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March 19, 2007

**Via Hand Delivery**

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Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
Room 445-G  
200 Independence Ave, SW  
Washington, DC 20201

Attention: **CMS-2258--P**

Dear Administrator Norwalk:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "*Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership.*" 72 Fed. Reg. 2236 (January 18, 2007). The Association represents nearly 300 general acute nonfederal major teaching hospitals and health systems. The Association also represents all 125 accredited U.S. allopathic medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation's medical students and residents.

We agree with the American Hospital Association (AHA) and the National Association of Public Hospitals and Health Systems (NAPH) that the proposed rule should be withdrawn. Its sweeping changes, many of which are not authorized under the Medicaid statute, would seriously compromise an already fragile safety net system—of which teaching hospitals are key participants—that ensures access and quality care for Medicaid beneficiaries and uninsured persons. The proposed rule estimates that the changes would result in \$3.9 billion in federal savings over five years, although the President's FY 2008 budget proposal estimates the savings at \$5 billion. While such numbers are daunting in and of themselves, based on conversations with our members we believe the actual overall reduction in Medicaid payments would be much higher.

The proposed rule provides neither data nor rationales justifying the restrictions the Agency seeks to impose. We urge CMS to work with Congress to determine whether, and to what extent, policy changes to the Medicaid program are needed. If

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notwithstanding the widespread opposition CMS moves forward with a final rule, the Agency should allow for a sufficient transition period that allows both states and providers to adjust their long-standing approved practices to ensure that the needs of Medicaid and other patients are met during the adjustment period.

In the remainder of this letter, we discuss the important relationship between state Medicaid programs and teaching hospitals and their clinical faculties. We then provide comments on specific aspects of the proposed rule.

## **MEDICAID AND TEACHING HOSPITALS AND THEIR CLINICAL FACULTY**

Major teaching hospitals and their clinical physician faculty take seriously their commitment to treating the nation's poor by providing a disproportionate amount of healthcare to Medicaid recipients and uninsured patients while maintaining their core missions of education, research and innovative patient care. While they represent only 6 percent of all hospitals, about 25 percent of Medicaid discharges are from major teaching hospitals. In 2004, these institutions provided nearly half of all hospital charity care in the country. Medicaid accounts for 16 percent of the healthcare provided by faculty practice groups, compared to only 10 percent provided by community-based multi-specialty groups.

In addition to being important participants in the nation's health care "safety net," teaching hospitals have unique roles that extend beyond the normative patient care services. These include being sites for the clinical education of all types of health professional trainees; providing environments in which clinical research can flourish; and being sources of specialized, unique, and referral/standby services. Because of their education and research missions, teaching hospitals typically offer the newest and most advanced treatments and technologies, and often care for the nation's sickest and most complex patients. Today, major teaching hospitals also are looked to as front-line responders in the event of a biological, chemical or nuclear attack and they are constantly refining their capabilities to fulfill this role.

Undertaking these missions has important financial consequences. Thus, it is not surprising that the aggregate total margin for the nation's major teaching hospitals is consistently and significantly below that of other hospital groups. In some years, the margins have hovered near zero. In 2004, the most recent and most complete data available, the aggregate total margin for major teaching hospitals (those with an intern/resident-to-bed (IRB) ratio of 0.25 or more) was only 3.4 percent; the average and median total margins were 1.5 percent and 2.4 percent respectively. By contrast, the aggregate total margin for other teaching hospitals was 5.0 percent, and 4.7 percent for nonteaching hospitals.

State Medicaid programs and the academic medical community have worked together over many years to ensure that the health care needs of Medicaid patients are met while allowing teaching hospitals and their faculty to also fulfill their other missions.

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Consequently, it is important that changes to the Medicaid program are viewed within this context. We are concerned that the totality of the changes in the proposed rule, if finalized, would significantly upset the delicate balance of resources that teaching hospitals rely on to fulfill their patient care and other missions.

### **THE PROPOSED COST LIMIT ON MEDICAID PAYMENTS TO PUBLIC PROVIDERS**

The proposed rule would limit reimbursement for government-operated hospitals to each entity's cost of providing Medicaid services to Medicaid recipients. Currently, state Medicaid programs have "upper payment limits (UPLs)" which, for government-operated providers, are based on what Medicare would pay for the same services and are calculated at an aggregate level. This allows states the flexibility to vary the amount paid to hospitals within the category, so long as the aggregate limit is not exceeded.

Over time, Medicaid has moved away from cost-based reimbursement because it does not provide incentives for efficient performance. Increasingly, states have followed the Medicare model and established prospective payment systems for their Medicaid programs. This approach encourages efficiency by rewarding hospitals that constrain their costs below the payment amount. Returning to cost-based limits would be returning to an ineffective policy that has been soundly rejected not only by Medicare but by many private payers as well.

CMS asserts in the proposed rule that facility level cost limits are necessary because providers "use the excess of Medicaid revenue over cost to subsidize health care operations that are unrelated to Medicaid, or they may return a portion of the supplemental payments to the State as a source of revenue." (72 Fed. Reg. at 2241). However, the proposed rule presents no data or other facts to support its assertion. Moreover in court filings, the Agency has explicitly recognized the value of allowing states flexibility to direct higher payments to certain hospitals having special needs (See AHA Comment Letter at 5-6).

The proposed rule position also is at odds with the current policy that establishes an aggregate UPL for private hospitals. The policy is the right policy for private hospitals and there is no reason to establish a separate and unequal policy for government providers.

