#1

CMS-

Because the referenced comment number does not pertain to the subject matter for CMS- , it is not included in the electronic public comments for this regulatory document.

#2.

CMS-

Because the referenced comment number does not pertain to the subject matter for CMS- , it is not included in the electronic public comments for this regulatory document.

CMS-2213-P-3 **Clarification of Outpatient Clinic and Hospital Facility Services Definfition and Upper Payment Limit**

Submitter : **Beverly Gilan** **Date & Time: 10/09/2007**

Organization : **Crossroads**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

1. We do not want to see billions of dollars taken out of the Medicaid funded system of care for people with mental illnesses. We do not want to see adults and children ignored and left behind in school, work, and life.

2. Delete all references to other systems and pay for rehabilitative services for individuals with serious mental illnesses when they need them and where they need them.

3. We ask that you revise these regulations to make it clear that the federal government encourages any state system to do all they can to provide effective treatments to people with serious mental illnesses.

4. Services should be provided to help prevent deterioration of an individual. We also would like to see other systems encouraged, not discouraged, from providing help to adults and children with serious mental illnesses.

5. Revise the proposed rule to allow payment for rehabilitative services to prevent deterioration as well as to restore functioning.

CMS-2213-P-4 **Clarification of Outpatient Clinic and Hospital Facility Services Definfition and Upper Payment Limit**

Submitter : **Mrs. Cynthia North** **Date & Time: 10/12/2007**

Organization : **Mrs. Cynthia North**

Category : **Individual**

Issue Areas/Comments

GENERAL

See Attachment

#4

CMS-

Because the referenced comment number does not pertain to the subject matter for CMS- , it is not included in the electronic public comments for this regulatory document.

CMS-2213-P-5 **Clarification of Outpatient Clinic and Hospital Facility Services Definfition and Upper Payment Limit**

Submitter : **Mrs. Nancy Weller** **Date & Time: 10/12/2007**

Organization : **Mrs. Nancy Weller**

Category : **Individual**

Issue Areas/Comments

GENERAL

See attachment

Outpatient Hospital Service and Rural Health Clinic Services

see attachment

#5

NANCY WELLER
3341 COREY DRIVE
RENO, NV 89509

October 11, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2213-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-2213-P – Medicaid regulations clarifying hospital outpatient and clinic services definition and UPL

Dear Sir:

Thank you for the opportunity to comment on the proposed regulations sited above.

As some background for my comments I wanted to share with you that I worked for a state Medicaid agency for many years and part of my job duties consisted of maintenance of the State Plan and negotiation with federal officials from HCFA and then CMS on various activities the state wished to pursue. Over those years, many of the federal officials I discussed Medicaid service and reimbursement issues with were under the impression that provider-based status was applicable to Medicaid. I think this was because many of these people had worked in Medicare before transferring to Medicaid. It was always our stance (the State) that provider-based status was not applicable to Medicaid from clear reading of Title XIX and regulations in 42 CFR applicable to Medicaid as the term is not used anywhere in federal law or regulation applicable to services and reimbursement under that program.

In fact, there appears to be a conflict between Medicaid regulatory language about clinics and the participation of clinics as provider-based under the Medicare construct. Since you are proposing to add language to 42 CFR 440.20 referencing provider-based status in relation to Medicaid for the very first time, you may want to address the conflict that appears to exist with clinic services in 42 CFR 440.90 and in section 4320 of the Medicaid Manual. 42 CFR 440.90 defines clinic services as preventive, diagnostic, therapeutic, rehabilitative or palliative services that are **furnished by a facility that is not part of a hospital** but that is organized and operated to provide medical care to outpatients. State Medicaid Manual section 4320 (C) goes on to clarify that clinic services do not include services provided by hospitals to outpatients and that outpatient hospital services are separate and distinct from clinic services. Additionally the section says that a clinic must be a freestanding facility and may not be part of a hospital however a clinic can be located in a hospital as long as there is no administrative, organizational, financial or other connection between the clinic and the hospital. In order for a clinic to receive provider-based designation under Medicare, the clinic must offer services under the name, ownership, and financial and administrative control of the main provider (42 CFR 413.65).

The differences between these two regulatory provisions has created confusion in enrollment of facilities with Medicaid over the years, as they may be enrolled in Medicare as one type of provider and with Medicaid as a different type of provider with different enrollment criteria and reimbursement methodologies. Alignment of these provisions, if that is your intent, should include a revision to the applicable Medicaid regulation and policy. If you are revising 42 CFR 440.90, you may also wish to revise subsection (b) to permit clinic services to be rendered outside of the facility; the current language permits clinic services to be rendered outside the facility only if a patient does not reside in a permanent dwelling or have a fixed mailing address. This provision makes little sense, and permitting services to be rendered outside of the clinic would align the definition of clinic services with other types of clinics such as an FQHC, RHC or IHS and Tribal are permitted to provide services outside of the facility.

In proposed language changes to 42 CFR 447.321, you reference 42 CFR 433.50(a) as defining state government, non-government and privately operated facilities. I suggest that this reference is made in error as that section defines none of the aforementioned types of facility.

Thank you again for the opportunity to comment on these regulations.

Sincerely,

Nancy Weller

CMS-2213-P-6 **Clarification of Outpatient Clinic and Hospital Facility Services Definfition and Upper Payment Limit**

Submitter : **Ms. Kathy Konishi** **Date & Time: 10/16/2007**

Organization : **IHC Health Services, Inc.**

Category : **Other Health Care Provider**

Issue Areas/Comments

Upper Payment Limits

CMS' proposal would change the outpatient Medicaid upper payment limit calculation to a choice between a Medicare cost-to-charge ratio or a Medicare payment-to-charge ratio applied to Medicaid services. Both ratios have problems as described below.

Regarding the Medicare Payment-to-Charge Ratio:

1. The Medicare cost report does not include payments for services that are paid on a fee schedule, such as: physical therapy, occupational therapy, speech therapy, outpatient clinical diagnostic lab, ambulance services, durable medical equipment, etc. In addition, children's hospitals have significant Medicaid volumes but very small Medicare volumes. As a result, any Medicare payment-to-charge ratio that could be obtained from a hospital's cost report for Medicare would not accurate for Medicaid.

2. The use of a single Medicare payment-to-charge ratio for all Medicaid services for a hospital also assumes that the facility has exactly the same mix of Medicare and Medicaid services. Of course, this would never be the case.

Regarding the Medicare Cost-to-Charge Ratio:

Whether the regulation requires States to calculate a single Medicare cost-to-charge ratio per hospital or whether it just allows States to use all of the computed cost-to-charge ratios on the cost report is not clear. Either choice has its own problems.

1. If the State calculates a single Medicare cost-to-charge ratio per hospital, all of the issues that exist under the Medicare payment-to-charge ratio scenario above will exist (i.e., missing Medicare services on cost report, skewed children's hospital volumes, differing mixes of Medicare and Medicaid services, etc.)

2. If the State uses all of the cost-to-charge ratios on the cost report, the administrative burden associated with computing the Medicaid cost would be significant. First, the State would have to

program its information system to summarize paid claims by revenue code. Then, it would have to obtain a crosswalk from the revenue codes to cost centers for each hospital to get the applicable cost-to-charge ratios for the Medicaid services summarized by revenue code. (Note that the crosswalks could also change from year to year.)

3. CMS' proposal for a 100% cost limit for Medicaid additionally does not consider the fact that critical access hospitals are allowed to receive 101% of costs by Medicare.

CMS-2213-P-7 **Clarification of Outpatient Clinic and Hospital Facility Services Definfition and Upper Payment Limit**

Submitter : **Mr. Konrad Capeller** **Date & Time: 10/17/2007**

Organization : **Mr. Konrad Capeller**

Category : **Other Health Care Professional**

Issue Areas/Comments

Clinic Upper Payment Limit

I appreciate the opportunity to comment on the proposed rule in question.

Comment: The proposed changes to ?440.20(ii) required clarification.

The current proposed rule is as follows:

(ii) Are furnished by an outpatient hospital facility, including an entity that meets the standards for provider-based
status as a department of an outpatient hospital set forth in ? 413.65 of this chapter;

The issue that concerns me is the specific language □&meets the standards for provider-based status as a department of an outpatient hospital set forth in ?413.65 of this chapter.□

This language only specifically allows the most current provider-based rules to be applied to whether or not a department could or should be considered a □provider-based□ department or entity. As you know, the rules at ?413.65 are subject to change. A strict reading of this proposed rule may allow Medicaid administrators to deny payment or inclusion of previously allowable services based solely on the fact that a provider-based entity designated by the CMS no longer meets the most current requirements for a provider-based entity. Hundreds, if not thousands, of provider-based entities across the country that have been approved and designated as provider-based by CMS may no longer meet the current requirements.

I believe a simple clarification is required in the proposed rule that would □grandfather□ and allow all provider based entities with designations as such be included.

