

Date: January 19, 2007

MEMORANDUM

To: National Association of Public Hospitals and Health Systems

From: Powell Goldstein LLP

Re: Proposed Rule Regarding Cost Limit for Public Providers and Defining “Public” Status

On Thursday, January 18, the Centers for Medicare and Medicaid Services (CMS) published a proposed regulation entitled “Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal State-Financial Partnership” (the Proposed Rule) that would make sweeping changes to public provider payment and financing arrangements with State Medicaid programs. The Proposed Rule would: (1) impose a cost limit on Medicaid payments to public providers; (2) impose a new federal definition of public provider status; (3) greatly restrict the sources of non-federal share funding through intergovernmental transfers (IGTs) and certified public expenditures (CPEs); and (4) require providers to receive and retain the full amount of Medicaid payments received.¹

Effective September 1, 2007, the Proposed Rule would cut \$3.87 billion from the Medicaid program over the next five years.² The public has until March 19, 2007 to submit comments, either electronically or via U.S. mail, to CMS. A copy of the Proposed Rule is available at: <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-195.pdf>.

I. Executive Summary

The Proposed Rule would enact significant changes to the Medicaid program in four broad areas:

- Cost limit. The Proposed Rule would impose a cost limit on Medicaid payments to “governmentally operated providers.” Providers would be required to complete cost reports in order to verify compliance with the new limit and would be subject to a narrow definition of reimbursable costs;
- Significant restrictions on non-federal share funding. CMS would impose sweeping changes to permissible sources of non-federal share funding under the Proposed Rule. IGTs would be limited to tax revenues, and CPEs would only be

¹ 72 Fed. Reg. 2236 (Jan. 19, 2007) [hereinafter *Proposed Rule*].

² *Proposed Rule* at 2245.

permissible in connection with cost-based reimbursement and would be subject to stringent new documentation requirements; and

- New definition of “unit of government”. The Proposed Rule would impose a new, restrictive definition of “unit of government,” which would substantially limit the types of entities authorized to provide non-federal share funding and determine which healthcare providers would be subject to the new cost limit. It is unclear whether CMS has the legal authority to impose such a new definition, as well as how NAPH members would individually be affected by its implications.
- Retention Requirement. Providers would be required to receive and retain the full state and federal share of all Medicaid payments received, and CMS would have the authority to examine any associated transactions to ensure compliance with the requirement. It is unclear how effective this provision will be in protecting providers.

These and other provisions of the Proposed Rule are explained in more detail below.

II. Background

For years, the stability of the healthcare safety net in the U.S. has been intertwined with the Medicaid program. In addition to its important role in providing health care coverage to low-income populations, Medicaid today provides a critical source of funding to safety net providers who provide essential services to low income and other vulnerable populations. States have used the payment flexibility available under Medicaid law to target supplemental payments, such as disproportionate share hospital (DSH) and upper payment limit (UPL) payments, to those safety net providers that shoulder a substantial burden of uncompensated care costs.

Supplemental payments are often financed from local sources, including local governments and public providers. Since at least 1977, federal law has permitted states to use IGTs and CPEs to complement Medicaid funding from state general revenues with funding provided by local governments and public providers.³ Traditionally, consistent with federalism principles, the federal government has deferred to states in determining which units of government could be considered “public” for purposes of contributing to the non-federal share of the states’ Medicaid expenditures. Moreover, Congress has been loathe to interfere with funding arrangements between states and local governments, carving out an explicit exclusion from restrictions on provider taxes and voluntary donations for funds transferred from local governments and prohibiting CMS from regulating certain protected IGTs and CPEs:

[T]he Secretary may not restrict States’ use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified

³ See 42 Fed. Reg. 60564 (Nov. 28, 1977).

by units of government within a State as the non-Federal share of expenditures . . . regardless of whether the unit of government is also a health care provider⁴

