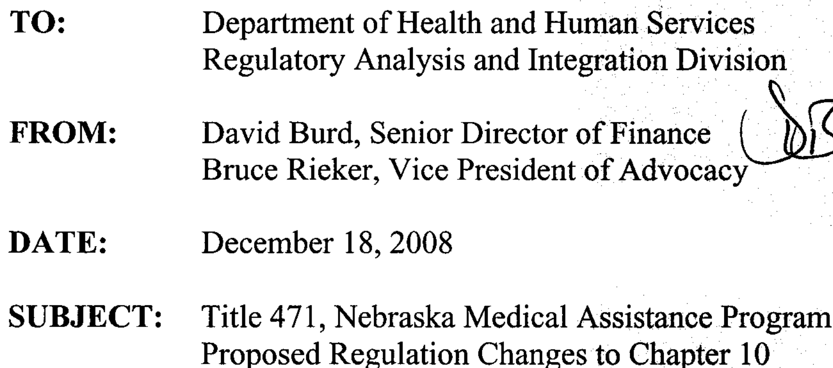
Nebraska Hospital Association



TO: Department of Health and Human Services
Regulatory Analysis and Integration Division

FROM: David Burd, Senior Director of Finance
Bruce Rieker, Vice President of Advocacy

DATE: December 18, 2008

SUBJECT: Title 471, Nebraska Medical Assistance Program
Proposed Regulation Changes to Chapter 10

The Nebraska Hospital Association (NHA) **opposes** the proposed changes to the Nebraska Disproportionate Share Hospital (DSH) program in Title 471, Chapter 10 of the Nebraska Administrative Code.

The DSH program was created by the United States Congress in 1981 to compensate hospitals for serving a disproportionate share of low income individuals who are part of the Medicaid system or are uninsured. Under current law, DSH payments are subject to a series of caps, both on the amount of DSH money an individual hospital can receive as well as on the total amount of DSH payments made within the state. The Medicare Modernization Act of 2003 increased state allotments by 16 percent annually over a five year period for low DSH states. A state is designated as a low DSH state if their DSH expenditures are less than 3 percent of their medical assistance expenditures. Nebraska is designated as a low DSH state and consequently is eligible for additional federal funding for the DSH program.

In order to receive these additional federal funds, the state must first produce its matching portion of the DSH payment. The NHA and our member hospitals have been working in cooperation with Health and Human Services (HHS) to find a solution that would not require new state funds. After much discussion and research, together we found a way to accomplish this goal and avoid losing millions of federal dollars made available to assist hospitals that treat an above average number of Medicaid and uninsured patients.

The solution consisted of utilizing existing general assistance payments from the counties and behavioral health payments from the regions as the state match in order to obtain the federal match and therefore, increase the overall funding available within the DSH program without requiring any new state expenditures. A significant amount of time and effort have gone into making this solution a reality. LB 292 was passed into law in 2007 to allow counties to transfer general assistance funds to HHS prior to the payments being made to providers. Agreements between HHS and Lancaster and Douglas counties have also been signed and implemented. In approximately June 2008, Lancaster and Douglas counties began transferring funds to HHS and to date $1.4 million of additional federal

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funds have been received. **It is critical that we implement a similar process with the behavioral health regions in order to avoid leaving a significant amount of federal funding on the table that has already been allotted to Nebraska.**

The proposed regulation would combine the previous Pool 1 and Pool 2 into one pool, decrease the funding in Pool 3 (would become Pool 2), maintain the funding for Pool 5 (would become Pool 4) and remove "hospitals that provide services to low-income persons covered by the state-administered public behavioral health system" from Pool 6 (would become Pool 5).

HHS has expressed concerns regarding whether behavioral health regions would be considered a "unit of government" and therefore eligible for an intergovernmental transfer. The NHA appreciates these concerns and agrees that steps should be taken to ensure that any process established with the regions would be in compliance with the Centers for Medicare and Medicaid Services (CMS) regulations.

On May 29, 2007, CMS issued a final rule titled "Medicaid program; cost limit for providers operated by units of government and provisions to ensure the integrity of federal-state financial partnership". On page 29826 of the final rule, CMS defines a unit of government as having "**taxing authority or direct access to tax revenues.**" According to CMS the phrase "has direct access to tax revenues" was added to recognize as governmental those entities that do not have taxing authority, but do have direct access to tax revenues that are imposed by a parent or related unit of government. CMS states "for example, when a tax is imposed and collected by a State but is dedicated for use by a municipality or other entity, that entity would satisfy the criteria of direct access to tax revenues."

The NHA contends that the behavioral health regions would qualify as a unit of government based upon this definition and therefore, establishing an intergovernmental transfer agreement with the regions would meet CMS regulations. **Consequently, the NHA recommends that HHS withdraw both the proposed DSH regulation and the state plan amendment recently submitted to CMS.**

The NHA is strongly committed to continued collaboration with HHS. It is critical that we engage the behavioral health regions in discussions and work together to establish an acceptable process that takes advantage of the additional dollars that have been allotted to Nebraska at the federal level without requiring any additional dollars from the state or regions. Hospitals are experiencing reduced reimbursement from multiple sources. Taking advantage of available federal funding to assist Nebraska hospitals in their mission to provide quality care to all patients 24 hours a day is essential.