Such suggested language is as follows (italics added)
□&is designated by CMS as a provider-based entity or department or meets the standards for provider-based status as a department of an outpatient hospital set forth in ?413.65 of this chapter.□

Konrad Capeller, CPA
Spokane, Washington

CMS-2213-P-8 **Clarification of Outpatient Clinic and Hospital Facility Services Definfition and Upper Payment Limit**

Submitter : **Mr. Scott Barrilleaux** **Date & Time: 10/19/2007**

Organization : **Allen Parish Hospital**

Category : **Hospital**

Issue Areas/Comments

Clinic Upper Payment Limit

Re: CMS-2213-P--Outpatient clinic and hospital services facility services definition

Dear Secretary Leavitt:

We are writing to object to the outpatient clinic and hospital services facility services definition proposed rule that was published in the Federal Register on September 28, 2007. Your reference is CMS-2213-P-- Outpatient clinic and hospital services facility services definition.

We are a small rural hospital located in Kinder, Louisiana, with a hospital-based rural health clinic (RHC) that functions as part of the hospital. The hospital employs the RHC□s personnel, pays its bills, performs quality assurance, credentials the physicians and physician assistants employed by the RHC, owns / leases the building in which the RHC is located, handles payroll functions for the RHC, and provides medical supplies to the RHC. Yet, under the proposed rule, the costs of the RHC would be excluded from □outpatient costs□ of the hospital for disproportionate share calculation purposes.

This will limit our hospital□s ability to provide services at the RHC, because disproportionate share funding covers much of the cost of the RHC□s services. This will limit our ability to provide care to those who need it most and are unable to pay for it. Our area, like the rest of the state, faces a severe problem with emergency room use by patients who actually only need clinic services. Because they can be seen in the emergency department (eventually), patients with no insurance traditionally have used the emergency department like a primary care clinic.

Such improper use of the emergency department by indigent patients strained our hospital□s limited resources. It also makes it difficult for those patients to get timely care. Our hospital- based RHC solved this problem by giving those patients a less expensive and readily-available alternative to the emergency room. This allowed us to meet their needs in a timely manner and at a much lower cost. It also allowed us to provide better emergency services, because we no longer faced the burden of providing expensive primary care through the emergency department.

In short, CMS□ effort to exclude our hospital-based RHC□s costs in disproportionate share calculations is a bad idea because it removes much needed monetary support for the RHC□s hospital-based clinic services. This will mean an increased inappropriate burden on our emergency department. It will also mean that many who need care simply will not get it.

The proposed definition will have a severe financial impact on our hospital, which will further limit our ability to provide the increased amount of uncompensated care that we have been asked to provide after the 2005 storms that devastated our state.

Sincerely,

Scott Barrilleaux, CEO
Allen Parish Hospital
GENERAL

Re: CMS-2213-P--Outpatient clinic and hospital services facility services definition

Dear Secretary Leavitt:

We are writing to object to the outpatient clinic and hospital services facility services definition proposed rule that was published in the Federal Register on September 28, 2007. Your reference is CMS-2213-P-- Outpatient clinic and hospital services facility services definition.

We are a small rural hospital located in Kinder, Louisiana, with a hospital-based rural health clinic (RHC) that functions as part of the hospital. The hospital employs the RHC□s personnel, pays its bills, performs quality assurance, credentials the physicians and physician assistants employed by the RHC, owns / leases the building in which the RHC is located, handles payroll functions for the RHC, and provides medical supplies to the RHC. Yet, under the proposed rule, the costs of the RHC would be excluded from □outpatient costs□ of the hospital for disproportionate share calculation purposes.

This will limit our hospital□s ability to provide services at the RHC, because disproportionate share funding covers much of the cost of the RHC□s services. This will limit our ability to provide care to those who need it most and are unable to pay for it. Our area, like the rest of the state, faces a severe problem with emergency room use by patients who actually only need clinic services. Because they can be seen in the emergency department (eventually), patients with no insurance traditionally have used the emergency department like a primary care clinic.

Such improper use of the emergency department by indigent patients strained our hospital□s limited resources. It also makes it difficult for those patients to get timely care. Our hospital- based RHC solved this problem by giving those patients a less expensive

and readily-available alternative to the emergency room. This allowed us to meet their needs in a timely manner and at a much lower cost. It also allowed us to provide better emergency services, because we no longer faced the burden of providing expensive primary care through the emergency department.

In short, CMS□ effort to exclude our hospital-based RHC□s costs in disproportionate share calculations is a bad idea because it removes much needed monetary support for the RHC□s hospital-based clinic services. This will mean an increased inappropriate burden on our emergency department. It will also mean that many who need care simply will not get it.

The proposed definition will have a severe financial impact on our hospital, which will further limit our ability to provide the increased amount of uncompensated care that we have been asked to provide after the 2005 storms that devastated our state.

Sincerely,

Scott Barrilleaux, CEO
Allen Parish Hospital
Outpatient Hospital and Clinic Seravices: Application of Upper Payment Limits

Re: CMS-2213-P--Outpatient clinic and hospital services facility services definition

Dear Secretary Leavitt:

We are writing to object to the outpatient clinic and hospital services facility services definition proposed rule that was published in the Federal Register on September 28, 2007. Your reference is CMS-2213-P-- Outpatient clinic and hospital services facility services definition.

We are a small rural hospital located in Kinder, Louisiana, with a hospital-based rural health clinic (RHC) that functions as part of the hospital. The hospital employs the RHC□s personnel, pays its bills, performs quality assurance, credentials the physicians and physician assistants employed by the RHC, owns / leases the building in which the RHC is located, handles payroll functions for the RHC, and provides medical supplies to the RHC. Yet, under the proposed rule, the costs of the RHC would be excluded from □outpatient costs□ of the hospital for disproportionate share calculation purposes.

This will limit our hospital□s ability to provide services at the RHC, because disproportionate share funding covers much of the cost of the RHC□s services. This will limit our ability to provide care to those who need it most and are unable to pay for it. Our area, like the rest of the state, faces a severe problem with emergency room use by patients who actually only need clinic services. Because they can be seen in the emergency department (eventually), patients with no insurance traditionally have used the emergency department like a primary care clinic.

Such improper use of the emergency department by indigent patients strained our hospital□s limited resources. It also makes it difficult for those patients to get timely care. Our hospital- based RHC solved this problem by giving those patients a less expensive and readily-available alternative to the emergency room. This allowed us to meet their needs in a timely manner and at a much lower cost. It also allowed us to provide better emergency services, because we no longer faced the burden of providing expensive primary care through the emergency department.

In short, CMS□ effort to exclude our hospital-based RHC□s costs in disproportionate share calculations is a bad idea because it removes much needed monetary support for the RHC□s hospital-based clinic services. This will mean an increased inappropriate burden on our emergency department. It will also mean that many who need care simply will not get it.

The proposed definition will have a severe financial impact on our hospital, which will further limit our ability to provide the increased amount of uncompensated care that we have been asked to provide after the 2005 storms that devastated our state.

Sincerely,

Scott Barrilleaux, CEO
Allen Parish Hospital

CMS-2213-P-9 **Clarification of Outpatient Clinic and Hospital Facility Services Definfition and Upper Payment Limit**

Submitter : **Date & Time: 10/23/2007**

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

"See Attachment"

#9

Abbeville General Hospital

118 North Hospital Drive
P.O. Box 580
Abbeville, Louisiana 70511-0580

October 22, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 2213-P
Mail Stop C4-26-05, 7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-2213-P--Outpatient clinic and hospital services facility services definition

Dear Secretary Leavitt:

We are writing to object to the outpatient clinic and hospital services facility services definition proposed rule that was published in the Federal Register on September 28, 2007. Your reference is CMS-2213-P-- Outpatient clinic and hospital services facility services definition.

We are a small rural hospital located in Abbeville, Louisiana, with a hospital-based rural health clinic (RHC) that functions as part of the hospital. The hospital employs the RHC's personnel, pays its bills, performs quality assurance, credentials the physicians and physician assistants employed by the RHC, owns the building in which the RHC is located, handles payroll functions for the RHC, and provides medical supplies to the RHC. Yet, under the proposed rule, the costs of the RHC would be excluded from "outpatient costs" of the hospital for disproportionate share calculation purposes.

This will limit our hospital's ability to provide services at the RHC, because disproportionate share funding covers much of the cost of the RHC's services. This will limit our ability to provide care to those who need it most and are unable to pay for it. Our area, like the rest of the state, faces a severe problem with emergency room use by patients who actually only need clinic services. Because they can be seen in the emergency department (eventually), patients with no insurance traditionally have used the emergency department like a primary care clinic.

Such improper use of the emergency department by indigent patients strained our hospital's limited resources. It also makes it difficult for those patients to get timely care. Our hospital-based RHC solved this problem by giving those patients a less expensive and readily-available alternative to the emergency room. This allowed us to meet their needs in a timely manner and at a much lower cost. It also allowed us to provide better emergency services, because we no longer faced the burden of providing expensive primary care through the emergency department.