Since 2001, however, CMS has grown increasingly assertive in its criticism of the arrangements states have in place to finance the non-federal share of their Medicaid programs, concerned that states were using such mechanisms inappropriately to draw down more than their statutory share of federal matching funds. In an April 2004 letter from CMS to the Iowa congressional delegation, former CMS Administrator Mark McClellan introduced new CMS policy (not promulgated in rules or other official guidance) which purported to limit the types of entities eligible to make IGTs or CPEs. In President Bush's Fiscal Year (FY) 2005 and 2006 budget proposals, the Administration called on Congress to enact legislation capping Medicaid payments to public providers to cost and restricting the options available to states for financing the non-federal share of their Medicaid programs. In August 2005, the Administration circulated legislative language to congressional staff, but such language was never even introduced. The Administration changed tactics in the President's FY 2007 budget request and proposed for the first time that such changes be made administratively, as opposed to legislatively.

The Proposed Rule memorializes many of the requirements CMS has imposed on states through individual negotiations over the past three years, but it goes much further in reducing payment limits and restricting non-federal share funding sources. If implemented, the Proposed Rule would effectuate major policy changes in the scope and financing of the Medicaid program.

III. Summary of Proposed Rule

A. Cost Limit

The Proposed Rule would limit payments to providers operated by units of government to "reimbursement not in excess of the individual provider's cost of providing covered Medicaid services to eligible Medicaid recipients."⁵ The limit would apparently apply to all provider types, institutional and non-institutional, except public managed care organizations (MCOs) and State Children's Health Insurance Program (SCHIP) providers. Although the Proposed Rule does not specifically mention professional services, it does not exempt such services, meaning that physicians employed by public entities (including public universities) could also be included. It is unlikely, however, that the limit will apply to payments public providers receive

⁴ 42 U.S.C. § 1396b(w)(6)(A).

⁵ Proposed 42 C.F.R. §206(c)(1). Note that this formulation of the cost limit, read literally, would prohibit any Medicaid payments for uninsured costs, including payments through DSH or through 1115 waivers. CMS clearly does not have statutory authority to eliminate DSH reimbursement for uninsured costs and it has granted expenditure authority to several states to reimburse providers for costs to non-Medicaid eligible individuals. We therefore believe it unlikely that CMS intended the regulation to go as far as the literal language implies, but will seek clarification on this point in comments to CMS.

from Medicaid MCOs, as CMS regulates only the managed care payments from the state to MCOs, not from MCOs to providers.⁶

The rationale relied upon for the new cost limit is CMS' belief that current payments to public providers in excess of cost are used either to subsidize provider operations unrelated to Medicaid or to return some or all of the federally-matched payments to the state. Based on these perceived improprieties, CMS concluded that limiting public providers to cost is necessary in order to ensure that provider payments are consistent with principles of "economy and efficiency" as required under federal law.⁷ According to the agency's Regulatory Impact Analysis (RIA), a cost limit would have the additional benefit of "promot[ing] a more even distribution of funds among all governmental providers."⁸

Although the Proposed Rule is clear in its intent to impose a new cost limit on public providers, there are a number of details that CMS has left ill-defined. For example, the Proposed Rule does not specify precisely how costs are to be determined for purposes of the new limit or which costs may or may not be included. It does, however, require costs to be documented through cost-finding methodologies allocating allowable costs to the Medicaid program subject to CMS approval. Assuming that CMS will apply the policies that it has been developing over the past year or two in the course of negotiations with states that have waivers or state plan amendments limiting payments to cost, it is fair to assume that CMS will allow only a very narrow set of costs to be reimbursed.

Should the Proposed Rule take effect, public providers would be required to complete cost reports in order to verify compliance with the new limit.⁹ Hospitals and nursing facilities would use a "standardized, nationally recognized cost report" (such as the Medicare 2552-96 cost report) to identify allowable Medicaid costs. CMS has stated that any hospital or nursing facility services that are not included in such a nationally recognized cost report are generally not reimbursable, although it would consider exceptions on a case-by-case basis.

