITIES THAT WE CUT HEALTH CARE TO THE MOST VULNERABLE, FIGHT OVER CHILDREN'S

HEALTH INSURANCE, YET, WASTE HUNDREDS OF BILLION ON THE WAR IN IRAQ.

I AM A SENIOR MEMBER OF THIS COMMITTEE FROM THE 10TH CONGRESSIONAL DISTRICT OF NEW YORK. MY DISTRICT WILL DIRECTLY SUFFER FROM THESE HORRENDOUS CUTS. MY CONSTITUENTS DEPEND HEAVILY UPON OUR PUBLIC HOSPITALS. WE NEED TO PUT AN END TO THESE INSENSITIVE AND DISASTROUS CUTS NOW. OUR POOR AND WORKING POOR MUST HAVE ACCESS TO THE CARE PROVIDED BY OUR CITY'S HEALTH AND HOSPITALS CORPORATION, THE LARGEST MUNICIPAL HOSPITAL SYSTEM IN THE UNITED STATES. THEY NEED BETTER ACCESS TO PRIMARY CARE, NOT LESS.

MY DISTRICT IS SERVED BY THREE MAJOR PUBLIC HEALTH FACILITIES; KING'S COUNTY HOSPITAL CENTER; WOODHULL MEDICAL AND MENTAL HEALTH CENTER; EAST NEW YORK DIAGNOSTIC AND TREATMENT CENTER; AND, CUMBERLAND DIAGNOSTIC AND TREATMENT CENTER. THESE FACILITIES PROVIDE HIGH-QUALITY CARE TO ALL, REGARDLESS OF ABILITY TO PAY. 30 PERCENT OF PATIENTS AT THESE AND OTHER PUBLIC HOSPITAL FACILITIES IN NEW YORK ARE

WHOLLY UNINSURED, WITH OVER 60 PERCENT OF THE PUBLIC HOSPITAL BUDGET COMING FROM MEDICAID. HOW WILL CITIZENS ACCESS THIS NEEDED CARE WITH THESE DISASTEROUS CUTS?

WE CANNOT AFFORD ANY MORE FRONTAL ASSAULTS ON OUR PUBLIC HOSPITAL SYSTEMS. THAT'S WHY CONGRESS IMPOSED A MORATORIUM ON THE IMPLEMENTATION OF TWO OF THESE RULES. THE IMPLEMENTATION OF THE ADMINISTRATION'S REGULATIONS THREATENS TO REDUCE FUNDING BY HUNDREDS OF MILLIONS A YEAR. THIS MUST STOP!

MY COLLEAGUE FROM NEW YORK, ELIOT ENGEL, HAS INTRODUCED A BILL H.R.3533 – THAT WILL EXTEND THE MORATORIUM FOR ANOTHER YEAR. HIS BILL NOW HAS 135 CO-SPONSORS. I URGE MY COLLEAGUES TO SUPPORT IT AND THAT WE PASS IT IN THIS THE PEOPLE'S HOUSE. WE MUST ACT NOW TO STOP THIS ATTACK ON OUR PUBLIC HOSPITAL SYSTEM.

THANK YOU, MR. CHAIRMAN, AND I YIELD BACK THE BALANCE OF MY TIME.

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**OPENING STATEMENT
CONGRESSMAN DANNY K. DAVIS
FULL OVERSIGHT AND GOVERNMENT REFORM COMMITTEE
“THE ADMINISTRATION’S REGULATORY ACTIONS ON
MEDICAID: THE EFFECTS ON PATIENTS, DOCTORS,
HOSPITALS AND STATES”**

THURSDAY, NOVEMBER 1, 2007

2154 RHOB- 10:00 A.M.

Chairman Waxman and Ranking Member Davis I commend you for holding today’s hearing to bring to light CMS outrageous regulatory actions on Medicaid. Under the auspices of “cost containment”, CMS regulatory actions contradict the administration’s pledge to leave no child behind, put the poor first, and above all, ensure homeland security. Cited proposed Medicaid regulatory actions and reductions will have devastating effects.

