Submitter : Kathy Reep **Date:** 10/29/2007

Organization : Florida Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2213-P-21-Attach-1.DOC

#21

FLORIDA HOSPITAL ASSOCIATION

An Association of Hospitals & Health Systems

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, September 28, 2007

Dear Mr. Weems:

On behalf of our nearly 200 member hospitals and health systems, the Florida Hospital Association (FHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule changing Medicaid policy related to reimbursement for Medicaid hospital outpatient services.

While CMS has described the proposed changes as clarifications to current rules, the proposed rule actually poses more questions than it answers. First, the rule appears to contain language that is part of the final cost limit rule that CMS is barred from implementing. It appears that the proposed rule violates the moratorium enacted by Congress prohibiting implementation of the Medicaid cost limit rule and changes to the policy surrounding graduate medical education (GME).

Also in the rule, CMS has proposed to narrowly define Medicaid hospital outpatient services to align with Medicare. The rationale for this proposal is unknown – other than to limit federal spending for services deemed appropriate by the state. Obviously Medicare was developed for a different population than Medicaid and exclusion of coverage for services such as early and periodic screening and diagnostic treatment (DPSDT) for children is most inappropriate. Such redefinition of the covered Medicaid outpatient services could also negatively impact a hospital's payment for disproportionate share, furthering its losses under the Medicaid program.

The FHA urges CMS to withdraw this rule as it will result in reductions to state Medicaid programs, decreased payments to the hospitals serving Medicaid patients, and potentially impacting access for services for those enrolled in the program.

Sincerely,

Kathy Reep
Vice President/Financial Services

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Submitter : Mr. David Winslow **Date:** 10/29/2007

Organization : Maine Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-22-Attach-1.DOC

#22

MHA

Maine Hospital Association

Representing community hospitals, healthcare organizations and the patients they serve.

October 26, 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 Maine Hospital Association appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule changing Medicaid policy for federal reimbursement of Medicaid hospital outpatient services. The Maine Hospital Association represents all of Maine's 39 acute care and specialty hospitals and their affiliates. All of our acute care hospitals are nonprofit, community-governed organizations. Maine is one of only a handful of states in which all of its acute care hospitals are non-profit.

In the Federal Register issued on September 28, 2007, CMS describes the Medicaid hospital outpatient proposed policy changes as clarifications to current rules. CMS further states that because these changes will not result in a significant financial impact, the proposed rule is not considered a major rule and, therefore, a 30-day comment period is sufficient. The Maine Hospital Association disagrees with all of these points, especially because we believe the change in the definition of hospital outpatient services will cause our hospitals to lose tens of millions of dollars in Medicaid reimbursement for outpatient hospital services. The change will also force patients to look for these services outside of the hospital in areas where the services simply don't exist in our small and rural state.

Furthermore, this proposed rule is making major policy changes to the Medicaid program therefore a 30-day comment period is insufficient for public comment. CMS is also violating the Congressional moratorium barring the agency from regulating matters pertaining to how states finance their Medicaid programs and fund graduate medical education (GME) payments. The Maine Hospital Association strongly opposes these changes and urges CMS to withdraw this rule.

Definition of Hospital Outpatient Services

The proposed rule repeals the long-standing definition of Medicaid outpatient hospital services and replaces it with new and much more narrow definition. CMS bases this dramatic shift in policy on the desire to align Medicaid outpatient policies with Medicare outpatient polices. This is not appropriate because these programs serve very different populations. For example, Medicaid serves a younger population with a large number of pediatric cases while Medicare serves the elderly population. Yet despite these differences, CMS is proposing to narrowly define Medicaid hospital outpatient services to align it with Medicare. The only justification for aligning the hospital

outpatient policies for these two programs would be to limit Medicaid spending for hospital outpatient programs and limit the flexibility of state Medicaid programs.

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 services for children; physical, occupational and speech therapy; outpatient clinical diagnostic laboratory services; ambulance services; durable medical equipment; outpatient audiology services; and most notably for Maine, outpatient and emergency department physician services. In many areas of Maine these services do not exist or are unavailable outside of hospital outpatient departments. This is especially true for Medicaid patients given the low reimbursement rates offered by the program to private practitioners.

CMS states in this proposal that the services no longer reimbursed through hospital outpatient departments will be paid for through other parts of the Medicaid program. This is not true in Maine and the agency would not be able to demonstrate that there is access to such services within the community outside of the hospital outpatient department in our state.

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 Maine Hospital Association believes that the agency may have failed to properly perform the due diligence necessary to make these statements. This rule change will cost Maine hospitals tens of millions of dollars in Medicaid reimbursement. Furthermore, we would contend that these policy changes will seriously affect access to important outpatient services, especially physician services for Medicaid patients.

The Maine Hospital Association 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 thousands of vulnerable people served by the Maine Medicaid program.

If you have any questions, please feel free to contact me at (207) 622-4794 or dwinslow@themha.org.

Sincerely,

David Winslow
Vice President of Financial Policy

cc: Senator Olympia Snowe
Senator Susan Collins
Representative Michael Michaud
Representative Thomas Allen

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Phone: 207-622-4794 Fax: 207-622-3073
web site: www.themha.org

Submitter : Ms. Lisa Patrick **Date:** 10/29/2007

Organization : Caldwell Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-23-Attach-1.DOC

#23

CALDWELL Memorial Hospital

October 21, 2007

Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-2213-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-2213-P Clarification of Outpatient Clinic & Hospital Facility Services Definition and Upper Payment Limit.

Dear CMS:

The purpose of this letter is to urge CMS to eliminate the provisions of proposed rule file code CMS-2213-P regarding outpatient clinic and hospital services facility services definition that was published in the Federal Register on September 28, 2007. This proposed rule will limit rural health care availability while simultaneously increasing ER costs to facilities, taxpayers and, in turn, the government. The proposed rule asserts that it is trying to align Medicare and Medicaid payments, but in reality, will end up pushing them further apart effectively paying significantly less for Medicaid services in already under-paid rural health settings. Additionally, the proposed rule, CMS-2213-P, does NOT support the *Medical Home Model for the Uninsured* that Secretary Leavitt endorsed for our state and it will not be feasible under this ruling.

We are a small rural hospital located in Columbia, Louisiana, with three hospital-based rural health clinic's (RHC) that fully function as part of our hospital. The hospital employs all of the RHC personnel, pays all the expenses of the RHC, performs quality assurance responsibilities, and credentials the physicians and mid-level practitioners employed by the RHC. The hospital 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. <u>This proposed rule, CMS-2313-P, will have a catastrophic effect on rural healthcare and the availability of services to those who need care the most--- the poor and the indigent.</u>

This proposal *will* limit our hospital's ability to provide services at the RHC's, because disproportionate share funding covers much of the cost of the RHC services. Nothing has changed to give the uninsured and indigent population more income to afford healthcare elsewhere, so now not only can they not afford healthcare, there will very few places, if any, for them to receive healthcare. It is the rural population as a whole that will suffer by this outpatient definition excluding RHC.

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 strains our hospital's limited resources. It also makes it difficult for those patients to get timely, preventative care.

Our hospital-based RHC solved this problem by giving those patients a less expensive and readily-available alternative to the emergency room (ER). This has 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. It is certain that there will be an increase in unnecessary ER visits that would have been avoided if the patient has a clinic to access.

