

# NATIONAL ASSOCIATION OF URBAN HOSPITALS

*Private Safety-Net Hospitals Caring for Needy Communities*

March 12, 2007

Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
P.O. Box 8017  
Baltimore, MD 21244-8017

Subject: File Code CMS-2258-P

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to express our concern about selected aspects of the 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,” which was published in the *Federal Register* on January 18, 2007.

NAUH is concerned about the implications of limiting Medicaid payments to providers operated by units of government to their actual costs. Specifically, our concerns are as follows:

1. The proposed regulation would reduce the ability of states to draw down federal financial participation for their Medicaid programs, reduce states’ overall Medicaid funding, and have serious implications for all providers of care to Medicaid recipients.
2. The proposed regulation would inappropriately cap federal participation in Medicaid payments to public providers at providers’ costs.
3. The proposed regulation’s definition of what constitutes a provider operated by a unit of government is unclear.

NAUH recognizes that to a significant degree, the proposals to which we object have been formulated by the Centers for Medicare & Medicaid Services (CMS) to prevent states from seeking federal financial participation through widely used mechanisms that are within the letter of the rules of the Medicaid program but appear, in some respects, to violate the spirit of those rules. We also realize that some states may be using these Medicaid funds for non-Medicaid purposes – and even for non-health care purposes. Instead of preventing states from drawing down additional federal funds to help pay for care for low-income residents, however, we urge CMS to develop better means of identifying inappropriate, non-health care uses of federal Medicaid funds and deal with offending states accordingly. We believe this is a situation in which the many states putting such funds to good use should not be penalized for the misdeeds of a few other states. Similarly, we do not believe individual providers should be penalized because of the actions of state governments – actions over which they have no control. This is especially a concern for NAUH because without question, the burden of this penalty would fall most heavily upon public hospitals and urban safety-net hospitals – providers that care for larger numbers of low-income patients than the typical provider and that together constitute the heart of the American health care safety net in this country today.

Keeping in mind that this is the context for the concerns we have about the proposed regulatory changes, we address each of those concerns separately below.

### **The Proposed Regulation Would Reduce the Ability of States to Draw Down Federal Financial Participation for Their Medicaid Programs**

*(Issue Identifier: Source of State Share and Documentation of Certified Public Expenditures)*

The proposed regulation would reduce state Medicaid resources by preventing states from claiming federal financial participation for payments to public providers that exceed 100 percent of those providers' costs for Medicaid services. This would have the net effect of reducing the overall total of federal Medicaid funds that states receive, which in turn would affect states' ability to compensate providers adequately for the care they provide to their Medicaid patients. This comes at a time when most states' Medicaid payments to providers do not even begin to cover the actual cost of the care for which they ostensibly are paying. Because states with public hospitals will probably favor their public hospitals in the distribution of available resources, we believe that reducing the overall pool of resources available to states may end up hurting private, non-profit safety-net hospitals – hospitals that are as much a part of the health care safety net as their public counterparts. Any reduction in resources made available to private hospitals – whether such reductions take the form of lower payments, limited benefits, or reduced eligibility of Medicaid – may jeopardize the financial health of providers that care for especially large numbers of low-income (Medicaid and uninsured) patients and could, in the long run, threaten the viability of the health care safety net by starving that safety net of the resources it requires to meet the needs of those who depend on it for access to care.

### **The Proposed Regulation Would Inappropriately Cap Federal Participation in Medicaid Payments to Public Providers at Providers' Costs**

*(Issue Identifier: Cost Limit for Providers Operated by Units of Government)*

Currently, Medicaid regulations permit states to pay providers, both public and private, more than their actual costs for serving their Medicaid patients. This is part of a long tradition in the program and is based on the belief that the states, because they are closer to the health care needs of their residents, are in a better position to decide how best to use their Medicaid resources than the federal government. This proposed regulation, however, effectively rejects this long-held belief and, by limiting payments to public providers to 100 percent of their costs, would increase federal control over how states spend their Medicaid funds. Similarly, among the biggest Medicaid priorities among governors in the U.S. today is their desire to have more flexibility, not less, in how they structure their Medicaid programs and expend their Medicaid resources. In general, the administration has supported this desire. This proposed regulation, however, would reduce states' flexibility, not increase it.

States traditionally pay limited numbers of providers more than their Medicaid costs because those providers are located in areas where, in addition to caring for large numbers of Medicaid patients, they also care for large numbers of uninsured patients. The cost of caring for these uninsured individuals is so great for some providers, however, that without these above-cost payments and other supplemental public funds (including but not limited to Medicaid DSH payments), the financial health of these providers would be in jeopardy – as would their continued ability to serve all of their patients: not just their Medicaid patients, but also their Medicare and privately insured patients. NAUH believes it is entirely appropriate for state Medicaid programs to pay some providers more than their costs and asks CMS to reconsider this aspect of the proposed regulation.

NAUH is concerned that if states cannot pay public hospitals more than their costs for treating Medicaid patients, those public hospitals will have a drastically reduced financial capacity to treat uninsured patients and be forced to turn away some or even many non-emergency, uninsured patients. If those patients turn to private safety-net hospitals, the financial burden of treating them could threaten the financial viability of private safety-net hospitals as well. NAUH believes it is entirely appropriate for state Medicaid programs to pay some providers more than their costs and asks CMS to reconsider this aspect of the proposed regulation.

NAUH opposes, in principle, limiting Medicaid payments to any hospitals to cost. Hospitals that care for large numbers of Medicaid recipients inevitably care for larger numbers of uninsured patients as well; this is certainly the case for public hospitals, as it is for private, non-profit urban safety-net hospitals. Like their public counterparts, private hospitals like these need supplemental funds if the cost of caring for so many uninsured patients is not to overwhelm them and jeopardize their future ability to serve all of their patients – not just their Medicaid and uninsured patients, but their Medicare and privately insured patients as well.

**The Proposed Regulation's Definition of What Constitutes a Provider Operated by a Unit of Government is Unclear**

*(Issue Identifier: Defining a Unit of Government)*

NAUH has attempted to apply the proposed regulation's definition of what constitutes a provider operated by a unit government to a number of different hospitals and types of hospitals and has found that the proposed guidelines do not always enable us to reach a definitive conclusion on some providers' status. We respectfully request that the Centers for Medicare & Medicaid Services look into this question and consider revisions that may clarify these guidelines.

**About the National Association of Urban Hospitals**

The National Association of Urban Hospitals (NAUH) advocates for adequate recognition and financing of private, non-profit, urban safety-net hospitals that serve America's needy urban communities. These private, urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private, urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

\* \* \*

We appreciate your attention to NAUH's suggestions and concerns and welcome any questions you may have about them.

Sincerely,

Ellen J. Kugler, Esq.  
Executive Director