In short, CMS' effort to exclude our hospital-based RHC's costs in disproportionate share calculations is a bad idea because it removes much needed monetary support for the RHC's hospital-based clinic services. This will mean an increased inappropriate burden on our emergency department. It will also mean that many who need care simply will not get it.

The proposed definition will have a severe financial impact on our hospital, which will further limit our ability to provide the increased amount of uncompensated care that we have been asked to provide after the 2005 storms that devastated our state.

Sincerely,

Ray Landry

Ray Landry
Chief Executive Officer
Abbeville General Hospital

RL/stl

CMS-2213-P-10 **Clarification of Outpatient Clinic and Hospital Facility Services Definfition and Upper Payment Limit**

Submitter : **Mr. Michael Carroll** **Date & Time: 10/24/2007**

Organization : **Richland Parish Hospital**

Category : **Critical Access Hospital**

Issue Areas/Comments

Clinic Upper Payment Limit

Dear Secretary Leavitt:
We are writing to object to the outpatient clinic and hospital services facility services definition proposed rule that was published in the Federal Register on September 28, 2007. Your reference is CMS-2213-P--Outpatient clinic and hospital services facility services definition.
We are a small rural hospital located in Delhi, Louisiana, with a hospital-based rural health clinic (RHC) that functions as part of the hospital. The hospital employs the RHC□s personnel, pays its bills, performs quality assurance, credentials the physicians and physician assistants employed by the RHC, owns / leases the building in which the RHC is located, handles payroll functions for the RHC, and provides medical supplies to the RHC. Yet, under the proposed rule, the costs of the RHC would be excluded from □outpatient costs□ of the hospital for disproportionate share calculation purposes.
This will limit our hospital□s ability to provide services at the RHC, because disproportionate share funding covers much of the cost of the RHC□s services. This will limit our ability to provide care to those who need it most and are unable to pay for it. Our area, like the rest of the state, faces a severe problem with emergency room use by patients who actually only need clinic services. Because they can be seen in the emergency department (eventually), patients with no insurance traditionally have used the emergency department like a primary care clinic.
Such improper use of the emergency department by indigent patients strained our hospital□s limited resources. It also makes it difficult for those patients to get timely care. Our hospital- based RHC solved this problem by giving those patients a less expensive and readily-available alternative to the emergency room. This allowed us to meet their needs in a timely manner and at a much lower cost. It also allowed us to provide better emergency services, because we no longer faced the burden of providing expensive primary care through the emergency department.
In short, CMS□ effort to exclude our hospital-based RHC□s costs in disproportionate share calculations is a bad idea because it removes much needed monetary support for the RHC□s hospital-based clinic services. This will mean an increased inappropriate burden on our emergency department. It will also mean that many who need care simply will not get it.

The proposed definition will have a severe financial impact on our hospital, which will further limit our ability to provide the increased amount of uncompensated care that we have been asked to provide after the 2005 storms that devastated our state.

CMS-2213-P-11 **Clarification of Outpatient Clinic and Hospital Facility Services Definfition and Upper Payment Limit**

Submitter : **Mr. William Adcock** **Date & Time: 10/24/2007**

Organization : **Union General Hospital**

Category : **Rural Health Clinic**

Issue Areas/Comments

GENERAL

See attachment

#11

UNION GENERAL HOSPITAL

October 24, 2007

Secretary Leavitt

Re: CMS-2213-P--Outpatient clinic and hospital services facility services definition

Dear Secretary Leavitt:
Thank you for the opportunity to comment on CMS' 2213-P- Outpatient clinic and hospital services facility services definition proposed rule that was published in the Federal Register on September 28, 2007.

On behalf of Union General Hospital, I am writing to object to the outpatient clinic and hospital services facility services definition proposed rule.

We are a small rural hospital located in Farmerville, Louisiana, with two (2) hospital-based rural health clinics (RHCs) that functions as part of the hospital. The hospital-based RHCs help the hospital provide the same care previously provided by the emergency department, but in a more clinically appropriate and less costly setting. The proposed rule would cover more expensive uncompensated emergency room care, but uncompensated hospital-based RHC care would not be included in DSH (disproportionate share hospital) eligible costs. By establishing hospital-based RHCs, our hospital has attempted to end the burden placed on emergency rooms that are used for primary care. Now, CMS is attempting to reestablish the use of the emergency department for routine medical care by those who are unable to afford other forms of care. This is not appropriate. Use of hospital-based RHCs should be encouraged, not discouraged, because RHC use will save taxpayer dollars.

Our hospital-based RHCs function as part of the hospital: therefore, the hospital employs the RHCs personnel, maintains payroll, pays all overhead expenses, owns or leases the RHC buildinga, provides medical supplies and credentials the physicians and nurse

practitioners. The RHCs are a vital component of the hospital as they assist the hospital with providing access to quality primary care services.

Under this proposal, the costs of the RHCs would be excluded from "outpatient costs" of the hospital for DSH calculation purposes. It is imperative that CMS is cognizant to the fact that excluding the hospital-based RHC from the eligible costs will have an adverse affect on our hospital's ability to provide services at the RHCs. As aforementioned, the majority of the overhead expenses to operate the RHCs are provided by the hospital using the DSH funding. If the rule is implemented, our hospital will lose approximately $80,000 annually in DSH funding. Excluding the hospital-based RHCs from DSH funding will limit our ability to provide care to those who live in poverty stricken areas and are in need of health care services.

CMS' efforts to exclude our hospital-based RHC's costs in disproportionate share calculations would impede care and will be a detriment to access to primary care in rural communities. This alone is contrary to good public policy. Rather than reward use of cheaper and more appropriate RHC services, the proposed rule does just the opposite. The rule actually creates financial incentives to use scarce and expensive emergency department services, even though hospital-based RHC services can be provided at a fraction of the cost and do not tie up critical emergency care resources.

Due to these concerns, I respectively ask that you withdraw the proposed rule you refer to as CMS-2213-P--Outpatient clinic and hospital services facility services definition.

Thank you for considering these comments.

Sincerely,

William Adcock, CFO
Chief Financial Officer
Union General Hospital

CMS-2213-P-12 **Clarification of Outpatient Clinic and Hospital Facility Services Definfition and Upper Payment Limit**

Submitter : **Mr. Jerry Fuller** **Date & Time: 10/24/2007**

Organization : **Alaska Dept of Health and Social Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

See Attachment

CMS -2213-P

Our analysis of the proposed regulation regarding private clinic services, if we understand the letter and intent correctly, will have a profound and negative impact upon our ability to provide mental health and substance abuse services to Medicaid eligible Alaskans. It is conceivable there will also be a negative impact upon private physician clinics.

Alaska Medicaid provides much of our behavioral health services (mental health and substance abuse services) through Community Mental Health Clinics (CMHC). These are generally local private and sometimes public non-profit agencies. They are reimbursed on a fee for service basis using a combination of CPT and HCPCS coding. CPT codes in Alaska are reimbursed based on the RBRVS system that CMS adopted for Medicare reimbursement, except the conversion factor used by Alaska Medicaid is higher than the one used by Medicare. If we understand this proposed regulation correctly Alaska would, at a minimum, need to reduce our CPT coding reimbursement to no more than what Medicare reimburses for the same codes. There in lies the problem.

Medicare reimbursement in Alaska is not high enough to attract a sufficient number of primary care physicians to serve those with Medicare coverage. The newspaper has been replete with articles about the great lengths that Medicare eligible folks have taken to be seen for primary care issues. Some have noted they take trips to the Lower 48 to see physicians there. The majority of Alaska primary physicians have opted out of Medicare. Others who continue to accept Medicare are taking no new patients. Public funded clinics and the emergency rooms appear to be the access points for these people. Setting a Medicaid private clinic UPL based on Medicare reimbursement is expected to have similar dire consequences, at least in relation to clinics providing rehabilitation services and potentially some physician directed clinics that focus on behavioral health services.

Requiring the Alaska Medicaid program to adhere to this new proposed private clinic UPL for the non-profit private clinics that provide behavioral health rehabilitation services and physician services will effectively raise access issues under 447.204, thus creating a perfect Catch 22. The proposed regulation appears to bind us to a new UPL no greater than Medicare, yet Medicare rates in Alaska are so low in proportion to the high cost of health care that primary care access through private providers is almost non-existent. Yet we would be required to adopt this lower rate for the bulk of the services provided by CMHCs, effectively ending their participation as Medicaid providers and ending behavioral health rehabilitation services. The consequence of this is more Medicaid eligible folks seeking mental health and substance abuse treatment in public clinics, already swamped serving Medicare eligibles; using higher cost settings, emergency rooms; or foregoing treatment until inpatient hospital or IMD treatment is necessary. The alternative settings for this treatment will cost much more than any savings due to the UPL. Another consequence is certain legal challenges under 447.204, which will certainly include CMS as a defendant, since the state cannot raise rates above the new UPL to address the access issues.