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 rule also asserts that it is trying to more closely align Medicare and Medicaid payments. Congressional intent was to let each State set rates that were efficient and economical. They have done this and it is successful in our state. **Under the current status, the disproportionate share funding payments align our Medicaid and indigent costs more closely with our Medicare costs. If you take away our ability to receive this funding, then there will be a severe payment gap unless some restructuring of the outpatient payment rates occurs simultaneously with this proposed ruling.** Medicare and Medicaid could effectively be aligned in a provider-based RHC by increasing the encounter fees paid for Medicaid and Indigent patients to match the higher costs we are paid for Medicare encounters. Under that rationale, it would be very costly and unnecessarily harmful to input severe changes when we know the whole healthcare system in the United States will be restructured within a few years. For these reasons, the status quo and current outpatient clinic and hospital services definition should remain because it already achieves what CMS claims this proposed rule is set up to accomplish.

The Office of Secretary Leavitt has been working hard with our State to make and endorse a medical home model for the uninsured. Healthcare should be a right of every person and not a whim of the government's retaliatory and/or ill-processed rulemaking. **Please take into consideration the grave impacts that CMS-2213-P will have upon rural health availability.** The proposed definition will have a severe financial impact on our hospital, which will greatly limit our ability to provide the increased amount of uncompensated care that we have been asked to provide.

Sincerely,

Heather Clark, CEO
Caldwell Memorial Hospital
411 Main Street/ P.O. Box 899
Columbia, LA 71418

Submitter : **Ms. Linda Welch** **Date: 10/29/2007**

Organization : **Rural Hospital Coalition, Inc.**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Clinic Upper Payment Limit

Clinic Upper Payment Limit

To:Centers for Medicare & Medicaid Services
Office of Health and Human Services
RE: CMS-2213-P--Outpatient clinic and hospital services facility services definition

We are writing on behalf of the membership of Louisiana s Rural Hospital Coalition, Inc. regarding the outpatient clinic and hospital services facility services definition proposed rule published at 72 Fed. Reg. 55158 (Sept. 28, 2007). The forty-one (41) members of the Coalition are rural hospitals, which provide much needed care in Louisiana s medically underserved areas, including the Mississippi and Red River delta regions which are among our nation s most impoverished.

Several years ago, CMS tried unsuccessfully to exclude the costs of such hospital-based rural health clinic (RHC) services from disproportionate share hospital (DSH) funding. That past attempt by CMS was struck down by the courts. Louisiana Dept. of Health and Hospitals v. CMS, 346 F.3d 517 (5th Cir. 2003). Because the Court found CMS rejection of Louisiana s state plan inconsistent with the Social Security Act, we do not believe that CMS may reverse the decision by rule. Congress, not CMS, must change the eligibility of hospital-based RHC s for inclusion in DSH calculations.

As the Fifth Circuit recognized, the broad goal of the DSH program [is] to support hospitals that serve low-income patients. Congress has, on multiple occasions, demonstrated an intention of broadly defining the DSH program. See, e.g., H.R. Rep. No. 100-391, at 524-27 (1987) (demonstrating: (1) Congress s solicitude for the needs of rural hospitals by exempting them from certain requirements otherwise applicable to DSH hospitals, and (2) Congress s awareness of state plans that offer extra payments to some hospitals because they provide outpatient services and outpatient pharmacy to Medicaid and non-Medicaid eligible low-income patients); H.R. REP. NO. 101-964, at 868, 871 (1990) (explaining new provision in ? 1396r-4(c)(3) that allows additional DSH payments to designated hospitals to finance services for Medicaid and low-income patients).
The hospital-based RHCs that CMS is again attempting to exclude from DSH eligibility function as part of the hospital, and help rural hospitals provide the same care previously provided by the emergency department, but in a more clinically appropriate and less costly setting. 346 F. 3d at 577. Ironically, under CMS proposed rule, more expensive uncompensated emergency room care would be encouraged and covered, but uncompensated hospital-based RHC care would be discouraged and not be included in DSH-eligible costs.

The Fifth Circuit explained that including the costs of such RHC services in the costs of the hospital for disproportionate share furthered the Congressional purpose in enacting the DSH legislation:

"Louisiana contends that the Administrator 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. Here too it seems that Louisiana presents the stronger argument."

346 F.3d at 578.

CMS partially justifies its rule making by stating only one state plan defines RHC services as outpatient services. We submit this comment is self serving and tainted, in that CMS has controlled what has been approved in the state plans and would have done the same in Louisiana, absent the Fifth Circuit decision regarding Louisiana.

CMS proposed rule undermines well-established public policy. Rather than reward use of cheaper and more appropriate RHC services, it does just the opposite.

(continued below)

GENERAL

GENERAL

The proposed 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. CMS proposed rule creates exactly the wrong incentive.

Our rural hospitals have 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 RHC s should be encouraged, not discouraged, because RHC use will save taxpayer dollars.

The proposed change will have an especially severe impact on our constituents, because the state is still recovering from Hurricanes Katrina and Rita and burdened by the poverty and lack of education in the Delta region. Uncompensated care costs to rural hospital-based RHC s many of which hospitals are already running at a deficit-- will exceed four million dollars. This additional shortfall will further limit the rural hospitals ability to provide the increased volume of uncompensated care that they have been asked to provide after the 2005 storms and the continued problems of the Delta region.

We ask that you please withdraw the proposed rule, docketed under CMS-2213-P- relating to the outpatient clinic and hospital services facility services

definition.

Submitter : **Ms. Karen Fisher** **Date: 10/29/2007**

Organization : **Association of American Medical Colleges**

Category : **Health Care Professional or Association**

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 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-25-Attach-1.DOC

#25

VIA ELECTRONIC SUBMISSION

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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

Attention: **CMS-2213--P**

Dear Mr. Weems:

On behalf of the Association of American Medical Colleges (AAMC or the Association), I write to urge the Centers for Medicare & Medicaid Services (CMS or the Agency) to rescind the proposed rule entitled "Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit" (September 28, 2007). The Association's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 300 adult nonfederal major teaching hospitals and health systems and 19 children's hospitals that receive Medicaid funding. The AAMC also represents all 125 accredited U.S. allopathic medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation's medical students and residents.

In brief, the proposed rule seeks to narrow the definition of outpatient hospital services with a resultant payment cut for many important services that are provided in hospital outpatient departments, as well as a potentially significant impact on disproportionate share (DSH) payments. The rule also proposes changes in the outpatient upper payment limit (UPL) calculation. While labeled a "clarification," the proposed rule in reality represents major changes to long-standing existing policies. We believe these changes could significantly reduce important funding for teaching hospitals--institutions that provide significant amounts of care to Medicaid and uninsured patients.

We also believe that the proposed rule violates the one-year legislative moratorium passed last May forbidding Agency action on implementation of a cost limit on payments to governmental providers or restrictions on Medicaid graduate medical education (GME). Consequently, we believe the Agency's best course of action is to withdraw the proposed rule, at least until the moratorium expires in May, 2008. In this letter we also are providing the Association's views on specific provisions of the proposed rule. However, these specific comments should not be interpreted to acknowledge any authority for CMS to propose this rule. Rather, we write to

express our concerns about the wisdom of these changes and urge CMS to reconsider the need for this entire rulemaking, even after the moratorium ends

THE PROPOSED RULE AND THE MORATORIUM

As you are aware, section 7002(a) of the Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (Pub. Law 110-28) prohibits, for one year, implementation of a May, 2007 final rule to impose a cost limit on Medicaid payments to governmental providers (Cost Limit Final Rule). Moreover, it prohibits the Agency from promulgating "any rule or provisions" restricting Medicaid payments for graduate medical education (GME). The publication of the proposed rule violates the moratorium on both of these fronts.

First, the proposed changes to the UPL methodology are based on new definitions of the categories of providers (state, non-state governmental and private) that were first contained in the Cost Limit Final Rule-the rule that is the direct subject of the moratorium. 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 Cost Limit Final Rule redefines the categories by removing ownership status. The new definitions are restated in the proposed rule on pages 55165-16658 of the Federal Register: "State government operated facilities . . . Non-State government operated facilities . . . privately operated facilities." These proposed provisions directly contravene Congress' directive not to implement any provision of the Cost Limit Final Rule.