For non-hospital and non-nursing facility services, where no standard cost report is available for use, the Proposed Rule would require providers to use a form that must be approved by CMS to provide auditable documentation in support of Medicaid costs. At a minimum, the form would be required to: (1) identify the expenditure category under the state plan; (2) justify the provider's status as a unit of government that falls within the exception to the provider-related tax and donations limitations (see discussion of the rule's requirements below); (3) demonstrate actual expenditures incurred; and (4) be subject to audit and review.

Where a state's Medicaid cost reimbursement system is funded using CPEs, states would be permitted to make interim payments to providers during the year based on costs included in their

⁶ Neither the preamble nor the text of the Proposed Rule explicitly restricts the reach of the regulation to fee-for-service payments only, however.

⁷ 42 U.S.C. § 1396a(a)(30)(A).

⁸ *Proposed Rule* at 2244.

⁹ *Proposed Rule* at 2243.

most recently filed cost reports, but both an interim and a final reconciliation would need to be performed using the as filed and final cost reports, respectively, for the spending year at issue. For states that do not rely on CPEs, the Proposed Rule would require states to review annual cost reports to confirm that actual payments made to public providers do not exceed cost.

As with other parts of the Proposed Rule, the cost limit would be effective as of September 1, 2007. However, the preamble states that the transition periods established under the current UPL rules would remain unchanged, and states still in transition periods will be able to make above-cost payments to public providers through the end of the transition period. A close reading of the proposed revisions to the UPL regulations indicates that although the transition periods are retained, the value of the remaining transition periods will be substantially diminished as transition payments will be phased down to a lower UPL (the cost limit) as opposed to the current law Medicare-based limit.¹⁰

B. Public Status

The Proposed Rule would create a new federal standard for being treated as public for purposes of the Medicaid program, based on a new regulatory definition of a “unit of government.” 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 refrained from regulating. Moreover, CMS’ authority to impose such a narrow definition on states is questionable, given that the statutory definition is much broader.

Title XIX defines a “unit of local government” as “a city, county, special purpose district, or other governmental unit in the State.”¹¹ The Proposed Rule narrows this definition by establishing 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.*”¹² In including the catchall “other governmental unit” in its definition without further restricting the designation to only those units of government with taxing authority, Congress has provided the leeway to recognize the many ways in which states have created local governmental units, including governmental units without taxing authority. In the Proposed Rule, CMS recognizes only a subset of governmental entities as “units of government.” CMS does not explain its authority for such an extraordinary move.

Under the Proposed Rule, only units of government or providers operated by units of government would be eligible to contribute to Medicaid financing through IGTs or CPEs. By the same token, the public provider cost limit would only apply to such providers that are units of

¹⁰ Under the UPL regulations, transition period payments above the current UPL are defined as a declining percentage of an amount defined as “X” – the difference between State Fiscal Year (SFY) 2000 payments in excess of the UPL for SFY 2000. Because the UPL calculation under the Proposed Rule would be reduced to cost, both the current UPL base and the value of the transition payment above the UPL based on X would be reduced. *See* 42 C.F.R. §§ 447.272(e) and 447.321(e); Proposed 42 C.F.R. §§ 447.272(b) and 447.321(b).

¹¹ 42 U.S.C. § 1396b(w)(7)(G).

¹² Proposed 42 C.F.R. § 433.50(a)(1)(i) (emphasis added).

government or are operated by units of government. All other providers would be deemed to be private. Any contributions they make to the non-federal share would be treated as “provider donations” (which are generally impermissible sources of Medicaid funding) and payments to them would be subject to the private hospital UPL (which is based on aggregate payments under Medicare payment principles to all private providers within the state).