Finally, section 705(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) directed CMS to apply an "aggregate upper payment limit to payments made to government facilities that are not state-owned or operated facilities." The proposed rule is in direct contradiction to this Congressional mandate and thus this proposal must be rescinded.

## **DEFINITION OF “COSTS” FOR PURPOSES OF APPLYING A FACILITY-SPECIFIC LIMIT**

The proposed rule does not address specifically what costs would be included in the determination of the facility specific-cost limits. We assume, but would like CMS to confirm, that such costs include all those costs necessary to operate the hospital. For teaching hospitals, such costs include those associated with graduate medical education.

The President’s fiscal year 2008 budget request includes an administrative proposal to eliminate federal Medicaid matching payments for graduate medical education (GME) funding . Along with Medicare, Medicaid is a key contributor in helping to offset some of teaching hospitals’ GME costs. As of 2005, Medicaid programs in 47 states and the District of Columbia provided funds for GME costs.<sup>1</sup>

We strongly oppose this budgetary proposal. We also question whether the Administration can implement such a proposal without explicit statutory direction. If the Administration does choose to raise this as a regulatory issue, we believe it would be necessary for CMS to issue a distinct and explicit notice and comment rulemaking process.

## **THE PROPOSED RE-DEFINITION OF “UNIT OF GOVERNMENT”**

The proposed rule would redefine the phrase “unit of government” by requiring that:

- The health care provider has generally applicable taxing authority; or
- The health care 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.

Source: 72 Fed. Reg. at 2240.

We agree with comments by the AHA and NAPH that this redefinition is both incompatible with and contrary to the Medicaid statute.

Such a narrow redefinition would drastically limit the number of providers that may participate in the state financing of Medicaid through allowable intergovernmental transfers (IGTs) or certified public expenditures (CPEs). It also would pre-empt long-standing state authority to define governmental entities.

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<sup>1</sup> Henderson, Tim. “Medicaid Direct and Indirect Graduate Medical Education Payments: A 50 State Survey (November, 2006).

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Perhaps most importantly, this proposal runs counter to the trend of states and their associated hospitals to identify ways that maintain important state-provider relationships while allowing such providers to pursue enhanced efficiencies that are unobtainable under traditional state relationships. By reorganizing the governance structures, a number of public teaching hospitals have been given the autonomy and flexibility to implement efficiency and cost-containment measures that yield hospital and program savings, and often result in improved access and higher quality care for patients.

NAPH's comments eloquently and articulately describe such restructuring arrangements. They also discuss how these reconfigurations enhance the fiscal viability of the health care safety net, as well as improve access, quality, program responsiveness and public accountability. While perhaps not fully contemplated by the Agency, we believe CMS's proposal would result in an operational retrenchment of no benefit to states, hospitals and, most importantly, Medicaid beneficiaries.

We urge the Agency to withdraw the proposed redefinition.

#### **PROPOSED LIMITATIONS ON INTERGOVERNMENTAL TRANSFERS (IGTS) AND CERTIFIED PUBLIC EXPENDITURES (CPEs)**

If finalized, in combination with its redefinition of "unit of government," the proposed rule would drastically restrict states' abilities to use allowable IGTs to finance the non-federal share of Medicaid payments. Specifically, the proposed rule preamble states that where a governmentally operated health care provider has transferred the non-Federal share in order to receive matching federal payments, the state must be able to demonstrate that "the source of the transferred funds is State or local tax revenue (which must be supported by consistent treatment on the provider's financial records)." (72 Fed. Reg. at 2238).

In the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234), Congress modified the use of provider taxes and donations to finance the non-federal share of Medicaid payments, but explicitly made clear that those restrictions did not affect IGTs (see Social Security Act 1903(w)(6)(A)). Given Congress' clear intent to protect states' uses of IGTs and CPEs as financing mechanisms, such direction must come from Congress and should not be unilaterally implemented through regulation.

We also have serious concerns on the proposed rule's treatment of CPEs, specifically the proposal to impose new documentation standards including the limitation to cost-based policies. We believe that there are less burdensome ways to ensure the accuracy of Medicaid claims submitted for purposes of CPEs.

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## **EFFECTIVE DATE AND TRANSITION PERIOD**

As stated above, we believe the prudent course of action is for CMS to withdraw this proposed rule and work closely with the Congress and the health care community to address Agency concerns about current Medicaid policies. However, if CMS decides to move forward with some form of final regulation, we believe that a) the effective date for the new cost limit, unit of government definition, and limitations on IGTs and CPEs must be extended beyond September 1, and b) the final rule must be accompanied by a significant transition period. Both states and providers will need time to accommodate to the new policies and find alternative funding sources to minimize access and financing problems. We support NAPH's recommendation that such a transition period be 10 years.

## **CONCLUSION**

The Medicaid program and teaching hospitals have a long history that has helped to ensure that poor and uninsured patients have access to high quality care. The proposed rule runs the grave risk of unraveling this fragile structure. We urge the Agency to rescind the proposed rule and work with states and providers alike to initiate improvements to the Medicaid program that both strengthen it and ensure its long term financial viability.

If you have questions concerning these comments, please do not hesitate to contact me or Karen Fisher, Senior Associate Vice President. We both may be reached at (202) 828-0490.

Sincerely,

/s/

Robert M. Dickler  
Senior Vice President  
Division of Health Care Affairs