Second, as discussed in the next section, the proposed rule is in violation of the moratorium because the UPL calculations would contravene current policy by not including GME costs.[1] While we believe that CMS's actions could have resulted from an inadvertent misunderstanding of the Medicare cost reports, nonetheless the result is that the proposed rule must be withdrawn and reissued.

THE UPL CALCULATION AND GME COSTS

States currently have some measure of flexibility in calculating the outpatient UPLs for the various provider groups (government, private, etc) because the states can best reflect their own Medicaid programs. The proposed rule, however, would limit states' flexibility by specifying only two methods for calculating the UPL for private providers. The first method would use hospital-specific Medicare outpatient cost-to-charge ratios that would be multiplied by Medicaid charges and aggregated to create a Medicare "cost-based" UPL. The second method would use Medicare payment-to-charge ratios multiplied by Medicaid charges and aggregated to create a Medicare "payment-based" UPL.

---

[1] The exact text of the moratorium language states "tak[ing] any action (through promulgation of regulation, issuance of regulatory guidance, or other administrative action) to ... promulgate or implement any rule or provisions restricting payments for graduate medical education under the Medicaid program." P.L. No. 110-28, Section 7002(a).

The proposed rule sets forth specific line items from hospitals' Medicare cost reports that states should use to calculate the UPL. For the cost-to-charge ratio, the proposed rule specifies column 9 of Worksheet C, Part 1 or Worksheet D, Part V, column 1.01 (which carries over the ratio from worksheet C). As set forth on Worksheet C, the cost portion of the ratio is obtained from Worksheet B, Part 1, column 27. However, this column does not include direct GME costs; the cost amount that includes GME costs is found in column 25.

As the Agency is aware, the vast majority of states make GME payments under their Medicaid programs. We understand that for a number of states, these payments are allocated between the inpatient and outpatient settings. Thus, in order for the outpatient UPL to function as intended, GME must also be reflected in the Medicare outpatient calculation.

Because the proposed rule fails to include GME costs in the calculation, we believe it must be withdrawn because it is in violation of the moratorium. However, we believe this problem can be rectified by modifying the requirement to ensure that the cost value used in the ratio calculation includes GME costs, which we believe is column 25 of Worksheet B, Part 1. We ask CMS to verify and confirm this assumption.

Even if the GME issue is addressed, we have other concerns about CMS specifying a specific methodology for determining the outpatient UPL. At the outset it important to recognize that the UPL will be reduced, inappropriately we believe, if CMS narrows the definition of hospital outpatient services. In addition, children's hospitals would not have their costs appropriately accounted for in the new UPL methodology, particularly the Medicare payment-to-charge ratio, because they have little to no Medicare volume. The proposed rule states that changes in the UPL methodology will apply only to private outpatient hospital UPLs. However, it is not possible to assess the impact of this provision because the definition of a governmental hospital remains unresolved because it falls within the scope of the Cost Limit Final Rule that is subject to the moratorium. It is possible that the number of private hospitals might increase as a consequence of that new definition if and when the Cost Limit Final Rule is implemented, which would increase and expand the impact of this proposed rule.

Finally, some members have questioned whether the CMS is capturing all Medicare-covered outpatient hospital payments and charges because apparently payments for some services, such as physical therapy and durable medical equipment, are not reflected on the cost reports. We ask CMS to investigate this matter and clarify whether the payments and charges for all outpatient hospital services reimbursed by Medicare are captured by cost report lines referenced in the proposed rule.

SCOPE OF HOSPITAL OUTPATIENT SERVICES

Currently, the Medicaid regulations broadly define hospital outpatient services to allow states to tailor their programs to best meet the needs of Medicaid patients. Such services include vision, specified psychiatric services, and dental care for children. The proposed rule would severely limit the scope of this definition, by aligning it with the definition of hospital outpatient services

under the Medicare program, resulting in a number of services provided in hospital outpatient departments being paid at lower, non-facility Medicaid rates.

It is unclear why such an "alignment" is necessary or desirable from a policy standpoint. The programs serve very different populations, with Medicare focusing on elderly population and Medicaid targeting a population comprising significant pediatric patients. Moreover, because teaching hospitals often are the primary source of all care for Medicaid patients, such a decision unfairly penalizes these institutions for providing necessary care to a vulnerable population.

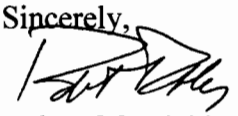
Further, while not mentioned in the proposed rule, a narrowing of the definition of allowable hospital outpatient services could have a significant impact for Medicaid disproportionate share hospital (DSH) payments. The DSH methodology recognizes only those uncompensated costs associated with providing inpatient and outpatient hospital services. If the Agency decides to apply its new definition of hospital outpatient services in the DSH context, significant costs could no longer be included in a hospital's DSH cap, thus reducing important funding to help offset these otherwise unreimbursed costs.

CONCLUSION

The AAMC urges CMS to withdraw this proposed rule and suspend any further regulatory activity that affects the issues encompassed under the Congressional moratorium. If at some point in the future, the Agency would like to proceed with rulemaking in this area, we urge that the comments in this letter be seriously considered during the development of a proposed rule.

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

Sincerely,



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

cc: Karen Fisher, AAMC

Submitter : **Mr. Rick Pollack** **Date: 10/29/2007**

Organization : **American Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2213-P-26-Attach-1.PDF

CMS-2213-P-26-Attach-2.DOC

#26

American Hospital Association

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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:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule changing Medicaid policy for federal reimbursement of Medicaid hospital outpatient services.

CMS describes the Medicaid hospital outpatient proposed policy changes as clarifications to current rules. CMS further states that because these changes will not result in a significant financial impact, the proposed rule is not considered a major rule and, therefore, a 30-day comment period is sufficient. The AHA disagrees on all points.

The proposed rule is making major policy changes to the Medicaid program; therefore, a 30-day comment period is an insufficient time period for public comment. Moreover, 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 AHA urges CMS to withdraw this rule and submits these comments in opposition to the changes proposed.

MORATORIUM

In this proposed rule, 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 congressional 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 more narrowly define Medicaid hospital outpatient services, limiting that definition to those services covered under Medicare. The only rationale for aligning the hospital outpatient policies for these two programs seems to 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 therapies; 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 that would 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 financial 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 number and type of hospitals affected is unknown.

In proposing a new methodology to determine UPL calculations, CMS contradicts its own description of the proposed rule as "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: cost-to-charge ratio based on Medicare allowable costs; and Medicare payment-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 cost-to-charge ratio based on the Medicare cost report. 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 AHA 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 AHA 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.

If you have any questions, please feel free to contact me or Molly Collins Offner, senior associate director for policy, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

Submitter : **Mr. Wayne Arboneaux** **Date: 10/29/2007**

Organization : **Assumption Community Hospital**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-27-Attach-1.DOC

October 20, 2007

Re: CMS-2213-P--Outpatient Clinic and Hospital Facility Services Definition

Dear Secretary Leavitt:

I appreciate the opportunity to comment on CMS' 2213-P- Outpatient Clinic and Hospital Facility Services Definition proposed rule that was published in the Federal Register September 28, 2007.

On behalf of OLOL Assumption Community Hospital & Rural Health Clinic, I am writing to express my grave concern and to respectfully express my objection to the outpatient clinic and hospital facility services definition proposed rule.

We are a small rural Critical Access Hospital located in Napoleonville, Louisiana, with a (provider) hospital-based rural health clinic (RHC) that compliments the primary care needs of our community and serves as an extension of our hospital services.