Hopefully I have misunderstood the requirements imposed by the proposed regulation and my concerns are not real. However, if I have a correct understanding then there will be very serious and probably unintended consequences that will require further CMS involvement to resolve. The state will be stymied by the Catch 22 created in Alaska by this new private clinic UPL regulation.

Submitter : Mr. Scott Merryman **Date:** 10/24/2007

Organization : CHRISTUS Coushatta Health Care Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Encapsulation of Comments on CMS PROPOSED RUEL 2213-P OUTPATIENT CLINIC AND HOSPITAL SERVICES FAILITY DEFINITION:

I am opposed to the above referenced CMS proposal for the following reasons.

1. The proposed rule targets Rural Health Clinics that extend the reach of appropriate and lower cost primary care to rural areas.
2. As proposed, the rule would cause reductions in reimbursement to CHRISTUS Coushatta Health Care Center that will jeopardize the financial viability of operating its two rural health clinics that exist in the most impoverished area in Louisiana.
3. Access to primary care in the rural areas served will be at risk, erasing several years of progress in increasing Louisiana s efforts to bring primary care access to its rural populations.
4. Service costs will flow from a relatively low cost environment (clinics) to a high cost environment (emergency department), creating an overall increase in operating costs.
5. Under the current regulations, CHRISTUS Coushatta Health Care Center, following a two-year program to change operations, has just begun to cash flow, or, at best, break even. The proposed rule will most likely move the hospital to a loss situation.
6. The current year s distribution of Uncompensated Care Cost (DSH) payments threatens the financial health of CHRISTUS Coushatta Health Care Center, as the payments are exclusive of the Rural Health Clinic component unless the proposed is defeated or otherwise revised to restore proper reimbursement for the reality of Rural Health Clinic uneompensated care costs.

Outpatient Hospital and Clinic Seravices: Application of Upper Payment Limits

Outpatient Hospital and Clinic Seravices: Application of Upper Payment Limits

Re: CMS-2213-P--Outpatient clinic and hospital services facility services definition

Dear Secretary Leavitt:

Thank you for the opportunity to comment on CMS 2213-P- Outpatient clinic and hospital services facility services definition proposed rule that was published in the Federal Register on September 28, 2007. (For ecapsulation, see General Comment Section)

On behalf of CHRISTUS Coushatta Health Care Center, I am writing to object to the outpatient clinic and hospital services facility services definition contained in proposed rule.

We are a small rural hospital located in Coushatta, Louisiana, in Red River Parish, with hospital-based rural health clinics (RHC) in Ringgold and Coushatta. These clinics function as part of the hospital. The hospital-based RHCs help the hospital provide the same care provided by higher cost emergency departments, but in a more clinically appropriate and less costly setting. Furthermore, the RHCs extend the reach of primary care to areas where need is great. The proposed rule would cover more expensive uncompensated emergency room care, but uncompensated hospital-based RHC care would not be included in DSH (disproportionate share hospital) eligible costs. By establishing hospital-based RHCs, our hospital has attempted to end the burden placed on emergency rooms that are used for primary care. After a two-year struggle, financially, we have finally managed to get CHRISTUS Coushatta to a near break-even point. Now, CMS is attempting to reestablish the use of the emergency department for routine medical care by those who are unable to afford other forms of care. This is not appropriate; it propels our communities back several years negating progress made in bringing primary care access to areas without other viable alternatives. Use of hospital-based RHC s should be encouraged, not discouraged, because RHC use will save taxpayer dollars. Our hospital-based RHC functions as part of the hospital: therefore, the hospital employs the RHC s personnel, maintains payroll, pays all overhead expenses, owns or leases the RHC building, provides medical supplies and credentials the physicians and mid-level providers. The RHCs are vital components of the hospital s overall mission to provide rural residents access to quality primary care services.

Under this proposal, the costs of the RHC would be excluded from outpatient costs of the hospital for DSH calculation purposes. It is highly likely that without the current form of reimbursement, the RHC s will become financially unviable. It is imperative that CMS is cognizant to that fact that excluding the hospital-based RHC from the eligible costs will have an adverse affect on our hospital s ability to provide services at the RHCs. As I have noted above, the majority of the overhead expenses to operate the RHC is provided by the hospital using the DSH funding. If the rule is implemented, our hospital will lose over $200,000 in DSH funding. Excluding the hospital-based RHCs from DSH funding will limit our ability to provide care to those who live in poverty-stricken areas and are in need of health care services. CMS efforts to exclude our hospital-based RHC s costs in disproportionate share calculations would impede care and will be a detriment to access to primary care in rural communities. This alone is contrary to good public policy. Rather than reward use of cheaper and more appropriate RHC services, the proposed rule does just the opposite. The rule actually creates financial incentives to use scarce and expensive emergency department services, even though hospital-based RHC services can be provided at a fraction of the cost and do not tie up critical emergency care resources.

Due to these concerns, I respectfully ask that you withdraw proposed rule CMS-2213-P- Outpatient clinic and hospital services facility services definition.

Submitter : **Mrs. Barbara Lever** **Date: 10/25/2007**

Organization : **Sunshine Physical Therapy Clinic**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

We are a non-profit free standing 'ORF' with no affiliation to any hospital and feel that we should be treated the same as any outpatient hospital and not be subject to the Medicare cap for physical and occupational therapy. Out patient is out patient and it shouldn't matter if you are treated at a hospital or a free standing clinic. We both bill on a UB04 and should be treated the same for as far as therapy caps go.

Submitter : **Mr. John Matessino** **Date: 10/25/2007**

Organization : **Louisiana Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-15-Attach-1.DOC

#15

LOUISIANA HOSPITAL ASSOCIATION

JOHN A. MATESSINO
PRESIDENT & CEO

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October 25, 2007

Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-2213-P, Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit (Vol. 72, No. 188) September 28, 2007

Dear Mr. Weems:

On behalf of our member hospitals, health systems and other health care organizations, the Louisiana Hospital Association (LHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit. The LHA is in opposition to the provisions set forth in this proposed regulation as it would severely affect both Louisiana's small rural hospitals and the State's public hospital system.

The LHA is commenting on several aspects of CMS' intentions, analysis, and proposals detailed in CMS-2213-P. We have concerns regarding CMS's disregard for the Fifth Circuit Court of Appeals' ruling in *Louisiana Department of Health and Hospitals v. CMS, 346 F.3d571 (2003),* CMS' interpretation of legislative intent, the impact on services provided by hospital-based Rural Health Clinics in Louisiana, the impact on Louisiana's public hospital system and CMS' violation of the year-long moratorium put in place by congress under P.L. 110-28. The LHA would like to make the following comments:

- The LHA fails to comprehend the rationale for CMS' efforts to more closely align the regulatory definition of Medicaid outpatient services with the definition of Medicare outpatient services as these populations are entirely different in acuity level and case mix. The concept of aligning definitions of services rendered through Medicaid which serves a largely pediatric population with Medicare which serves an elderly population is flawed at its most basic level.

- Hospital-based Rural Health Clinics provide timely and efficient outpatient care not otherwise readily available in many areas. As is well documented and accepted fact throughout the healthcare industry, it is far more efficient to deliver primary care and preventive services in the clinic setting versus the emergency department. The implementation of this rule would essentially result in an estimated $4.2 - $4.5 million budget shortfall for the hospital-based Rural Health Clinics in Louisiana thus resulting in a significant reduction of services, and in some instances, probable closure of some Rural Health Clinics. This will result in more individuals seeking primary and preventive care in hospitals' overcrowded emergency

departments at a higher cost to taxpayers. Furthermore, CMS' decision to exclude rehabilitative, school-based, and practitioner services from the current definition would exacerbate existing access issues by cutting necessary funding, thus cutting available services.

- The basic underlying logic behind the Fifth Circuit Court of Appeals ruling is that the services the Rural Health Clinics render are classified as outpatient hospital services and therefore should be eligible for funding through Disproportionate Share and Uncompensated Care monies. In the proposed rule, CMS stated an absence of a fiscal impact analysis due to lack of available data. We are very concerned that CMS would attempt to circumvent a judicial ruling and invalidate the Court's decision to allow for inclusion of hospital-based Rural Health Clinics in the DSH statute.

- The proposed limitations in the Upper Payment Limit (UPL) calculations will cause significant, detrimental impact to Louisiana's public hospitals. The proposed rule will result in immediate loss of at least $11.3 million in Medicaid Physician UPL payments. Additionally, once CMS applies the proposed rule to state government providers, there will be a loss of $16.5 million in Medicaid outpatient hospital UPL payments. Second and more importantly, there will be a much greater loss (at least $80.6 million) should CMS exclude all costs related to interns and residents. These losses will jeopardize the State's plans to implement its "medical home model for the uninsured," a model which has been embraced by the Office of Secretary Michael Leavitt.