Indeed, CMS is calling for new regulatory with dramatic limitations in defining activities, which will result in cut backs on federal matching for a range of health services including:

- Administrative activities associated with Medicaid outreach to children; helping with Medicaid eligibility determination and enrollment of children and referral, coordination and monitoring of medical services to children;
- Reimbursements of “all” transportation, including specialized transportation with special breathing apparatus or special attendant for a child with seizure disorders;
- Funding for hospital outpatient, non-hospital clinic services, mental health; and
- Direct and indirect graduate medical education (GME) payments to teaching hospitals.

In the State of Illinois alone, the rippling effects of proposed regulations will be catastrophic especially for:

- The 52,000 students with disabilities and health related needs being serviced by the Chicago Public Schools (CPS) 1,000 case managers and counselors, as well as 1,600 clinical professionals including social workers, psychologists, nurses, speech pathologists, physical and occupational therapists and hearing/vision technicians to these students at over 600 school sites;
- The 25,000 CPS Medicaid-eligible children with chronic disabilities that impedes them from participation in normal activities of daily living, including education;
- The Illinois Medical District, one of the largest concentrations of medical facilities in the world and home of the John H. Stroger Jr. Hospital of Cook County that provides services over 110,000 patients annually in Adult ER; 45,000 children and adolescents each year in Pediatric ER; and boasts one of the most respected emergency rooms in Chicago and a Level 1 Trauma Center; and
- The University of Illinois at Chicago Medical School—the largest medical school in the United States—that relies upon Medicaid for reimbursements and federal matching of funds for costs of Graduate Medical Education (GME) programs as part of Medicaid reimbursement for inpatient or outpatient hospital services.

Significantly, CMS proposed rule 2261 redefines Medicaid reimbursable rehabilitative services, among other things, excludes from Medicaid reimbursement the rehabilitative services that are “intrinsic elements of programs other than Medicaid, such as . . . education . . .” The failure to define “intrinsic elements”, as used in the proposed rule, provides CMS the discretion (leverage) to eliminate all Medicaid reimbursement for rehabilitative services and administrative activities provide in a school setting.

By all accounts, CMS proposed changes and cost containments will chop away Medicaid for low-income Americans as we know it today. More broadly, proposed reductions will create reimbursements disincentives for schools' to provide wrap-around services, as well as compromise alliances between schools, social service agencies, hospitals and clinics. Above all, the health of children across America, a prerequisite to success in school as measured in No Child Left Behind goals.

While I'm encouraged by CMS eagerness to cut cost, I'm disturbed by proposed outrageous regulations, especially in light of March 2007 CBO Medicaid Baseline, which found that:

- Elderly and disabled account for 26% of enrollees—68% of Medicaid spending;
- While children account for 48% of enrollees, but only 19% of spending.

It's my hope that invited guest panelist will bring to light why there's a sudden urgency to change statues and implement cost containment measures that contradict the administration's pledge to leave no child behind, put the poor first, and above all, ensure homeland security.

Congressman Danny K. Davis (IL-07)
Oversight & Government Hearing

On:

"The Administration's Regulatory Actions on Medicaid:
The Effects on Patients, Doctors, Hospitals, and States"

Follow-up Questions

Submitted: November 1, 2007

Questions on the School-based Services Proposed Rule for Dennis Smith

1. What are the sources of data CMS relied on to develop this proposed rule with respect to both school-based administrative claiming and transportation services? Please explain how these data sources demonstrated significant improper claiming of Medicaid payments by schools, school districts and states, and how this rule addresses those erroneous claims.
2. A 2000 GAO report on school-based Medicaid services indicated that then HCFA was providing confusing and inconsistent guidance across regions and had failed to prevent improper practices and claims in some states. What activities has CMS engaged in to improve such oversight of school-based administrative claiming in response to this GAO report? (Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight, HEHS/OSI-00-69, April 5, 2000)
3. CMS estimates a reduction in federal spending of \$635 million in FY2009 and \$3.6 billion over the FY2009 - FY2013 period with implementation of the proposed rule on school-based services under Medicaid. How are these cuts distributed across the states? What will the loss in federal dollars be for each state in the first full year of implementation of this rule? And how can states offset these cuts in federal spending?