Since opening our hospital-based RHC, we have been able to provide services to our rural population that was previously provided through our emergency department. We are now providing that service in a more clinically appropriate and less costly setting.

The proposed rule would still cover more expensive uncompensated emergency room care while disallowing Hospital-based RHC DSH eligible costs. By establishing our hospital-based RHC, we have attempted to end the burden placed on our emergency department that is often used for primary care treatment.

If this rule is implemented, it has the potential impact of re-establishing the use of the emergency department for routine primary medical care by those who are unable to afford other provider forms of care. Use of hospital-based RHCs should be encouraged, not discouraged. RHCs like FQHCs can provide needed services while saving taxpayer dollars.

Our hospital-based RHC functions as part of the hospital: therefore, the hospital employs the RHC personnel, maintains payroll, pays all overhead expenses, owns the RHC building, provides medical supplies and credentials the physicians and mid-level practitioners.

The RHC is a vital component of the hospital as it assists the hospital with providing 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 critical 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 RHC. As aforementioned, the majority of the overhead expenses to operate the RHC are provided by the hospital using the DSH funding. If the rule is implemented, our

hospital will lose close to $ 168,000 in DSH funding. Excluding the hospital-based RHC from DSH funding will limit our ability to provide care to those who live in the rural poverty stricken areas and are in need of health care services.

CMS's efforts to exclude our hospital-based RHC costs in the DSH calculations would certainly impede our ability to continue the same level of care and would be a detriment to adding any needed primary care services for our rural patients.

This seems to be contrary to good public policy. Rather than reward use of cheaper and more appropriate RHC services, the proposed rule appears to do 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 department resources.

Due to these concerns, I respectively ask that you withdraw the proposed rule and assist Louisiana in its ongoing efforts to reform healthcare.

Thank you for taking my comments under consideration.

Sincerely,

Wayne M. Arboneaux, CEO
Assumption Community Hospital & Rural Health Clinic

Submitter : Ms. Ellen Kugler **Date:** 10/29/2007

Organization : National Association of Urban Hospitals

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-28-Attach-1.PDF

#28

NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

October 29, 2007

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-2213-P

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to convey our concerns about aspects of the proposed rule "Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit," which was published in the *Federal Register* on September 28, 2007.

NAUH believes the proposed approach would pose problems for state Medicaid programs, providers of outpatient care to Medicaid patients, and to Medicaid patients themselves, possibly jeopardizing the latter's access to care. In particular, we object to aspects of how the UPL would be calculated under the new regulation and oppose what we understand will be the creation of separate outpatient UPLs for private hospital-based outpatient providers and for private non-hospital outpatient providers. We fear these new approaches are overly restrictive and will unduly limit the ability of state Medicaid programs to draw down legitimately the federal financial participation they need to reimburse adequately their participating providers. We also are concerned about the impact the proposed regulation could have on the hospital-specific Medicaid DSH upper payment limits of many important providers of outpatient care to Medicaid patients. Finally, we are very concerned that the Centers for Medicare & Medicaid Services (CMS) seeks to implement this regulation without a meaningful analysis of its potential impact on providers that receive outpatient Medicaid payments. Together, we fear that these problems could cause financial harm to many such providers and eventually affect access to care for some Medicaid recipients.

We address these concerns separately below.

Concern About the Proposed UPL Calculation Methodology

Medicare and Medicaid, in NAUH's view, are not similar in many important ways that seem to be assumed, to a degree, in this proposed regulation. The result, we believe, is that state Medicaid programs could be deprived of the flexibility they need to expend their limited resources in the most productive manner possible.

NAUH is concerned, for example, about the proposal that states only be permitted to use Medicare cost-to-charge ratios (or payment-to-charge ratios – the same arguments basically apply to both ratios) to calculate what Medicare would pay for state-approved Medicaid services. We believe this is an overly restrictive approach. It assumes, for example, that such ratios are uniform within hospital-based

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www.nauh.org

outpatient provider organizations; this is not necessarily true. CMS has acknowledged this concept in the past when proposing a new methodology for calculating relative values for the Medicare inpatient prospective payment system. Within individual hospitals, and even within individual hospital departments, in fact, different cost centers can and do have different cost-to-charge ratios. This, in turn, means that the cost-to-charge ratio that applies to one patient population may not be appropriate for estimating the cost of care for a different population that requires a different mix of services.

Medicare and Medicaid provide different services to different patient populations. Medicare is seldom called upon, for example, to reimburse outpatient providers for fetal ultrasounds, myringotomies, measles vaccines, and treatment for HIV. Consequently, the cost-to-charge ratios for the types of services that the Medicaid population requires often are very different from the cost-to-charge ratios calculated for the Medicare population.

Because of the problems posed by this proposed methodology for calculating the outpatient UPL, NAUH also believes this new approach may fail in what appears to be its most basic function: assuring that providers of Medicaid services are not paid more than what Medicare would pay for those services. *Under the proposed approach, every single provider of Medicaid outpatient services in a given state could be paid according to the Medicare outpatient prospective payment system – not a penny more and not a penny less – and that state could still exceed its UPL.* Because of the use of Medicare cost-to-charge ratios to estimate Medicaid costs instead of permitting other defensible methodologies, states could pay providers what Medicare pays and still exceed their UPLs. In this sense, using Medicare cost-to-charge ratios to calculate state UPLs – or, alternatively, using payment-to-charge ratios – could end up costing Medicaid outpatient providers and depriving them of fair payment for the services they deliver.

For these reasons, NAUH believes the proposed methodology does not produce a "reasonable estimate of the amount the provider would be paid under Medicare payment principles" (*Federal Register,* September 28, 2007, p. 55160). We respectfully ask CMS to consider allowing states to seek approval for alternative methodologies for calculating this UPL.

The Overly Restrictive Definition of "Hospital Outpatient Facility" Used in the Calculation of the Upper Payment Limit for Outpatient Hospital Services

NAUH believes the proposed regulation is far too restrictive in how it defines "hospital outpatient facility" for purposes of calculating the UPL for hospital outpatient services. By employing restrictive Medicare provider-based requirements, CMS would effectively force outpatient facilities sponsored by hospitals into the non-hospital provider group for UPL calculation purposes.

Throughout the country, hospitals operate and sponsor and have financial responsibility for outpatient facilities and programs that are recognized by their state Medicaid programs as hospital-affiliated but would not be recognized under the Medicare provider-based requirements proposed in this regulation. NAUH believes that if a state Medicaid program recognizes a facility as hospital-based, CMS should do so as well when calculating the hospital-based provider UPL under this new regulation. NAUH urges CMS to modify the regulation to incorporate this concept.

Effect on the Calculation of Hospital-Specific DSH Limits

NAUH believes the proposed change in the definition of outpatient hospital facilities would affect hospitals' individual hospital-specific Medicaid disproportionate share (DSH) upper payment limits. Specifically, we are concerned that the costs to hospitals of providing care for many Medicaid recipients and medically indigent patients would no longer be considered hospital costs for the purposes of calculating the hospital-specific DSH limit. This would result in a reduction of those upper limits, thereby reducing the amount of Medicaid DSH payments for which many hospitals would be eligible. This would be a major change in policy that would hurt the very hospitals – including many private, non-profit, urban safety-net hospitals – that do the most to care for the low-income residents of their communities. In the long run, this practice could affect the financial condition of these hospitals and possibly jeopardize access to care in the communities they serve.