In order to be considered a provider that is operated by a unit of government under the Proposed Rule, the provider must establish that:

- The provider has generally applicable taxing authority; or
- The provider is able to access funding as an integral part of a governmental unit with taxing authority (that is legally obligated to fund the governmental health care provider’s expenses, liabilities, and deficits), so that
- A contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues.¹³

This definition largely adopts the standard articulated in former CMS Administrator Mark McClellan’s letter to Senator Charles Grassley (R-IA) in 2004 for determining which providers can make IGTs or CPEs that are protected under the 1991 statute. Notably, however, in identifying providers “operated by” units of government, the definition departs from the formulation used in UPL rules which refers to government “owned or operated” facilities. Public ownership of a provider does not appear to be a relevant factor under the Proposed Rule.

The Proposed Rule would require a significant amount of involvement by government in a healthcare provider’s operations in order for the provider to be deemed an “integral part” of a unit of government. Mere receipt of local government funding would not be a sufficient basis for establishing such a relationship. CMS specifically states that payments from the unit of government for the provision of Medicaid or other services, or payment of special purpose grants, construction loans or similar funding arrangements would not suffice. However, appropriated funding to finance the provider’s general operating budget would establish such a connection. CMS notes that the inclusion of the provider in the unit of government’s consolidated annual financial reports would be an indication that it is “an integral part” of the government. Generally, the unit of government must have a legal obligation to fund the provider’s expenses, liabilities, and deficits.

Many public hospitals have undergone restructuring over the last few decades to establish independence from local governments to improve efficiency and quality while maintaining their public status and public accountability. The Proposed Rule ignores the wide variety of such public restructurings and imposes a single nationwide definition of a unit of government. The types of public providers at risk of being excluded from CMS’s new definition of unit of

¹³ *Proposed Rule* at 2240.

government include authorities, public benefit corporations, and even some state university hospitals. The spillover effects of this novel federal definition into other areas of law and policy are uncertain.

CMS has released an evaluation tool that could assist providers in determining whether they maintain public status under the Proposed Rule.¹⁴ The “tool,” a standard question form, must be completed by states for each provider claimed to be governmentally operated. A copy of this form is available at:

<http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=descending&itemID=CMS1192476&intNumPerPage=10>.

Given the highly fact-based nature of the new standard, it is unclear how every NAPH member would fare under the Proposed Rule. Members should consult their legal counsel for a determination as to the risk of being determined to be a private entity by CMS.

C. Financing the Non-Federal Share: CPEs and IGTs

Permissible sources of non-federal share funding are greatly restricted under the Proposed Rule for both Medicaid and SCHIP. Only units of government or providers operated by units of government – pursuant to the narrow definition described above – would be eligible to participate in Medicaid financing. Moreover, CPEs could be used only in connection with cost-based reimbursement, and IGTs could only be derived from tax revenues. Non-federal share funding that does not meet these requirements would be considered provider-related donations that are largely impermissible under federal law. The result is a significantly narrowed pool of local funding available to support the Medicaid program. States that have been relying on sources that would be deemed impermissible under the Proposed Rule would either have to find other sources of non-federal share funding (such as provider taxes) or cut their programs.

CPEs

The preamble to the Proposed Rule clarifies that certified public expenditures must be actual expenditures tied to a specific provision in the state plan authorizing such expenditures. The CPE, in other words, must be an expenditure “eligible for FFP” (federal financial participation). The CPE equals 100 percent of the total Medicaid expenditure – both state and federal share. CMS then pays the requisite federal share of the expenditure that is certified. Public providers (meeting the new “unit of government” standard) can certify actual expenditures if the state plan provides for cost-based reimbursement of that expenditure. If Medicaid reimbursement is not based on costs, the provider cannot certify its expenditures. Alternatively, a local government that pays a provider (whether or not the provider is considered public or private under the rule) for a Medicaid covered service or DSH-eligible expenditure can certify the amount of those payments (whether or not the payment rate is cost-based). Note that in this latter instance,

¹⁴ *Proposed Rule* at 2242.

however, a \$100 expenditure by a local government to support a provider would draw down only \$50 of federal match (in a state with a 50 percent matching rate), whereas the same \$100 transferred to the state to be used as an IGT would draw down an additional \$100 of match.¹⁵