- This proposed rule violates Congress' Legislative Moratorium on CMS' Cost Limit Rule published May 29, 2007. Congress issued said moratorium in U.S. Public Law 110-28, effectively keeping CMS from making changes on how states finance their Medicaid programs or cutting graduate medical education (GME) payments.

The LHA urges CMS to withdraw this rule and suspend any further regulatory activity that affects the issues encompassed under the moratorium secured by P.L. 110-28. These proposed policy changes will result in cuts to state Medicaid programs, cuts in payments to Louisiana's hospitals and reduced access to needed services for Louisiana's vulnerable citizens served by the Medicaid program.

The LHA would like to again thank CMS for the opportunity to comment on behalf of our member hospitals on the proposed changes. If you have any questions, please feel free to contact me or Paul Salles, Vice President of Healthcare Reimbursement Policy at (225)928-0026.

Sincerely,

John Matessino

John A. Matessino
President & CEO
Louisiana Hospital Association
9521 Brookline Avenue
Baton Rouge, LA 70809
225-928-0026

Submitter : Dr. Bruce Chernof **Date:** 10/26/2007

Organization : Los Angeles County Department of Health Services

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-2213-P-16-Attach-1.PDF

#16

Health Services
LOS ANGELES COUNTY

October 26, 2007

Kerry N. Weems, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2213-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Comments on Proposed Rule CMS-2213-P
Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit

Dear Mr. Weems:

On behalf of Los Angeles County Department of Health Services (LAC/DHS), I am writing to express our opposition to CMS' Proposed Rule CMS 2213-P, which limits the definition of outpatient hospital services and has a negative impact on disproportionate share hospital (DSH) payments and the upper payment limit for Medicaid payments to public providers. LAC/DHS urges CMS to withdraw this proposed rule.

California's public hospitals, including LAC/DHS hospitals: LAC+USC Medical Center, Harbor/UCLA Medical Center, Rancho Los Amigos National Rehabilitation Center and Olive View Medical Center, are a cornerstone of the State's health care system. We operate nearly 60% of California's top-level trauma centers, which are state-of-the-art emergency medical units that treat the most catastrophic, life-threatening injuries. We, and California's other public hospitals, participate in the Medicaid program by providing a comprehensive range of services to a substantial portion of the state's Medicaid population. While public hospitals account for only 6 percent of the acute care hospitals in California, we consistently provide over 35 percent of hospital care to the state' Medicaid beneficiaries, 50 percent of the hospital care to California's uninsured, and over 80 percent of the state's hospital care to the medically indigent. LAC/DHS serves as a major provider of healthcare to more than two million county residents without health insurance and provides 85 percent of all uncompensated medical care in Los Angeles County.

The proposed outpatient rule is yet another attempt by CMS to curtail Medicaid payments to public hospitals, which provide a significant amount of Medicaid services to eligible low-income and disabled patients. If this rule goes into effect, it will likely result in the reduction of critical outpatient clinic and hospital facility services that public hospitals such as ours are uniquely qualified to provide. In the past year, LAC/DHS will have provided more than 2.6 million outpatient visits to its low-income and uninsured communities.

We believe that this rule should be withdrawn for a number of reasons. First, it violates the moratorium that prevents CMS from implementing its restrictive cost-limit and GME rules.

Beyond its contravention of the moratorium, the rule has numerous harmful implications for Medicaid payments. Though the rule neglects to refer specifically to its negative impact on DSH payments, we are concerned that the uncompensated care costs associated with the disallowed services may no longer be included in

Bruce A. Chernof, MD
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our hospital's DSH cap. The DSH program recognizes the unique role that safety net hospitals play in the treatment of the Medicaid and uninsured patients, and any reduction to those payments will restrict our ability to continue to provide those services.

The proposed rule also changes the methodology by which the upper payment limit ("UPL") is calculated for private hospitals. The UPL currently in place bases Medicaid payments on a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles. The rule would base the UPL calculation on costs and payments for outpatient services from the Medicare cost report. As Medicare pays separately for GME costs related to outpatient services of GME, those costs are not reflected on the cost report worksheets specified in the proposed methodology and the proposed methodology would result in the exclusion of GME costs from the DSH payments. We are concerned that CMS may attempt to apply this flawed methodology to governmentally operated hospitals.

As a member of the California Association of Public Hospitals (CAPH), LAC/DHS joins in the comments submitted by that organization in response to this proposed regulation. In particular, LAC/DHS shares CAPH's concern that the proposed restrictions on Medicaid hospital outpatient services will inappropriately limit the State's flexibility to respond to special circumstances to ensure adequate access to quality services for Medicaid beneficiaries. State flexibility in the development and implementation of the Medicaid program is guaranteed by statute and is a fundamental tenet of the program. As CAPH notes, CMS has provided no valid reason for this proposal to restrict the states' longstanding flexibility to define and pay for hospital outpatient services.

The application of the proposed regulation to LAC/DHS' Cost Based Reimbursed Clinic program (CBRC) illustrates the validity of these concerns. Under proposed Section 440.20(a)(4)(iii), Medicaid hospital outpatient services would be limited to those services that "are not covered under the scope of another Medical Assistance service category under the State Plan. . . ." As CAPH notes, the meaning of this provision is not entirely clear. However, it appears to preclude the State from treating a service as a hospital outpatient service if it also could fall within any other service category.

In an effort to support and restructure LAC/DHS' financially troubled health care system, in 1995 the Federal, State and County governments undertook a decade-long Medicaid demonstration project, authorized under Section 1115 of the Social Security Act. The CBRC program was developed as part of that project. Under CBRC, the ambulatory services provided in LAC/DHS' hospital outpatient departments and freestanding clinics are reimbursed at 100% of reasonable costs. Because this represents a different payment method from the existing rate-based payments for these services, CMS approved a State Plan amendment to address the special circumstances faced by LAC/DHS. A proposed amendment to extend the program beyond the term of the demonstration project is currently pending CMS approval.

Although they fall within this special CBRC payment category under the State Plan, the services provided by LAC/DHS in its hospital outpatient departments fall within the definition of outpatient hospital services in all other respects. If proposed Section 440.20(a)(4)(iii) means that these services are no longer hospital services because they overlap with CBRC services, the adverse financial consequences to LAC/DHS will be significant. Such an interpretation would mean that the uncompensated costs of services rendered to the uninsured in these outpatient hospital departments would no longer be considered in determining the hospital's DSH payment limit (OBRA 1993 limit) under 42 U.S.C. § 1396r-4(g). The result would be a devastating loss of critical DSH funding for Los Angeles County hospitals. As CAPH explains in its comments, CMS provides no justification whatsoever for its attempt to limit DSH payments through this proposed regulation. Certainly, this adverse impact on LAC/DHS' health care system after CMS' decade-long attempt to support the system through a demonstration project could not have been intended and cannot be justified.

LAC/DHS urges CMS to withdraw the proposed rule, and in particular the proposed Section 440.20(a)(4)(iii). At least, CMS should explain the meaning of this Section to make it clear that it does not apply to the CBRC program as discussed above.

Moreover, as discussed in the CAPH letter, the rule is not a "clarification" of existing law as CMS states, but instead involves substantive policy changes. Furthermore, the rule fails to provide an adequate Regulatory Impact Analysis, as required by Executive Order 12866. In light of CMS' failure to accurately describe the action proposed in the rule and to provide an adequate Regulatory Impact Statement, the rulemaking notice is inadequate and the rule should be withdrawn.

LAC/DHS opposes this Medicaid rule and strongly urges CMS to withdraw it. If the rule goes into effect, we will suffer harmful effects that will affect our ability to care for our patients and communities. CMS must recognize the damage that this rule will have to our community's health care system and withdraw its proposed rule.

Sincerely,

Bruce A. Chernof, M.D.
Director and Chief Medical Officer

BAC:hj

c: Melissa Stafford Jones, President and CEO, CAPH
Anita Lee
Carol Meyer
Allan Wecker

Submitter : Leah Pogoriler **Date:** 10/27/2007

Organization : On behalf of the State of Louisiana

Category : State Government

Issue Areas/Comments

Clinic Upper Payment Limit

Clinic Upper Payment Limit

See attachment.

GENERAL

GENERAL

See attachment.

Medicaid Outpatient Hospital Service and Rural Health Care Services

Medicaid Outpatient Hospital Service and Rural Health Care Services

See attachment.

Outpatient Hospital Service and Rural Health Clinic Services

Outpatient Hospital Service and Rural Health Clinic Services

See attachment.

Outpatient Hospital and Clinic Seravices: Application of Upper Payment Limits

Outpatient Hospital and Clinic Seravices: Application of Upper Payment Limits

See attachment.

Upper Payment Limits

Upper Payment Limits

See attachment.