Failure to Determine the Proposed Regulation's Impact

NAUH believes CMS has failed to meet its obligation to prepare a complete and meaningful analysis of this proposed rule's potential impact. The agency concedes this failure, writing that "Due to a lack of available data, we cannot determine the fiscal impact of this defined rule" (*Federal Register,* September 28, 2007, p. 55164). Despite this admission, CMS goes on to state that "We have reviewed the effects of the proposed rule and have determined that it would clarify current vague regulatory language but would not significantly alter current practices in most States" (*Federal Register,* September 28, 2007, p. 55164). In the absence of an analysis of the fiscal impact of the rule, it is not clear how CMS could reach such a conclusion.

This is not a good way to make public policy. CMS opines – with no supporting data – that the changes brought about by this regulation would not be significant. NAUH – and others – believe it would be. The only way to be sure is for the agency to undertake a more definitive analysis of the proposed rule's potential impact. The stakes in this matter are exceptionally high, and NAUH urges CMS not to implement this proposed rule until it can offer a more definitive conclusion about its impact.

Conclusion

Overall, NAUH believes the proposed methodology for calculating states' Medicaid UPL is overly restrictive. The new calculation methodology will make it more difficult for states to draw down federal matching funds while the division of outpatient providers into hospital-based and non-hospital for UPL calculation purposes will deprive states of the flexibility they need to ensure that their largest and most important institutional providers can receive the level of reimbursement they need to preserve their financial health while still caring for significant numbers of Medicaid patients. The proposed rule also could affect – and we believe lower – the hospital-specific Medicaid DSH upper payment limit for hospitals that are major providers of care to the Medicaid population. Finally, we believe that no major change should be implemented without a thorough and reliable analysis of the potential impact on the objects of this regulatory proposal.

While NAUH understands CMS's desire to ensure that providers operate as efficiently and economically as possible and that states receive no more federal funds than they should, we believe the proposed approach is too restrictive and may hurt states' finances, hurt hospital-based providers' finances, and eventually jeopardize access to care for Medicaid recipients in some communities. We urge CMS to withdraw the proposed regulation and work to develop a more flexible approach that meets the needs of all involved parties: the federal government, state governments, providers, and of course, the millions of Americans who are eligible for Medicaid but need appropriate providers of Medicaid-covered services.

About the National Association of Urban Hospitals

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

* * *

We appreciate your attention to these matters and welcome an opportunity to answer any questions you may have and to discuss our concerns and possible alternative approaches with you. Please feel free to contact us at 703-444-0989.

Sincerely,

Ellen Kugler, Esq.
Executive Director

Submitter : **Ms. Roberta Risper** **Date: 10/29/2007**

Organization : **Sinai Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

On behalf of Sinai Health System, I am expressing our concern regarding the issuance of CMS-2213-P. Sinai Health System is the largest private provider of health care for low-income patients in Illinois. Sinai is located in and serves the West and South Sides of Chicago. Sinai is one of four Level I trauma centers in chicago. Over 60% of our patients are covered by the Illinois Medicaid program and an additional 12% are without insurance. Without adequate Medicaid payments, Sinai would be unable to continue to serve our community. We are extremely reliant on supplemental payments to the Illinois Medicaid program. Sinai is the major provider of inpatient services and specialty outpatient care for over 50 federally qualified health center sites.

We are opposed to the proposed rule for the following reasons:
1. We believe the proposed rule violates the Congressional moratorium on implementation of cost limits on payments to government probiders and restrcitions on Medicaid graduate medical education payments. This moratoriuim was placed in to effect by Congress in May of this year and does not expire until May 25th of 2008. We believe this disregard of Congressional intent alone is serious enough to justify withdrawal of the proposed rule.

2. We believe that the proposed rule will have a negative impact on DSH payments by excluding outpatient services that are currently allowable for inclusion in the DSH cap, including uncompensated care costs that would be excluded such as dental costs, routine vision, psychiatric, observation and physician services, and provider-based FQHC services.

3. The proposed rule would discourage the provision and expansion of community -based ambulatory care services that are both cost-effective and relective of current medical practice.

4. The rule places limitations on state flexibility in calculating the upper payment limit for outpatient hospital services provided by private hospitals. The current regualtion allows states to acccurately capture costs and payments made to hosptiasl for outpatient care while ensuring compliance with statutory requirements.

5. The proposed rule ignores significant differences in the scope and purposes of the Medicaid and Medicare programs in requiring coterminous coverage of outpatient hospital services.

6. The definition of allowable outpatient hospital services that excludes services otherwise covered by the Satte Plan is not required by the Medicaid statute.

7. As a teaching hospital, we are opposed to the overly prescriptive proposed outpatient upper payment limit that excludes the costs of interns and residents. Sinai provides invaluable medical education in medicine, psychiatry, physiatry, medicine, surgery, pediatrics, and family practice. Our medical education prepares students for the unique challenges of providing care in low-income underserved communities. This type of graduate medical education whould be encouraged rather than discouraged .

We strongly urge CMS to withdraw this rule.

Submitter : **Ms. Roberta Rakove** **Date: 10/29/2007**

Organization : **Sinai Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

On behalf of Sinai Health System, I am expressing our concern regarding the issuance of CMS-2213-P. Sinai Health System is the largest private provider of health care for low-income patients in Illinois. Sinai is located in and serves the West and South Sides of Chicago. Sinai is one of four Level I trauma centers in chicago. Over 60% of our patients are covered by the Illinois Medicaid program and an additional 12% are without insurance. Without adequate Medicaid payments, Sinai would be unable to continue to serve our community. We are extremely reliant on supplemental payments to the Illinois Medicaid program. Sinai is the major provider of inpatient serviees and specialty outpatient care for over 50 federally qualified health eenter sites.

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We strongly urge CMS to withdraw this rule.

Submitter : **Mr. Sean Hopkins** **Date: 10/29/2007**

Organization : **New Jersey Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-31-Attach-1.DOC

#31

NJHA
NEW JERSEY HOSPITAL ASSOCIATION

October 29, 2007

Mr. 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 nearly 116 member hospitals, health systems and other healthcare organizations the New Jersey Hospital Association (NJHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule changing Medicaid policy for federal reimbursement of Medicaid hospital outpatient services.

CMS describes the Medicaid hospital outpatient proposed policy changes as clarifications to current rules. CMS further states that because these changes will not result in a significant financial impact, the proposed rule is not considered a major rule and, therefore, a 30-day comment period is sufficient. NJHA disagrees on all points.

The proposed rule is making major policy changes to the Medicaid program; a 30-day comment period is an insufficient time period for public comment; and 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. NJHA urges CMS to withdraw this rule and submits these comments with strong opposition to the changes proposed.

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

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Tel 609-275-4000

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 it 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 financial 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.

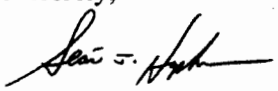
CONCLUSION

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. NJHA 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.

NJHA 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.

If you have any questions, please feel free to contact me at (609) 275-4022 or shopkins@njha.com.