Proposed rule on Medicaid rehabilitation services

CMS contends that some states have viewed the rehabilitation benefit under Medicaid as a "catch-all" category to cover services included in other federal, state and local programs. CMS defines rehabilitation to include services provided for the maximum reduction of physical and mental disability and measures used to restore individuals to their best functional levels. One purpose of the proposed rule is to draw clearer distinctions between rehabilitative services and, for example, (1) habilitation services under Medicaid (helping persons acquire new functional abilities) which may be provided in intermediate care facilities for the mentally retarded (ICF/MRs), under home and community-based waiver

programs, and through the new state plan option for home and community based services established under DRA, and (2) inpatient psychiatric hospital services for persons under age 21, another Medicaid benefit which may also be provided in accredited psychiatric residential treatment facilities for children that are not hospitals.

Although rehabilitative services may be provided in a facility, home or other setting, the proposed rule specifies that such care does not include room and board in an institution, community or home setting, and thus, is not an inpatient benefit. When rehabilitative services are provided in a residential setting and delivered by qualified providers, only the costs of the specific rehabilitative services would be covered under the rehabilitation benefit.

CMS says this proposed rule is intended to ensure that services claimed under the optional Medicaid rehabilitative benefit are rehabilitative outpatient services, delivered by qualified providers to Medicaid beneficiaries according to a written, individualized rehabilitation plan, and are not for services that are included in other social or educational programs with a non-medical focus (e.g., foster care, child welfare, education, child care, vocational and pre-vocational training, housing, parole and probation, juvenile justice, or public guardianship). Coverage of rehabilitative services would also exclude services that are "intrinsic elements" of programs other than Medicaid.

CMS estimates that this proposed rule would reduce federal Medicaid spending by approximately \$180 million in FY2008 and \$2.24 billion for the period FY2008 - FY2012.

Potential Questions on the Rehab Rule for Dennis Smith

1. What are the sources of data that CMS relied on to develop this proposed rule? Please explain how these data sources demonstrated significant improper claiming of Medicaid payments for rehabilitation services by providers (e.g., schools and school districts) and states, and how this rule addresses those erroneous claims.
2. Does the proposed rule on rehabilitation services completely eliminate all federal reimbursement for such services when delivered in a school setting or arranged by school personnel? If not, what rehabilitation services can schools still be reimbursed for?
3. How will the proposed rule on rehabilitation services affect the delivery of physical, occupational and speech therapy services provided in schools or arranged by school personnel?

4. The proposed rule on rehabilitation services indicates that covered services must be identified under a written, individualized rehabilitation plan. Will the IEPs and IFSPs developed for children with disabilities as required under IDEA fit this definition of a written rehabilitation plan? If not, why not?

5. CMS estimates a reduction in federal Medicaid spending of \$180 million in FY2008 and \$2.24 billion for FY2008 through FY2012 with implementation of the proposed rule on Medicaid rehabilitation services. How are those cuts distributed across the states? What will the loss in federal dollars be for each state in the first full year of implementation of this rule? And how can states offset these cuts in federal spending?

**.Opening Statement
Congresswoman Diane E. Watson
Oversight & Government Reform
Hearing: "The Bush Administration's Assault on Medicaid"
November 1, 2007**

Thank you Mr. Chairman for holding today's important hearing concerning the changes by the Department of Health and Human Services to the Medicaid program. Although, all but one of the new proposed regulations has been finalized, it has been halted by a Congressional moratorium.

If all of the new regulations were to be implemented federal Medicaid funds to states would be cut by over \$11 billion over five years. This loss in funding would be detrimental to the program and its recipients, and would cause states to roll back valuable

services that poor and low income families would need and otherwise would not be able to afford.

Medicaid alone is the nation's largest single insurer, which serves more than 60 million people, which represents 20 percent of the entire population. In California, the Medicaid program is known as Medi-Cal and serves some 6.6 million low income children, their parents, elderly, and disabled people in the state.

For Fiscal Year 2006 through 2007 the State of California budgeted 17.2 billion dollars for Medi-Cal recipients. This is the source of health coverage for almost one in five Californians under the age of 65; one in three of the state's children; and the majority of people with AIDS.

Medi-Cal pays for forty-six percent of all births in the state; two thirds of all nursing home residents; and almost two-thirds of all net patient revenue in California's public hospitals.