CMS-2213-P-17-Attach-1.PDF

#17

BEFORE THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

In the Matter of	)
	)
Proposed Medicaid Program Rules on	)
	)
OUTPATIENT HOSPITAL AND CLINIC SERVICES	)
	)
CMS 2213-P	)
	)

The State of Louisiana ("Louisiana") submits the following comments on the proposed rule amending the definition of outpatient hospital services in the Medicaid regulations. 72 Fed. Reg. 55158 (Sept. 28, 2007). In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) purports to override a binding statutory interpretation of a United States Court of Appeals. This proposed action is unlawful. Moreover, the proposed rule would cause serious and unjustified harm to some of the nation's poorest and most vulnerable patients, to the providers who seek to serve them, and to the States that fund their care.

Provisions of rule commented upon: CMS proposes to amend the definition of outpatient hospital services at 42 C.F.R. § 440.20 by adding a provision stating that such services are "limited to the scope of facility services" that (1) "[w]ould be included, in the setting delivered, in the Medicare outpatient prospective payment system (OPPS) as defined under § 419.2(b) . . . or are paid by Medicare as an outpatient hospital service under an alternate payment methodology," (2) "[a]re furnished by an outpatient hospital facility, including an entity that meets the standards for provider-based status as a department of an outpatient hospital set forth in § 413.65," and (3) "[a]re not covered under the scope of another Medical Assistance service category under the State Plan." *Id.* at 55165.

The proposed rule is inconsistent with controlling statutory authority: The proposed rule implements two false premises: first, that any definition of outpatient hospital services for Medicaid purposes should be based on Medicare regulations rather than Medicaid statutes; and second, that the manner in which a service is reimbursed under the Medicaid State plan automatically dictates whether the costs of that service may be taken into account for purposes of disproportionate share hospital (DSH) reimbursement. The Social Security Act (SSA) rejects both premises.

As CMS recognizes, 72 Fed. Reg. at 55159, outpatient hospital services are not defined in the portion of the Social Security Act that outlines the scope of medical assistance. SSA § 1905(a)(2)(A). Nor are outpatient hospital services – or hospital services generally – defined in the statutory provision that imposes the hospital-specific DSH limit. SSA § 1923(g)(1)(A). Neither portion of the Social Security Act provides that any definition that might apply for one purpose automatically applies for the other. And neither provision refers to Medicare definitions.

Congress did not intend the phrase "hospital services" in Section 1923 to exclude services that might also fit other definitions of types of services, such as rural health clinic (RHC) services. CMS has already raised this argument, and the United States Court of Appeals for the Fifth Circuit has squarely rejected it – not just as a matter of regulatory interpretation, but also as a matter of statutory interpretation wholly beyond CMS's authority to modify. In *Louisiana Department of Health & Hospitals v. Centers for Medicare & Medicaid Services*, 346 F.3d 571 (5th Cir. 2003), Louisiana appealed CMS's determination that "because hospital services and RHC services are defined separately under the Social Security Act and its implementing regulations, RHC services can never be considered outpatient hospital services."

Id. at 575. CMS's determination was a matter of statutory interpretation. *See id.* at 576 ("The dispositive issue in this case is whether the Administrator's disapproval of Louisiana's proposed state plan amendment was arbitrary or capricious, where the Administrator determined that the term 'hospital services' as used in 42 U.S.C. 1396r-4(g) does not include services provided by RHCs."); *id.* at 577 (noting CMS's argument that "federal statutes and regulations distinguish the terms in at least two places"). In reversing CMS's determination, the Fifth Circuit plainly rejected CMS's statutory interpretation as well as its regulatory interpretation.

The Fifth Circuit did not just reject CMS's attempt to impose a mutual exclusivity requirement. The Fifth Circuit also agreed with Louisiana that CMS's interpretation of Section 1923(g) "conflict[ed] with the broad goal of the DSH program – to support hospitals that serve low-income patients." *Id.* at 577. The court cited numerous signs of Congress's "intention of broadly defining the DSH program." *Id.* at 577-78. The court also agreed with Louisiana that Section 1923(g)'s language based on the cost of furnishing "hospital services" was designed to *expand* the DSH program, not narrow it, by making clear that it was not limited to the costs of inpatient services. *Id.* at 578. The Fifth Circuit was also persuaded by Louisiana's argument that "[CMS's] interpretation – which precludes reimbursement to hospitals for uncompensated care provided in their RHCs even though the *same care* provided to the *same patients* in a less clinically appropriate and more costly emergency room would be covered – is antithetical to the intention of Congress." *Id.*

In short, the Fifth Circuit held that Congress intended States to be able, through the DSH program, to reimburse hospital-based RHCs for their costs of caring for uninsured patients. Prohibiting such reimbursements on the basis of artificial distinctions between services or unjustified references to Medicare is not required by the Social Security Act; it is prohibited

by it. CMS is not free to disregard congressional intent and the binding statutory interpretation of the Fifth Circuit.

The proposed rule implements bad public policy: Even if CMS had the authority to enact the proposed regulation, doing so would impose serious and unjustified burdens on low-income patients, on the providers that serve them, and on the States that fund the services. As noted above, the effect of CMS's interpretation is that the uncompensated costs of services provided by hospital-based RHCs may not be reimbursed through the DSH program even though the costs of the same exact services could be reimbursed if provided in a hospital emergency department. This outcome creates a terrible incentive: to provide care through expensive and scarce emergency room resources, instead of providing identical care through relatively cheap and available hospital-based RHCs.

The proposed rule will not result in reduced DSH spending, because States already have capped allotments that are insufficient to reimburse hospitals for all of their uncompensated care. Instead, it will simply shift payments from hospitals that are trying to provide outpatient services in RHC settings to those that are not. This perverse incentive scheme punishes low-income patients, who suffer because of the scarcity of emergency room services and the inferiority of these services compared to regular primary care offered through RHCs. It punishes RHCs, which cannot recover the uncompensated costs of the care they do provide. And it punishes States, which are forced to fund care through emergency department services, at the cost of the public fisc and the public health. The proposed rule, moreover, creates a substantial risk that hospital-based RHCs in Louisiana will be forced to close. These providers are a crucial part of the health care safety net in the State. Our low-income citizens cannot and should not be asked to bear this risk.

The proposed rule is unclear: Without conceding the validity of the proposed rule, Louisiana notes that the proposed rule does not take a clear position on whether and under what conditions the uncompensated costs of hospital-based RHC services may *ever* be included in a hospital's hospital-specific DSH limit. Additionally, the preamble to the proposed rule states that "[t]he definition of rural health clinic services would be revised to apply to all clinic settings," 72 Fed. Reg. at 55163, but there is no explanation of what such a change might mean, and no amendment to the definition of RHC services in 42 C.F.R. § 440.20.

Conclusion: For the foregoing reasons, Louisiana asks that the proposed rule be withdrawn or substantially modified in accordance with the foregoing comments.

Respectfully submitted,

Caroline Brown
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Covington & Burling LLP
1201 Pennsylvania Ave, N.W.
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(202) 662-6000
Attorneys for the State of Louisiana

October 27, 2007

Submitter : Mr. David McClure **Date:** 10/28/2007

Organization : Tennessee Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached Comments

CMS-2213-P-18-Attach-1.DOC

#18

October 29, 2007

Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: (CMS-2213-P) Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit (Vol. 72, No. 188), September 28, 2007

Dear Mr. Weems:

The Tennessee Hospital Association (THA), on behalf of our over 200 healthcare facilities, including hospitals, home care agencies, nursing homes, and health-related agencies and businesses, and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other health professionals, appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule changing Medicaid policy for federal reimbursement of Medicaid hospital outpatient services.

THA is especially concerned that CMS is in violation Congress' moratorium from regulation of Medicaid state finance matters. CMS describes the Medicaid hospital outpatient proposed policy changes as clarifications to current rules. THA believes CMS is violating Congress' moratorium barring the agency from regulating on matters pertaining to how states finance their Medicaid programs and fund graduate medical education (GME) payments. The THA urges CMS to withdraw this rule and submits these comments with strong opposition to the changes proposed.

Our detailed comments are attached. Thank you for considering these comments. If you have any questions, please contact me or David McClure, THA vice president of finance, at (615) 256-8240 or dmcclure@tha.com.

Sincerely,

Craig Becker, FACHE
President

cc: Rick Pollack, AHA, Executive Vice President

THA DETAILED COMMENTS

MORATORIUM

CMS violates the year-long moratorium secured by P.L. 110-28 because the policy changes proposed are based on provisions within the May 28 final rule that Congress explicitly instructed the agency not to implement. ((CMS-2258) *Final Rule - Medicaid Program; Cost Limit for Providers Operated by Units of Government* (Vol. 72, No. 102), May 29, 2007) CMS' proposed rule violates the moratorium in two ways.