Sincerely,



Sean J. Hopkins
Senior Vice President
Health Economics

ja

cc: G. S. Carter, NJHA
E. Ryan, NJHA

Submitter : Mr. Larry Gage **Date:** 10/29/2007

Organization : Natl Assn of Public Hospitals and Health Systems

Category : Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-32-Attach-1.DOC

National Association of Public Hospitals and Health Systems

1301 Pennsylvania Avenue, NW
Suite 950
Washington, DC 20004
202 585 0100 tel / 202 585 0101 fax
www.naph.org

October 29, 2007

Mr. Kerry N. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

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

Dear Mr. Weems:

The National Association of Public Hospitals and Health Systems (NAPH) writes to express our serious concern regarding the issuance of the above-referenced Proposed Rule.[1] This Rule (1) unnecessarily narrows the definition of outpatient hospital services, with a significant but unacknowledged impact on disproportionate share hospital (DSH) payments; and (2) is overly prescriptive in dictating upper payment limit (UPL) methodologies for private outpatient hospitals and clinics. Of more concern, however, the Proposed Rule violates a recent legislative moratorium[2] (the Moratorium) on implementation of a cost limit on payments to governmental providers or restrictions on Medicaid graduate medical education (GME) payments. For these reasons, NAPH urges CMS to withdraw the Proposed Rule immediately.[3]

NAPH represents more than 100 metropolitan area safety net hospitals and health systems. Our members are the primary hospital providers of care in their communities for Medicaid recipients, receiving on average 35% of their net revenues from Medicaid, and for many of the more than 46 million Americans without insurance. Member hospitals represent only 2% of the acute care hospitals in the country but provide 25% of the uncompensated hospital care. As a result, these hospitals rely upon Medicaid disproportionate share hospital (DSH) and other supplemental payments, including supplemental outpatient payments, for survival; without supplemental payments, overall NAPH member margins would drop to a negative 10.5 percent. NAPH members serve a

[1] 72 Fed. Reg. 55158 (Sep. 28, 2007).
[2] U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, Section 7002(a).
[3] NAPH does not concede through submission of these comments that CMS has the authority to propose these provisions, nor to request, receive or review related comments, during the period of the Moratorium.

critical role in their communities of ensuring access to ambulatory care for uninsured and Medicaid patients. In 2004, NAPH members provided more than 29 million non-emergency outpatient visits, which represented more than one-third of all ambulatory care visits at safety net providers (including community health centers). Of the non-emergency visits at NAPH members, approximately 59 percent were for specialty care services and 41 percent for primary care services. The vast majority of this ambulatory care is reimbursed as outpatient hospital services.

The attached comments detail the following policy and technical concerns with the Proposed Rule:

- CMS has violated the congressional Moratorium and, in any event, failed to clarify how this Proposed Rule interacts with the Moratorium.
- The Proposed Rule will have a potentially significant impact on DSH payments, which CMS does not acknowledge.
- The Proposed Rule discourages hospitals from expanding important ambulatory care services.
- The Proposed Rule ignores significant differences in the scope and purposes of the Medicaid and Medicare programs in requiring coterminous coverage of outpatient hospital services, and in any event requires clarification.
- CMS' definition of outpatient hospital services to exclude services otherwise covered by the State Plan is not required by the Medicaid statute and is inconsistent with language in the preamble to the Proposed Rule.
- The overly prescriptive proposed outpatient UPL excludes the costs of interns, residents and supervising physicians, potentially resulting in millions of dollars in losses for providers in certain states, reduces state flexibility, and does not capture all Medicare-covered costs.
- The proposed private clinic UPL prohibits cost-based reimbursement without justification and includes a circular definition of the UPL for otherwise excluded dental services.

Because the Proposed Rule violates the Moratorium, CMS is legally obligated to withdraw it, and we urge you in the strongest terms to do so immediately. Congress enacted the Moratorium specifically to prevent CMS from taking "any action" to develop new policies in areas in which this Proposed Rule purports to regulate. Moreover, the Proposed Rule is bad policy, and would have a significant negative financial impact on both governmental and private hospitals serving Medicaid and uninsured patients. Coming in the wake of several other regulations issued by CMS that would impose large cuts on these hospitals—including the rule imposing a governmental provider cost limit and restricting sources of non-federal share funding,[4] the rule to eliminate Medicaid funding for graduate medical education,[5] and the proposed rule which has never been

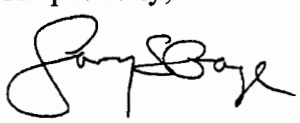
[4] 72 Fed. Reg. 29748 (May 29, 2007).
[5] 72 Fed. Reg. 28930 (May 23, 2007).

finalized adopting narrow new DSH policies[6]—CMS' latest administrative action would be devastating to public, teaching and other safety net hospitals. Cumulatively these rules would eviscerate the health care safety net as well as jeopardize care for all Americans in communities across the country.

NAPH urges CMS to step back and consider the cumulative effect of its ever more restrictive Medicaid policies on the nation's safety net and the patients who rely on it for care. In addition to covering care for eligible populations, Medicaid supports an institutional safety net of health care providers that are critical to the well-being of their communities. If enacted, these rules would mean that such providers will no longer be able to train the next generation of doctors and health care professionals, to serve as the health care backbone of local emergency response systems, to provide critical yet under-reimbursed specialized services such as trauma care, burn care, neonatal intensive care and emergency psychiatric care, or to provide access where none would otherwise exist for the nation's poor, uninsured and underinsured individuals. Absent a more thorough analysis of real world implications of proposed policies and their impact on the health care system, we are relying on Congress to stop these policies in their tracks. We urge you to withdraw this regulation and all of the above mentioned pending regulations immediately. We need policies that strengthen, rather than dismantle, essential components of our nation's health care infrastructure.

If you have any questions, please contact Barbara Eyman or Charles Luband of NAPH counsel Powell Goldstein LLP at (202) 347-0066.

Respectfully,



Larry S. Gage
President

[6] 70 Fed. Reg. 50262 (Aug. 26, 2005).

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COMMENTS BY THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS ON PROPOSED RULE: CMS-2213-P-Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit

Prepared on Behalf of NAPH by Powell Goldstein LLP

MAJOR POLICY CONCERNS

I. The Issuance of the Proposed Rule Directly Violates the Recently Adopted Congressional Moratorium.

CMS' action in issuing the above-referenced Proposed Rule[1] violates a recent legislative moratorium[2] (the Moratorium) prohibiting "any action" to implement a rule to impose a cost limit on Medicaid payments to governmental providers (CMS-2258-FC, the Cost Limit Rule)[3] or similar provisions, or any rule restricting payments for Medicaid graduate medical education (GME). For this reason alone, the rule should be withdrawn immediately.

A. The Proposed Rule violates the Medicaid GME provision of the Moratorium.

The Proposed Rule effectively prohibits states from including GME costs in the outpatient UPL, thereby narrowing states' flexibility to support GME through outpatient payments and thus violating the Moratorium. The language of the Moratorium prohibits CMS from "tak[ing] any action (through promulgation of regulation, issuance of regulatory guidance, or other administrative action) to ... promulgate or implement any rule or provisions restricting payments for graduate medical education under the Medicaid program."[4] CMS' detailed new requirements for calculating cost for purposes of the outpatient hospital UPL excludes GME costs from the equation, essentially prohibiting states from providing outpatient-related GME payments.[5] Because states have never before been prohibited from providing outpatient GME support, CMS' proposal directly violates the Moratorium.

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[1] 72 Fed. Reg. 55158 (Sep. 28, 2007).
[2] U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, Section 7002(a).
[3] 72 Fed. Reg. 29748 (May 29, 2007).
[4] Pub. L. No. 110-28, Section 7002(a).
[5] A more complete discussion of how CMS' proposed UPL methodology precludes states from reimbursing outpatient related GME costs is contained in technical section II.A.1. below.

B. The Proposed Rule violates the Moratorium by reissuing regulatory provisions contained in the Cost Limit Rule.

In the Proposed Rule, CMS reissued regulatory language from the final Cost Limit Rule redefining the categories of providers (state, non-state governmental and private) subject to upper payment limits (UPLs).[6] The outpatient UPL in effect at the time of the Moratorium applied to three categories of providers: "State government-owned or operated facilities ... Non-State government-owned or operated facilities ... [and] Privately-owned and operated facilities."[7] The Cost Limit Rule amended these categories to "State government operated facilities ... Non-State government operated facilities ... [and] Privately operated facilities," essentially removing all references to ownership.[8] The language of the Moratorium prohibits CMS from "tak[ing] any action (through promulgation of regulation ...) to ... finalize or otherwise implement provisions contained in the [Cost Limit Rule] ...."[9] In proposing to reissue the revised category language from the Cost Limit Rule in this Proposed Rule, CMS has violated Congress' directive not to take any action to implement any provision of that rule.