Any reduction in funding would cut access to health coverage for countless amounts of children, elderly and disabled people. This is absolutely unnecessary! The Bush Administration had promised to leave no child behind, but left thousands behind or falling through the cracks. Now the Administration is trying to leave everyone behind by cutting healthcare services to some of the most vulnerable people in our country—children, the elderly and disabled people.

We have a moral obligation to take care of those who cannot care for themselves, and I hope we can continue to fund Medicaid as it performs a valuable service to this nation's citizens.

Mr. Chairman, thank you for the time and I look forward to the panel's testimony. I yield back.

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CHAIRMAN, CONTRACTING AND
TECHNOLOGY SUBCOMMITTEE

**Congress of the United States
House of Representatives
Washington, DC 20515**

**Statement of Congressman Bruce Braley
Committee on Oversight and Government Reform
"The Administration's Regulatory Actions on Medicaid"
November 1, 2007**

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I would like to thank Chairman Waxman and Ranking Member Davis for holding this important hearing today to examine proposed regulatory changes to our nation's Medicaid program. I am very concerned about these proposed changes which, if implemented, would cut federal Medicaid funds to states by billions of dollars. I am also concerned that the Centers for Medicare and Medicaid Services (CMS) is pushing these changes over the strong objections of Congress, hospitals, states, and the bipartisan National Governors Association.

I have personally heard concerns from Iowa hospitals about a proposed regulation which would restrict what states may cover as hospital outpatient services. Under this rule, hospitals would not be reimbursed under Medicaid for many programs like annual checkups, vaccinations, and school-based services. Iowa hospitals have also

expressed concerns about a proposed change which would eliminate federal matching funds for Medicaid graduate medical education payments. Unfortunately, this rule would be severely harmful to teaching hospitals like the University of Iowa, which provide essential health services and simultaneously educate our future health care providers. This change would damage these hospitals' ability to treat patients and serve their communities, and would also be harmful to graduate medical education.

I've also heard concerns from people in the state of Iowa about a proposed regulation which would eliminate Medicaid reimbursement for school-based administrative expenditures and costs related to the transportation of children between home and school. The Department of Education in my state is strongly opposed to this change, which would cut critical school-based services for our nation's poorest children. These funds have helped many students in Iowa and throughout the nation, and eliminating these funds would be an irresponsible change that is both harmful to our children and our education system.

I hope that this hearing will shed light on the consequences these regulations could have on patients, doctors, hospitals, and

states, and will help Congress determine how best to respond. I look forward to the testimony of the witnesses. Thank you, Mr. Chairman.



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**Statement for the Record
of the
American Hospital Association
before the
Committee on Oversight and Government Reform
of the
U. S. House of Representatives**

**“The Administration’s Regulatory Actions on Medicaid:
The Effects on Patients, Doctors, Hospitals, and States”**

November 1, 2007

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record for the committee’s hearing to examine the administration’s recent Medicaid regulatory actions. The committee is rightfully concerned that these regulatory actions amount to significant policy changes that may have a negative effect on state Medicaid programs, the hospitals and physicians serving this vulnerable population and, most importantly, the patients themselves.

Since late December 2006, the Centers for Medicare & Medicaid Services (CMS) has issued half a dozen regulations in either proposed or final form that will significantly affect the Medicaid program’s financial and administrative support for hospitals. The majority of these regulatory actions have been described by CMS as necessary to root out problems, particularly with the financing of the program. However, in the written justification for these regulations, CMS suggests that no significant or widespread problems have been identified. Yet, CMS continues to move forward in the face of significant concerns raised by Congress, the states and the provider and advocacy communities.



REGULATIONS UNDER CONGRESSIONAL MORATORIUM

Cost-limit Proposed and Final Rules: Of critical importance are two regulations upon which Congress has imposed a year-long moratorium, as secured by P.L. 110-28. The first regulation restricts payments to financially strapped government-operated hospitals, narrows the definition of hospitals qualifying as public hospitals, and restricts state Medicaid financing through intergovernmental transfers and certified public expenditures. It limits reimbursement for government-operated hospitals to the cost of providing Medicaid services to Medicaid recipients. In addition, the rule restricts states' ability to make supplemental payments to providers with financial need by setting the Medicaid upper payment limit (UPL) for government-operated hospitals at the individual facility's cost. The rule's restrictive definition of government-operated hospitals will have significant practical implications for public hospitals, particularly those that have restructured to achieve gains in efficiency. This regulation is effectively a cut in funding for those public hospitals and safety-net providers that – as CMS has recognized – are in stressed financial circumstances and are most in need of enhanced payments. These cuts will undermine the ability of states and hospitals to ensure quality of care and access to services for Medicaid beneficiaries, as well as to continue their substantial investments in health care initiatives to promote the Department of Health and Human Services' policy goals, including adoption of electronic health records, reducing disparities in care provided to minority populations, and enhancing access to primary and preventive care.