First, the agency proposes changes to the hospital outpatient upper payment limit (UPL) methodology. The proposed changes are based on a new definition of the categories of providers (state, non-state governmental and private) found in the final rule subject to the moratorium. The definition of these categories is important because each category has a different aggregate UPL calculation. Current regulations define the three categories as: state government-owned or -operated facilities; non-state government-owned or -operated facilities; and private-owned and -operated facilities. (42 C.F.R. Section 447.321 (a)) The May 28 final rule redefines the categories by removing ownership status and the proposed rule relies on this new definition and restates it as, "State government-operated facilities ...Non-state government-operated facilities ...privately operated facilities" (pp 55158, 55165-66).

Second, the rule violates the moratorium with regard to the treatment of GME costs. The proposed rule does not permit state Medicaid programs to count GME costs in determining the UPL – a clear violation of the moratorium barring any regulatory activity on restricting GME or such payments made.

SCOPE OF HOSPITAL OUTPATIENT SERVICES AND UPL CALCULATIONS

The proposed rule substantially departs from long-standing Medicaid policy regarding the definition of Medicaid outpatient hospital services and how costs for such services are treated for the purposes of calculating the hospital outpatient UPL. CMS bases its dramatic shift in policy on the need to align Medicaid outpatient policies with Medicare outpatient polices, although these programs serve very different populations. Medicaid serves a largely pediatric population while Medicare serves an elderly population. Yet despite these differences, CMS is proposing to narrowly define Medicaid hospital outpatient services to align them with Medicare. The only justification for aligning the hospital outpatient policies for these two programs would be to limit Medicaid federal spending for hospital outpatient programs and state Medicaid programs overall.

Scope of Services. Current Medicaid regulations broadly define allowable hospital outpatient services to include preventative, diagnostic, therapeutic, rehabilitative or palliative services provided under the direction of a physician or dentist in a hospital. Under the proposed rule, the types of services that are at risk for not being reimbursed through hospital outpatient programs include Medicaid's early and periodic screening and diagnostic treatment dental services for children; physician emergency department services; physical, occupational and speech therapy; outpatient clinical diagnostic

laboratory services; ambulance services; durable medical equipment; and outpatient audiology services. However, CMS does not identify a problem with current state Medicaid programs to justify this policy change. In fact, the agency states in the proposed rule's preamble that in examining 32 state plan amendments over the last four years, CMS found only one state that defines non-hospital services as part of the outpatient hospital Medicaid set of services. (72 Fed. Reg. at 55161) In addition, while CMS states that the services no longer reimbursed through hospital outpatient departments will be paid for through other parts of the Medicaid program, the agency fails to demonstrate that there is access to such services within the community outside of the hospital outpatient department.

Further, CMS' attempt to narrow the definition of allowable hospital outpatient services poses serious implications for Medicaid disproportionate share hospital (DSH) payments. A hospital's uncompensated care costs help determine a hospital's DSH reimbursement. Currently, CMS views only the costs for providing inpatient and outpatient hospital services as allowable for determining a hospital's uncompensated care costs. The agency's proposed narrow definition would exclude many costs now included in hospitals' Medicaid DSH calculations, potentially limiting DSH payments to already financially strapped hospitals.

UPL Calculations. CMS states that the proposed changes in the UPL methodology will apply only to private outpatient hospital UPLs. While this may appear straightforward, it is not. The definition of a governmental hospital remains unresolved because it falls within the scope of the final rule that is subject to the congressional moratorium. Therefore, we find it nearly impossible to assess the change in UPL methodology because the universe is unknown.

In proposing a new methodology to determine UPL calculations, CMS violates its own description of the proposed rule as one of "clarifications." States currently have some measure of flexibility in calculating the UPL. However, the proposed rule would limit states to two permissible methods of calculating the new UPL: Medicare cost-to-charge ratio based on Medicare allowable costs; and Medicare payments-to-charge ratio based on allowable costs. The cost information is to be derived from hospitals' filed Medicare cost reports. The selected ratios would be multiplied by Medicaid outpatient charges based on Medicaid paid claims.

This new formula for calculating UPL would have a major impact on hospitals. For example, children's hospitals would not have their costs appropriately accounted for in the new UPL methodology, particularly the Medicare payment-to-charges ratio, because they have little to no Medicare volume. GME costs also would not be accounted for in the new UPL methodology using the Medicare cost-to-charge ratio. In addition, state Medicaid programs would face a new administrative burden in attempting to adapt their current UPL calculations to this new proposed methodology.

CONCLUSION

CMS states in the preamble that the fiscal impact of this rule would be minimal because the rule is a clarification of existing policy and would not result in the elimination of coverage. The THA believes that the agency has failed to perform the due diligence necessary to make these statements. Furthermore, we would contend that these policy changes not only will have a significant fiscal impact on many state Medicaid programs, but could potentially affect coverage for outpatient hospital services.

The THA urges CMS to withdraw this rule and suspend any further regulatory activity that affects the issues encompassed under the moratorium secured by P.L. 110-28. These proposed policy changes will result in cuts to state Medicaid programs, cuts in payments to hospitals, and reduced access to needed services for potentially millions of vulnerable people served by the Medicaid program.

End of Comments

Submitter : Ms. Aimee Ossman **Date: 10/29/2007**

Organization : National Association of Children's Hospitals

Category : Health Care Provider/Association

Issue Areas/Comments

Clinic Upper Payment Limit

Clinic Upper Payment Limit

The Proposed Rule Overlooks Critical Outpatient Hospital Services for Children
We understand that CMS is trying to provide more clarity on what is and what is not a Medicaid outpatient hospital service, but the narrow Medicare definition included in the proposed regulation does not reflect the reality of the Medicaid program today and the significant role it plays for children. More than one-fourth of all children are insured by Medicaid and over 50 percent of Medicaid beneficiaries are children.

The Medicare definition for outpatient services is inappropriate for children because it was not developed to address their unique health care needs. Serviees not specified in the Medicare definition include, but are not limited to, dental and vision services, annual checkups, and immunizations. The different health care needs of children and adults should be examined and changes made before the Medicare definition is adopted for the Medicaid population. If this is not done, important outpatient health care services for children could be threatened.

The Proposed Rule Threatens the Financial Viability of Children s Hospitals
Children s hospitals are major providers of outpatient hospital services for children; on average a children s hospital provides care in more than 300,000 outpatient visits per year. In addition, on average, children insured by Medicaid accounted for 50 percent of all outpatient visits at children s hospitals. Most children s hospitals provide a full range of outpatient services to children insured by Medicaid, including primary, specialty and emergency care.

We recognize that the regulation says that services taken out of the outpatient hospital services definition could still be provided under different benefit categories. However, by taking services out of the definition, CMS would be lowering reimbursement for these important services that children s hospitals provide to children insured by Medicaid. This reduction would exacerbate the inadequate Medicaid outpatient reimbursement children s hospitals receive, which already falls substantially below the cost of care provided.

The proposed regulation would exclude services provided by entities that are not provider-based departments of a hospital. This new requirement could jeopardize the outpatient care children s hospitals provide in outpatient clinics. If the services provided in these clinics or other outpatient sites would no longer be reimbursed at the outpatient hospital services level than that would affect the hospital s ability to provide these services in the community. Again, the adoption of a Medicare policy in the Medicaid program would be inappropriate given the different populations and purposes of the two programs.

The proposed regulation may also affect the calculation of Medicaid Disproportionate Share Hospital (DSH) payments for children s hospitals. If services are no longer classified as outpatient hospital services, then they would no longer be included in the calculation of the DSH cap. This could result in smaller payments for children s hospitals. As safety net hospitals, DSH payments are vital to ehildren s hospitals ability to care for all children.

GENERAL

GENERAL

CMS Is Unable to Estimate Impact of the Proposed Rule
Due to lack of data, CMS says it is unable to estimate the impact of the proposed regulation. This is extremely troubling for children s hospitals. Before a regulation of this magnitude is implemented, the impact should be specified and addressed. CMS does not address the potential effect on children and children s providers of adopting a Medicare service definition. This change could impact the services hospitals are able to provide for children and therefore children s access to outpatient hospital services. CMS should explore the potential effects of these changes and any revisions needed to continue to provide quality and aceessible health care services for children.

Sec attachment.

Outpatient Hospital and Clinic Seravices: Application of Upper Payment Limits

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CMS-2213-P-19-Attach-1.DOC

#19

National Association of
Children's Hospitals

401 Wythe Street
Alexandria, VA 22314
(703)684-1355 Fax (703)684-1589

N • A • C • H •

October 26, 2007

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2213-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attn: CMS—2213--P
Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit

Dear Sir/Madam:

The National Association of Children's Hospitals (N.A.C.H.) appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on its proposed rule on Medicaid outpatient hospital services published in the September 28th *Federal Register.* Children's hospitals are major providers of outpatient services for children insured by Medicaid. The proposed regulatory changes would have a negative impact on children's hospitals and the children they serve.