C. The Moratorium violations completely disregard the clearly-expressed views of Congress on Medicaid policy.

These violations of the Moratorium continue a pattern in which CMS has ignored Congress' statutory direction and contravened legislative intent regarding proper interpretation of the Medicaid Act. President Bush's FY 2007 and 2008 budget requests contained several Medicaid policy proposals to be implemented through administrative action.[10] Some of the proposals had previously been proposed as legislative measures but Congress declined to act on them.[11] In response to the administrative proposals, an overwhelming majority of both the House and Senate expressed public opposition to CMS' plans.[12] CMS moved forward nonetheless in issuing proposed cost limit and GME regulations. Congress responded swiftly by adopting the Moratorium in both areas, which was initially vetoed as part of a larger supplemental appropriations bill,[13] and later

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[6] *See* 42 C.F.R. § 447.321(a), as revised by the final Cost Limit Rule, 72 Fed. Reg. at 29835, and reissued in the Proposed Rule, 72 Fed. Reg. at 55165-66.

[7] 42 C.F.R. § 447.321(a).

[8] 42 C.F.R. § 447.321(a), as revised by 72 Fed. Reg. 29748, 29835 (May 29, 2007).

[9] U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, Section 7002(a).

[10] Budget of the United States Government, Fiscal Year 2007, at 125-27; Budget of the United States Government, Fiscal Year 2008, at 68-69.

[11] Budget of the United States Government, Fiscal Year 2005, at 149-50; Budget of the United States Government, Fiscal Year 2006, at 143; Letter from Michael O. Leavitt, Secretary of HHS, to the Honorable Richard B. Cheney, President, United States Senate, August 5, 2005 (transmitting legislative language to Senate implementing the fiscal year 2006 proposals); Letter from Michael O. Leavitt, Secretary of HHS, to the Honorable J. Dennis Hastert, Speaker of the House of Representatives, August 5, 2005 (transmitting legislative language to House of Representatives implementing the fiscal year 2006 proposals).

[12] In 2006, 55 Senators and 300 Members of the House publicly opposed the cost limit and IGT restrictions. In 2007, 65 Senators and 263 Members of the House have gone on record against these proposals and the proposed GME restrictions.

[13] H.R. 1591, 110th Congress (2007).

included in a revised bill that the President signed.[14] In an apparent rush to regulate and "beat the clock," CMS issued the final cost limit rule on May 25, 2007, the very day that CMS knew the President would sign the Moratorium into law. NAPH believes the issuance of the Final Rule itself violates the Moratorium, as by its terms the Moratorium took effect at 12:01 AM on May 25, the date of enactment.[15] Legalities aside, however, it is disconcerting to NAPH that an agency would deliberately disregard the clearly-expressed views of Congress in this manner. Unfortunately, the issuance of the Proposed Rule appears to indicate a troubling pattern.

II. The Proposed Rule Will Have a Potentially Significant Impact on DSH Payments.

Perhaps the most damaging aspect of this Proposed Rule is its indirect impact on disproportionate share hospital (DSH) reimbursement for private and governmental hospitals alike—an impact that is not even acknowledged by CMS. NAPH is concerned that to the extent the proposed outpatient hospital definition excludes services a state is currently treating as outpatient hospital services, CMS will take the position that the uncompensated care costs associated with those services could no longer be included in a hospital's DSH cap. Our members report that their states are currently including the costs of services that would be excluded under the proposed definition, including dental care (primarily care to children as required under the Medicaid EPSDT benefit), routine vision, psychiatric, observation, and physician services, and provider-based FQHC services.[16]

NAPH opposes any narrowing that will reduce the resources available to safety net hospitals to provide access to care for Medicaid and uninsured patients. The DSH program, over the years, has become the "lifeblood" for many safety net hospitals. DSH payments help to offset some of the unreimbursed costs that hospitals incur in caring for uninsured patients, but the adequacy of DSH allotments is declining as costs climb and insurance coverage drops. As a percentage of Medicaid expenditures, DSH has fallen dramatically in the last decade, declining from 14 percent of overall Medicaid expenditures in 1993 to approximately 6 percent in 2004. CMS has already proposed a rule that would cut back on what it would allow to be considered costs for DSH payment purposes.[17] Policy changes in DSH payments directly affect the ability of these hospitals to provide access to care for Medicaid and uninsured patients.

If this proposal would in fact narrow the costs reimbursable through DSH, CMS may have significantly underestimated the fiscal impact of the Proposed Rule, which it determined would not have "significant economic effects."[18] In that case, this Proposed

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[14] Pub. L. No. 110-28, Section 7002(a).

[15] *See, e.g., Arnold v. United States*, 13 U.S. (9 Cranch) 104, 119 (1815); *United States v. Casson*, 434 F.2d 415, 419 (D.C. Cir. 1970).

[16] In the case of provider-based FQHC services, hospitals that have established FQHCs, which are paid at clinic rather than hospital rates, include the uncompensated costs of providing these services in their DSH cap.

[17] 70 Fed. Reg. 50262 (Aug. 26, 2005).

[18] 72 Fed. Reg. at 55158, 55164 (Sep. 28, 2007).

Rule potentially should have been a major rule, requiring a longer period after final publication before implementation and certainly warranting a longer comment period than 30 days.

III. The Proposed Rule Discourages Hospitals from Expanding Important Ambulatory Care Services.

In prohibiting states from reimbursing certain ambulatory services provided by hospitals as outpatient hospital services, CMS is effectively reducing the reimbursement rate for those services because reimbursement for non-hospital services cannot include hospital overhead. In addition, CMS has stated that hospitals may not receive DSH reimbursement for non-hospital services. Therefore, a narrowing of the definition of outpatient hospital services is essentially a cut in hospital Medicaid reimbursement. Moreover, restrictive upper payment limit policies similarly have a direct impact on hospital funding. The cut discourages safety net hospitals from providing exactly the type of community-based primary and preventive ambulatory care services that have proved so effective in driving down health care costs yet are in short supply in so many states. NAPH questions the policy basis for such a proposal.

NAPH members and similarly situated hospitals play a critical role in the provision of outpatient services, particularly for low-income Medicaid and uninsured patients. In response to increasing demand for accessible ambulatory care, NAPH hospitals have established elaborate networks of off-campus, neighborhood clinics with expanded hours, walk-in appointments, assigned primary care providers and access to appropriate follow-up and specialty care. In 2004 alone, 89 NAPH member hospitals provided 29 million non-emergency outpatient visits, with ambulatory care volume increasing by 49 percent between 1993 and 2003. These 89 hospital systems alone provided over one-third of all outpatient visits provided by safety net hospitals and community health centers (the other two-thirds were provided by 914 HRSA community health centers). The specialty ambulatory care provided by NAPH members is often the only such care available for patients referred from community health centers and other federally funded primary care clinics.

As explained in more detail below, this Proposed Rule narrows the definition of outpatient hospital services in multiple ways, many of which would have the effect of reducing reimbursement for the very ambulatory care services that states have sought to encourage our members to provide. It is inconceivable that CMS would adopt this policy when it admits that it has found no actual violations or problems with current state practices.[19]

[19] 72 Fed. Reg. at 55164 ("As part of our review process, we have determined that only one of the 32 States currently defines non-hospital services as part of the outpatient hospital Medicaid State plan service benefit. . . We believe the fiscal impact would be minimal.").