GME Rule: The second rule subject to the Congressional moratorium proposes to eliminate any federal Medicaid support for graduate medical education (GME). This regulatory action represents a substantial departure from long-standing Medicaid policy by no longer permitting matching federal dollars for hospitals' GME costs. CMS claims this rule is a clarification, when in fact it reverses over 40 years of agency policy and practice recognizing GME as medical assistance. The agency's recent action will result in a cut of nearly \$2 billion in federal funds from the program. Finalizing this new policy will put many safety-net hospitals in financial jeopardy, ultimately harming the most vulnerable Medicaid beneficiaries served by these hospitals.

OTHER REGULATIONS

Outpatient Rule: CMS recently issued a proposed rule that substantially departs from long-standing Medicaid policy regarding the definition of Medicaid outpatient hospital services and how costs for such services are treated for the purposes of calculating the hospital outpatient UPL. Under the proposed rule, the types of services at risk for not being reimbursed through hospital outpatient programs include Medicaid's early and periodic screening and diagnostic treatment dental services for children; physician emergency department services; physical, occupational and speech therapy; outpatient clinical diagnostic laboratory services; ambulance services; durable medical equipment; and outpatient audiology services. CMS says this dramatic shift in policy is needed to align Medicaid and Medicare outpatient policies, despite the fact that these programs serve very different populations – Medicaid serves a largely pediatric population, while Medicare serves an elderly population. The effect of "aligning" the Medicaid policies with

Medicare would be to limit overall Medicaid federal spending for hospital outpatient programs and state Medicaid programs.

Provider Tax Rule: The proposed provider tax rule makes changes to Medicaid policy on health care-related taxes used by the states to help support their share of Medicaid expenditures. The AHA specifically objects to CMS' changes to the standards for determining whether an impermissible hold-harmless arrangement exists within a health care-related tax. The rule represents a substantial departure from long-standing Medicaid policy by imposing largely subjective, overly broad standards for determining the existence of hold-harmless arrangements. These proposed policy changes will create great uncertainty for state governments and providers, making it difficult for them to adopt or implement Medicaid health care-related tax programs with reasonable assurance that they are compliant, leaving them unreasonably open to after-the-fact challenges. In addition, the vaguer and broader standards CMS proposes will unduly limit states from implementing legitimate provider tax programs that are consistent with the Medicaid statute and congressional intent.

Drug Rebate/NDC Reporting Rule: CMS, in issuing regulations implementing the Medicaid Drug Rebate program provisions of the *Deficit Reduction Act of 2005*, has chosen to expand a requirement imposed on state Medicaid agencies to collect National Drug Code (NDC) numbers. This regulation expands the NDC reporting requirement for "physician administered" drugs to drugs administered in hospital outpatient settings that are properly exempt. The underlying statute is clear that drugs administered by a medical professional in most hospital outpatient clinic settings are exempt from the Medicaid Drug Rebate program and the new NDC reporting and collection requirements. This policy change is inconsistent with the statute and will result in costly and burdensome reporting requirements for hospitals already straining under tight financial resources.

CONCLUSION

Hospital and state Medicaid programs are hard hit by these new regulatory policy decisions, and Congress and the general public have often been excluded from these policy decisions. The impact of CMS' policies is to limit federal spending and affect access to needed services. And the most significant impact will be felt by the poor children and mothers, the elderly and the disabled that are served by the Medicaid program.