The Proposed Rule also proposes new documentation requirements whenever CPEs are used to fund the non-federal share of Medicaid expenditures. Governmental entities must submit a certification statement to the Medicaid agency which must in turn submit it to CMS within two years from the date of expenditures attesting that the expenditures are in fact eligible for FFP.¹⁶ To prove that this requirement is met, states will be required to submit auditable documentation in a form approved by the Secretary that will: (1) identify the expenditure category under the state plan; (2) justify the provider's status as a unit of government that falls within the exception to the provider-related tax and donations limitations; (3) demonstrate actual expenditures incurred; and (4) be subject to audit and review. These factors are the same four items required under the new cost limit documentation requirement discussed above in Section (A).

For certain types of Medicaid services, where CMS has found that improper claims have occurred in the past, the Secretary will issue special forms to be used by states to certify that CPEs used to finance the non-federal portion of these services are proper. For example, CPEs used to fund school-based Medicaid services will need to be reported using a CMS-issued form. Any such required forms will be issued through a separate Federal Register notice.

The Proposed Rule offers some guidance as to conditions that would *not* constitute compliance with the new CPE rules. In particular, examples of unacceptable bases for CPEs include:

- A certification that funds are available for expenditure at a state or local level to finance Medicaid expenditures. The funds must actually be spent to be certified;
- Medicaid cost estimates based on provider surveys;
- CPEs based on the provider's provision of services to Medicaid recipients that are higher in amount than actual cost; or
- A certification that presents costs as anything less than 100 percent of the total computable expenditure (e.g., a CPE of the non-federal share amount only).¹⁷

IGTs

With respect to IGTs, the Administration proposes two new major restrictions. First, only units of government (under the new definition) would be permitted to make IGTs. Second, according to the preamble to the regulation, IGT funding can only be derived from tax revenue, as

¹⁵ The local government would have to ensure that the \$100 IGT was properly structured, however, to avoid being considered an indirect provider donation. See discussion of IGT requirements below.

¹⁶ *Proposed Rule* at 2241.

¹⁷ *Id.*

supported by consistent treatment on the provider's financial records. (Interestingly, the text of the regulation (as opposed to the preamble) requires "funds from units of government" and does not repeat the tax revenue source requirement.¹⁸) Notwithstanding the difference in preamble and regulation text, CMS is proposing to require that IGT funding be derived only from tax revenue, which is a significant shift from the current regulation, which permits the use of "public funds" transferred from "public agencies" and has been interpreted to mean any source of public funding (other than federal funds), including patient care revenue and non-patient care revenue received by a public provider.

In addition, CMS has proposed the adoption of a new regulatory requirement mandating that "all providers . . . receive and retain the full amount of the total computable payment provided to them for services furnished under the approved State plan (or the approved provisions of a waiver or demonstration, if applicable)."¹⁹ CMS' rationale for proposing this new IGT requirement is both to prevent the improper inflation of the federal government's proportionate share in funding a state's Medicaid program (through the redirection or assignment of federal Medicaid funds back to the state for purposes of funding additional federal matching payments), and to benefit government providers currently obligated to return a portion of their Medicaid payments to the state. Under the Proposed Rule, CMS would enforce this new IGT restriction by requiring states to show that "the funding source of an IGT is clearly separated from the Medicaid payment that a health care provider received."²⁰ Factors that CMS could look for to determine that a sufficient separation of IGT funding and Medicaid payment has occurred include: (1) evidence that the IGT took place before the Medicaid payment to a provider was made; and (2) the use of a separate account to finance the IGT, where the account is funded by taxes and is separate from the provider's account that receives Medicaid payments.

The regulation gives CMS the authority to "examin[e] any associated transactions that are related to the provider's total computable payment to ensure that the State's claimed expenditure, which serves as the basis for Federal Financial Participation, is equal to the State's net expenditure."²¹ This authority to examine associated transactions could potentially give CMS broad authority to disallow FFP where unrelated payments flow from providers to state or local governments. Moreover, although designed to benefit providers, given the fungible nature of government funding, it is likely that states could reduce other sources of support for providers receiving supplemental payments so that on a net basis the provider is not necessarily benefited by the retention provision.