We urge CMS not to implement the rule for two reasons. First, Congress' moratorium on implementation of changes to state financing mechanisms and graduate medical education payments under Medicaid deny CMS the authority to implement the rule as currently drafted. Second, The National Association of Public Hospitals has done a detailed analysis of the proposed regulation on outpatient hospital services and found that the regulation violates the moratorium in two ways: 1) the proposed regulation includes language from the state financing mechanism regulation that redefines categories of providers for the purposes of the upper payment limits (UPLs); and 2) the proposed regulation would no longer allow graduate medical education costs in the calculation of the outpatient UPL.

We also urge CMS not to implement the rule for several additional reasons:

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regulation does not reflect the reality of the Medicaid program today and the significant role it plays for children. More than one-fourth of all children are insured by Medicaid and over 50 percent of Medicaid beneficiaries are children.

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Conclusion

As you can see from our comments, we are extremely concerned about this proposed regulation and the impact it would have on children enrolled in Medicaid and on children's hospitals. We encourage CMS to delay the implementation of the regulation to allow time for a thorough review of the proposed regulation's impact on children enrolled in Medicaid and the providers who serve them.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Aimee Ossman at 703/797-6023 or aossman@nachri.org. Thank you for your consideration.

Sincerely,

Peters D. Willson

Peters D. Willson
Vice President for Public Policy

Submitter : R. Scott Ward, PT, PhD **Date:** 10/29/2007

Organization : American Physical Therapy Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2213-P-20-Attach-1.PDF

#20

APTA
American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

October 29, 2007

Kerry N. Weems
Acting Administrator
Center for Medicare & Medicaid Services
Attention: CMS-1541-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit – Proposed Rule (File Code: CMS-2213-P)

Dear Mr. Weems:

On behalf of the American Physical Therapy Association (APTA), I would like to submit the following comments regarding the "Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit" proposed rule that was published in the *Federal Register* on September 28, 2007 *(72 FR 55158)*. The APTA is a professional organization representing the interests of over 72,000 physical therapists, physical therapist assistants, and students of physical therapy. The proposed amendments would directly affect the delivery of and patient access to physical therapy services under Medicaid, and therefore, we are greatly concerned about implementation of these provisions.

In this proposed rule, the Centers for Medicare & Medicaid Services (CMS) states that the current broad definition of outpatient hospital services is not clear on whether outpatient hospital services can include types of services that are outside the normal responsibility of outpatient hospitals, such as practitioner, school-based, and rehabilitative services. CMS is concerned that the broad definition does not limit the scope of the outpatient hospital services benefit to those services over which the outpatient hospital has oversight and control.

Therefore, CMS has identified a need to restrict the services payable under the outpatient hospital services benefit of Medicaid. Specifically, the Agency proposes to limit Medicaid coverage and payment for outpatient hospital services to facility services only. For example, as illustrated in the preamble of the proposed rule, States would be allowed to cover and reimburse prosthetics, supplies, and other orthotic devices and durable medical equipment as outpatient hospital services but not practitioner or professional services such as physical therapy.

CMS proposes to amend 42 CFR §440.20 *"Outpatient Clinic and Hospital Facility Services and Rural Health Clinic Services"* to read:

(a) Outpatient hospital services means preventative, diagnostic, therapeutic, rehabilitative, or palliative services that –
(1) Are furnished to outpatients;
(2) Are furnished by or under the direction of a physician or dentist;
(3) Are furnished in a facility that –
(i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
(ii) Meets the requirements for participation in Medicare as a hospital;
(4) Are limited to the scope of the facility services that –
(i) Would be included, in the setting delivered, in the Medicare outpatient prospective payment system (OPPS) as defined under §419.2(b) of this chapter or are paid by Medicare as an outpatient hospital service under an alternate payment methodology;
(ii) Are furnished by an outpatient hospital facility, including an entity that meets the standards for provider-based status as a department of an outpatient hospital set forth in §413.65 of this chapter;
(iii) Are not covered under the scope of another Medical Assistance service category under the State Plan; and
(5) May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State.

We strongly urge CMS to explore less stringent methods to ensure that costs under the outpatient hospital services benefit of Medicaid are not duplicative of costs incurred elsewhere in the program. We believe that the implementation of these provisions will limit access to necessary physical therapy services in the Medicaid program.

The Current State of Physical Therapy Within the Medicaid Program

Physical therapy services are critical services for many Medicaid beneficiaries. Physical therapy services are provided in a variety of settings, including hospitals, outpatient clinics, home care, Intermediate Care Facilities for People with Mental Retardation (ICF/MR), private offices; inpatient rehabilitation facilities; skilled nursing, extended care, sub-acute facilities; patients' education or research centers, hospices and schools. Physical therapy helps beneficiaries to obtain the best possible functional ability.

Physical therapy services encompass the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health. Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations.

This proposal would exclude States from covering, under the Medicaid outpatient hospital benefit, services that are covered under another medical assistance service category under the State plan as specified in §1905(a) of the Social Security Act (the Act). Although physical therapy is delineated as an allowable covered service under §1905(a)(11) of the medical assistance service category, it is not mandatory for the State to cover physical therapy services under this option of the Medicaid State Plan.

In fact, physical therapy is currently covered under the physical therapy benefit (§ 1905(a)(11)) in approximately 34 states. Currently, states are only mandated to cover physical therapy services when found

medically necessary under the Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) program as mandated in the school-setting or when delivered as an inpatient hospital service under Medicaid.

Therefore, by eliminating the ability for services, such as physical therapy to be included under the Medicaid outpatient hospital services benefit, patient care would be severely compromised in those States that do not have physical therapy as a covered service in their State Plans. In other words, Medicaid beneficiaries would not have access to critical and necessary rehabilitative services.

Distinguishing the Medicare and Medicaid Population

In the proposed rule, CMS seeks to adopt services reimbursed under the Medicare Outpatient Prospective Payment System (OPPS) within the Medicaid program. It should be recognized that the Medicare and Medicaid programs are vastly different in scope and nature and that provisions of Medicare that work well within that program are not necessarily feasible within Medicaid.

The following distinctions should be noted:

First, while these federal assistance programs have several aspects that are common, they vary greatly in their overall administration. The Medicare program was designed to ensure health insurance for: (1) persons over the age of 65, (2) persons under the age of 65 with certain disabilities, and (3) people of all ages with End-Stage Renal Disease. In contrast, the Medicaid program provides medical benefits to groups of low-income people of all ages including children, the aged, and people with disabilities. Therefore, CMS should carefully consider the adverse implications of uniformly applying coverage standards of the Medicare program to Medicaid

Secondly, Medicare is a program that is solely operated by the federal government. In contrast, the Medicaid program is a federal-state partnership that gives wide discretion to the States to form their individual programs as they see fit. Due to this wide discretion, there is much variance from state-to-state of what services are covered under Medicaid. This is not the case in Medicare. Under the Medicare program, CMS has clearly defined eligibility and coverage benefits that are evenly applied throughout the program on a national basis.

Thirdly, under the Medicare program, physical therapy services are furnished in the outpatient hospital setting. In this setting, these services are billed under the physician fee schedule rather than the outpatient hospital PPS system. In the Medicare program, physical therapy is recognized and codified as a separate benefit, and physical therapists are qualified to perform certain services independent of physician supervision. The provision allows outpatient physical therapy services to be furnished in a physical therapy private practice office, outpatient hospital, rehabilitation agency, and other outpatient settings without physician supervision.

Specifically, the physical therapy benefit is defined under §1861(p) of the Act, which states:

"The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient -- who is under the care of a physician, and with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established by a physician or by a qualified physical therapist and is periodically reviewed by a physician"

As illustrated above, under the Medicare program, beneficiaries are still provided access to physical therapy services, although not reimbursed under the OPPS system . Unfortunately, physical therapy is not provided the same coverage benefit under Medicaid, and in several instances, the only coverage benefit available for the furnishing of physical therapy services in the outpatient hospital setting is under the Medicaid outpatient hospital services benefit.

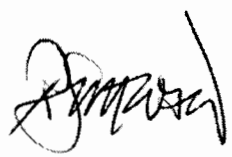
Therefore, CMS should carefully consider the impact of removing medically necessary services such as physical therapy from the Medicaid outpatient hospital services benefit.

Conclusion

For millions of children, adults, and persons with disabilities, Medicaid is their first and only resource for obtaining medical care. It is the duty of the federal government to ensure that Medicaid beneficiaries are afforded access to comprehensive and quality care. APTA believes that this proposed rule would defeat this stated obligation and impede the progress that has been made by CMS to reform Medicaid and to increase state flexibility. **Therefore, we urge CMS to allow states to cover medically necessary physical therapy services under the Medicaid outpatient hospital services benefit.**

APTA appreciates the opportunity to provide these comments and looks forward to working in partnership with CMS, the Administration, and Congress in reforming the Medicaid program while ensuring that beneficiaries have access to comprehensive and quality health care. Please contact Roshunda Drummond-Dye, Esq., Associate Director of Regulatory Affairs at (703) 706-8547 or at roshundadrummond-dye@apta.org, if you have any questions regarding these comments.

Sincerely,



R Scott Ward, PT, PhD
President

RSW:rdd