GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner *Sonny Perdue, Governor*

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March 19, 2007

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

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

Dear Ms. Norwalk:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule.

The department **opposes** this rule for the following reasons:

1. The state's loss of federal funds without alternative matching state funds sources threatens the financial viability of public providers who would be deemed private under the new rules.
2. Cost-based payment requirements will have an adverse financial effect on public providers who provide a health care safety net to the uninsured and indigent and who are the least able to deal with the loss of revenue.
3. The proposed rules eliminate the state's flexibility in targeting supplemental payments where they are most needed to support the state's healthcare infrastructure.
4. There is insufficient time for the state to obtain alternative matching fund sources or make other changes the proposed rules require.
5. The proposed rules are administratively burdensome for both the state and CMS.

Impact to the State of Georgia

Under this new rule scheduled to go into effect in less than 6 months:

- **HOSPITALS IMPACTED**:
  80 DSH HOSPITALS RECEIVING DISPROPORTIONATE SHARE FUNDING
  65 UPL HOSPITALS RECEIVING UPPER PAYMENT LIMIT PAYMENTS
  None of the non-state, public hospitals in the state of Georgia that currently provides an IGT as the state share of their supplemental payment would receive supplemental Medicaid funds (DSH/UPL) for indigent care.
  THIS INCLUDES GRADY MEMORIAL HOSPITAL IN ATLANTA.

- **NURSING HOMES IMPACTED**:
  78 PUBLIC NURSING HOMES (NON-STATE) RECEIVING UPL FUNDING AND
  12 INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED
  None of the public nursing homes in the state of Georgia would receive supplemental Medicaid funds.

- **PUBLIC HEALTH & MENTAL HEALTH IMPACT**
  159 PUBLIC HEALTH DEPARTMENTS FUNDING AND
  27 COMMUNITY MENTAL HEALTH CENTERS MAY BE SIGNIFICANTLY IMPACTED.

- **GEORGIA'S STATEWIDE HEALTHCARE SAFETY NET WOULD BE SEVERELY UNDERMINED AND IS ANTICIPATED TO COLLAPSE**

Georgia's DSH and UPL programs are primarily financed with intergovernmental transfers (IGTs) made to the state on behalf of non-state governmental hospitals and nursing homes. Under the proposed CMS rules, the state does not believe that any non-state facility previously considered public would be able to retain such a status based on the proposed rules. This is because IGTs are received from hospital and developmental authorities; units of local governments that have access to local tax revenue but do not have authority to levy taxes.

As a result, the state would need new state matching fund sources of approximately $204 million to replace intergovernmental transfers previously used to support the DSH Program ($138 m) and the Hospital ($31 m) and Nursing Home ($35 m) UPL programs. Without such new state matching funds, the state would stand to lose access to $236 million in federal DSH funds, $53 million in federal Hospital UPL funds, and $59 million in federal Nursing Home UPL funds.

While state owned and operated providers are not impacted by the new public provider definitions, they are impacted by that part of the rule that would limit their reimbursement to cost. The department estimates that state owned and operated nursing homes for the developmental disabled would lose federal matching funds of $8.9 million per year and state owned and operated hospitals would lose federal matching funds of $5.0 million per year due to the cost-based payment limits.

The state is additionally concerned about the reimbursement changes that would be necessary for non-institutional based providers who are state owned and operated that are currently paid on a fee-schedule basis. The state has identified the following other state owned and operated providers that would be impacted by the proposed rule: public health departments, community mental health centers, and local boards of education. In each case, the department treats these providers like any other private provider and pays on a fee-for-service basis. In the state, there are 159 public health departments, 180 local boards of education, and 27 community service boards with multiple mental health centers. There are currently no efforts to collect cost for these providers. The absence of cost reporting forms and cost definitions (to be determined by CMS at a later date) makes it difficult to determine the fiscal impact to the state or determine what administrative efforts will be necessary to conduct cost settlements for each and every public provider.

Questions for CMS

The state asks that CMS address the following questions when responding to public comment.

1. Under what regulatory authority can CMS move to more narrowly define a unit of government when the Social Security Act has already defined it in Section 1903(w)(7)(G)?

2. Why does CMS believe it necessary to require statutorily recognized local units of government to have taxing authority before they can be considered public entities?

3. Can CMS' policy objectives be met if a state could demonstrate that a local unit of government had access to local tax revenues?

4. Please address the concern that it appears public providers who are able to operate without local tax subsidies are being penalized.

5. What is the policy basis for limiting reimbursement to cost for public providers? Supplemental payments are already limited to the lesser of charges or what Medicare will pay. Are Medicare rates believed by CMS to be excessive?

6. Why does CMS wish to limit states' flexibility in distributing supplemental payments by requiring provider-specific, cost-based payment limits for public providers?

7. Is CMS aware of the administrative burden that will be created by requiring that no public provider can be paid more than cost--an administrative burden for both the state and CMS? How will this burden be minimized?

8. How does CMS expect states to make alternate financing arrangements to replace the use of intergovernmental transfers or certified public expenditures in less than 6 months? Please describe how time to transition will address the time required for state legislative sessions to meet regarding policy and budgetary changes and the time required for state rule making processes.

9. How does CMS plan to authorize the significant number of required state plan changes that will be necessary to convert to cost-based reimbursement for all public providers before September 1, 2007?

In summary, Georgia's healthcare infrastructure is in danger of the collapse of its health care safety net and of losing $348 million in federal funds without new state matching funds of $204 million. The state expects to lose an additional $13.9 million in federal funds for state owned and operated providers due to cost-based payment limitations and there is an unknown impact on local boards of education, community mental health centers, and public health departments.

On behalf of the department, I respectfully oppose the implementation of these proposed rules and look forward to CMS' response to my questions. Should additional time and consideration be granted to address the federal objectives prompting this rule, its impact on states and our safety nets, and the needs of the people served in the Medicaid program, we are more than willing to work with you on creating a viable alternative.

Sincerely,

Rhonda M. Medows, M.D.