It is unclear whether and to what extent the retention requirement applies to CPEs. A strict reading of the provision could require states to pass all of the FFP received by the state in connection with public provider CPEs to the certifying public provider.

¹⁸ See Proposed 42 C.F.R. § 433.51(b).

¹⁹ *Proposed Rule* at 2242.

²⁰ *Id.*

²¹ See Proposed 42 C.F.R. § 447.207.

D. Applicability to Waiver States

Throughout the Proposed Rule, CMS confirms that the proposed changes would apply to states that operate Section 1115 waiver programs.²² Although CMS does not elaborate on this applicability, there are at least two ways in which the regulation could apply to Medicaid payments in states operating under waiver and demonstration authorities. First, unless CMS has specifically waived upper payment limit requirements (which it has not done in current waivers), Medicaid payments to public providers would need to conform with the cost limits in the new regulation. Similarly, any IGTs or CPEs permitted in the waiver would need to conform with the requirements in the Proposed Rule. Most waivers include a provision in the Demonstration Special Terms and Conditions which provides that “The State will, within the time frame specified in law, come into compliance with any changes in Federal statutes or regulations affecting the Medicaid program that occur after the approval date of this demonstration.”²³

Even more significant, however, is the potential mandatory revision of expenditure caps negotiated by states in connection with their waivers. Medicaid demonstrations typically must comply with a budget-neutrality expenditure cap calculated based on the Medicaid payments 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. This money becomes available because although the payments are eliminated, the amount of these payments are recognized in the budget-neutrality expenditure caps and can be used for other purposes, such as expanded coverage, Safety Net Care Pools or Low Income Pools to reimburse uninsured costs, or for other Medicaid purposes permitted by the demonstration. However, to the extent a revision in the law such as the Proposed Rule eliminates or severely restricts payments to public providers that formed the basis for the budget-neutrality expenditure cap calculation, the Terms and Conditions require CMS to adjust the cap accordingly.²⁴

Thus, the proposed regulation is likely to have a dramatic impact on budget-neutrality expenditure cap calculations in states where reductions in payments to public providers formed a significant part of the budget-neutrality calculation.

²² See, e.g., *Proposed Rule* at 2240, “all Medicaid payments (including disproportionate share hospital payments) made under the authority of the State plan **and under Medicaid waiver and demonstration authorities** are subject to all provisions of this regulation.”

²³ See, e.g., *California Medi-Cal Hospital/Uninsured Care Demonstration Special Terms and Conditions*, ¶ 3.

²⁴ See, e.g., *California Medi-Cal Hospital/Uninsured Care Demonstration Special Terms and Conditions*, ¶ 4 (“To the extent that a change in Federal law, regulation, or policy statement impacts State Medicaid spending on program components included in the Demonstration, **CMS shall incorporate** such changes into a modified budget neutrality expenditure cap for the Demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law.”) (emphasis added).

E. Projected Federal Savings

Under the Regulatory Impact Analysis (RIA), the federal government would save \$3.87 billion over five years under the Proposed Rule.²⁵ Broken down by year, federal savings include:

- \$120 million in FY 2007;
- \$530 million in FY 2008;
- \$840 million in FY 2009;
- \$1.17 billion in FY 2010; and
- \$1.21 billion in FY 2011.

IV. Public Comment Period

Under federal law, agencies are required to receive public comments on a Proposed Rule for a period of 60 days before a final rule may be issued. Accordingly, comments on this Proposed Rule may be submitted to CMS either electronically or via U.S. mail until March 19, 2007. Comments received prior to the close of the comment period will be posted to the CMS web site, at <http://www.cms.hhs.gov/eRulemaking> as soon after receipt as possible.

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²⁵ *Proposed Rule* at 2245.