**RESPONSES TO QUESTIONS FOR THE RECORD
House Oversight and Government Reform Committee
Hearing on Medicaid Regulations, November 1, 2007**

- 1. Mr. Cooper requested the policy choices that could have been made instead of the six regs to save money in the Medicaid program (why the six regs were chosen and what other options were rejected).**

The purpose of the six regulations was not simply to save money in the Medicaid program. Each of the regulations was intended to address specific issues, some of which involved fiscal integrity issues and would result in program savings. Two of the regulations, concerning rehabilitative services and case management services, contain substantial beneficiary protections that CMS believes will substantially improve the quality and accountability of Medicaid services. Two of the regulations address expenditures that are simply not authorized under the Medicaid statute, for school administration and transportation to and from schools, and for graduate medical education. And two regulations address the integrity of the State-federal partnership by ensuring that program funds are not recycled or diverted to effectively increase the federal share of responsibility.

CMS examined the impacts of regulatory changes and detailed the policy options contemplated in the discussion entitled "Alternatives Considered," covered in the preamble of the following regulations: 72 FR 29748 (Cost Limit for Governmental Providers); 72 FR 28930 (Graduate Medical Education); 72 FR 45201 (Rehabilitative Services Coverage); 72 FR 73635 (School-based Administration and Transportation); and 73 FR 9685 (Health Care Related Taxes). Specific alternatives considered were not detailed for the interim final rule on optional state plan case management services (72 FR 68077), a regulation promulgated under a Deficit Reduction Act requirement.

As is customary when developing regulations, CMS did weigh the options carefully before deciding on the policies contained in them. We ultimately undertook the rulemaking process in order to inform affected parties, allow for public input, and make clear that the requirements set forth are uniform, fair and consistent with the underlying statutory intent.

The Administration believes that all of these rules will help ensure that Medicaid is paying providers appropriately for services delivered to Medicaid recipients, that those services are effective, and that taxpayers are receiving the full value of the dollars spent through Medicaid. They are rooted in the statutory construction of Medicaid as a matching program and some are the direct result of years of audits and recommendations by the Office of the Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS), and the Government Accountability Office (GAO), as well as our experience in reviewing State plan amendments. These watchdog agencies, for the Executive Branch and Congress respectively, have sounded the alarm about the integrity of the program for years.

CMS believes that these rules are vital to inform policymakers about the nature of activities in the Medicaid program that are all too often hidden from view. When definitions of “rehabilitative services” and “targeted case management” are so broad that they are meaningless, or when the Federal government cannot identify precise spending on Graduate Medical Education or its direct benefits to the Medicaid population, public trust is eroded. These rules will help bring billions of dollars in taxpayer funds out of the shadows and will provide the accountability that is long overdue.

2. Mr. Engel requested a written response as to how public hospitals will be able to provide essential care to patients when faced with sweeping cuts to their funding, and who will pay for graduate medical education if \$1.2 billion in Medicaid GME payments are eliminated.

While we appreciate your concerns and believe it is important for our nation to have access to a workforce of trained physicians, we also believe that CMS must abide by the statutory requirements set forth for the Medicaid program.

Under section 1903(a)(1) of the Social Security Act, federal financial participation (FFP), is available to States for a percentage of amounts “expended ... for medical assistance under the State plan.” The care and services that may be included within the scope of medical assistance under a Medicaid State plan are generally set forth in section 1905(a) of the Act. Included in this list, for example, are inpatient and outpatient hospital services. Graduate medical education (GME) is not included in this list of care and services within the scope of medical assistance. CMS does not believe that it is consistent with the Medicaid statute to pay for GME activities either as a component of hospital services or separately. GME is not a health service that is included in the authorized coverage package. Nor is GME recognized under the Medicaid statute as a component of the cost of Medicaid inpatient and outpatient hospital services.

To address these concerns, CMS issued the proposed rule relating to Medicaid GME payments which you have referenced. States have the option of continuing to make GME payments to hospitals using other funding sources including state funds, national grants or requiring other local entities to participate in the funding of the state’s medical education program.

The proposed rule addressing governmental providers will protect public hospitals from being required to return or refund some or all of their Medicaid payment. Instead, public hospitals will receive the full benefit of claimed Medicaid payments. This proposed rule will also provide that public hospitals may receive payment for the full cost of serving Medicaid patients, and so should not affect the ability of public hospitals to provide essential care to Medicaid patients. In addition, the Medicaid statute permits States to make additional payments to disproportionate share hospitals that may address the costs such hospitals may incur in serving uninsured patients.