LEGAL AND TECHNICAL ISSUES

In addition to our broad policy concerns, NAPH has several technical concerns and questions about the Proposed Rule:

I. Narrowing the Definition of Outpatient Hospital Services *(II. D. Background, Medicaid Outpatient Hospital Services Definition; III.B. Provisions of the Proposed Rule, Proposed § 440.20)*

The Proposed Rule would limit the scope of services included in the definition of outpatient hospital services by: (1) excluding any services not reimbursed as outpatient hospital services under Medicare; (2) excluding services provided by entities that are not provider-based departments of a hospital; and (3) excluding services covered elsewhere in the State Plan. This proposed narrow definition will result in less support for safety net hospitals and potentially significant losses in DSH funding. If, however, CMS insists on adopting a more precise definition, we believe that more clearly specifying that outpatient hospital services must be provided in a provider-based setting would adequately address any potential concerns.

A. CMS should remove the requirement to align Medicaid outpatient hospital services with Medicare, or at the very least provide necessary clarification.

1. Medicaid and Medicare legitimately include a different range of services in the outpatient hospital services benefit.

CMS justifies the requirement to include only Medicare-reimbursed outpatient hospital services as "provid[ing] greater consistency between the two federally funded programs" and aligning Medicaid outpatient hospital services with the "industry-accepted class of services" recognized as outpatient hospital under Medicare regulations.[20] Given the separate statutory authority for the Medicare and Medicaid programs, it is unclear why "consistency" would provide a sufficient statutory basis for this regulation. Moreover, NAPH questions the policy basis for insisting on rigid, coterminous definitions when the two programs are very different in scope, have very different purposes and cover different populations, with Medicaid's focus on providing services to low-income populations with differing needs. For example, Medicare completely excludes from coverage services such as dental care for children or vaccinations that policymakers have determined are critical to the health of Medicaid populations. Medicare also does not include outpatient hospital reimbursement for vision, psychiatric services and observation that state Medicaid programs have seen the value of reimbursing at a hospital rate to meet specific needs of their patient populations.

Recommendation: The Proposed Rule should be amended to eliminate the requirement that the Medicaid definition be no broader than the Medicare definition.

[20] *Id.* at 55161.

2. *CMS should provide clarification regarding reimbursement as an outpatient hospital service under alternate payment methodologies.*

If CMS retains this requirement, additional clarification is necessary for states and providers on how to determine whether a service is reimbursed as an outpatient hospital service under an alternate Medicare payment methodology sufficient to be included under the proposed definition. For example, physician services provided in an outpatient hospital setting could conceivably be considered to be reimbursed as an outpatient hospital service—they are reimbursed under the physician fee schedule as the professional component of outpatient hospital services, which is an alternative payment methodology—but CMS explicitly excludes them from the proposed definition. Laboratory services are similarly reimbursed under a fee schedule, yet are explicitly included as outpatient hospital services under the proposed definition.[21]

Recommendation: CMS should provide clarification as to the scope of services paid under alternate Medicare payment methodologies as outpatient hospital services that would be included under this proposed definition.

3. *CMS should clarify the interpretation of Medicare OPPS regulations as they apply to the proposed definition.*

Title 42, Section 419.2(b) of the Code of Federal Regulations (CFR), as referenced in proposed section 440.20(a)(4)(i),[22] sets out an illustrative, but not exclusive, list of costs that may be included in the outpatient prospective payment system (OPPS).[23] Additional provisions list costs explicitly excluded from outpatient prospective payment rates,[24] and services excluded from payment under the hospital OPPS.[25]

Recommendation: CMS should confirm that costs for services not explicitly excluded from the OPPS are therefore includable (assuming that these services meet the other proposed criteria). If this is the case, NAPH requests that CMS clarify how it will permit states to factor these other costs into the highly prescriptive private hospital outpatient UPL.

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[21] *See id.* (stating that "[f]or example, States may cover and reimburse prosthetic devices, prosthetics, supplies, and orthotic devices, durable medical equipment, and clinical diagnostic laboratory services as outpatient hospital services."). In addition, there is concern that Medicare criteria for coverage of hospital versus non-hospital laboratory services are themselves complicated and that more detailed guidance is necessary to determine appropriate Medicaid coverage.

[22] Proposed 42 C.F.R. § 440.20(a)(4)(i), *Id.* at 55165.

[23] 42 C.F.R. § 419.2(b) ("these costs include, but are not limited to...").

[24] *Id.* § 419.2(c).

[25] *Id.* § 419.22.

Title 42, Section 419.20(b) of the CFR also excludes certain categories of hospitals from the Medicare hospital OPPS.[26]

Recommendation: CMS should clarify that Medicaid outpatient hospital services in these categories of hospitals are includable under the proposed definition.

B. CMS should remove the exclusion of services covered elsewhere under the State Plan from the definition, or at the very least provide necessary clarification.

The Proposed Rule would further exclude from the outpatient hospital services definition those services that are covered and paid "under the scope of another Medical Assistance service category under the State Plan,"[27] though states "may continue to cover any service that is authorized under section 1905(a) of the Act within the State Plan under a coverage benefit that is distinct from outpatient hospital services."[28]

1. This exclusion is not required by the language of the Medicaid statute.

Nothing in the language or the history of the Medicaid statute requires categories of covered services to be discrete and mutually exclusive. Indeed, the U.S. Court of Appeals for the Fifth Circuit implicitly rejected mere reliance on a service being referenced in a different enumerated category from outpatient hospital services under section 1905(a)(2) of the Act as sufficient reasoning for excluding the service from the regulatory definition of outpatient hospital services.[29] Because CMS' proposed insistence on discrete categories prohibits hospitals from receiving full outpatient hospital reimbursement for services that are clearly provided by outpatient hospital departments, CMS should abandon this unnecessary requirement.

Recommendation: CMS should amend the Proposed Rule to allow services covered elsewhere in the State Plan to be included in the outpatient hospital definition when provided to individuals receiving care in hospital outpatient settings.

2. CMS' proposed definition appears inconsistent and requires clarification.

If CMS nonetheless chooses to retain this requirement, CMS should clarify apparent inconsistencies between the requirement and preamble language listing outpatient hospital services under the proposed definition. CMS explicitly provides that "states may

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[26] *Id.* § 419.20(b) (excluding Maryland hospitals, critical access hospitals, hospitals located outside of the 50 states, DC and Puerto Rico, and hospitals of the Indian Health Service).

[27] Proposed 42 C.F.R. § 440.20(a)(4)(iii), 72 Fed. Reg. at 55165.

[28] 72 Fed. Reg. at 55161.

[29] *Louisiana Dep't of Health and Hosps. v. CMS.*, 346 F.3d 571 (5th Cir., 2003) ("CMS analyzes the term 'hospital services' [as used in the DSH statute] with the premise that 'outpatient hospital services' and 'rural health clinic services' are mutually exclusive. CMS notes: (1) federal statutes and regulations distinguish the terms in at least two places, see 42 U.S.C. §§1396d(a)(2) (enumerating categories of medical assistance services, including outpatient hospital services and rural health clinic services)...CMS assumes, without explanation, that any service that a RHC renders may never be considered an outpatient hospital service even if the service fits within the regulatory definition of 'hospital outpatient service.'").

cover and reimburse prosthetic devices, prosthetics, supplies, and orthotic devices, durable medical equipment, and clinical diagnostic laboratory services as outpatient hospital services."[30] Yet, prosthetic devices,[31] laboratory services,[32] and rehabilitative services[33] are each separate benefit categories under section 1905(a) of the Social Security Act. NAPH agrees that these services should be encompassed by the outpatient hospital services definition; however, states and providers require consistent guidance in order to apply this requirement to other services.

C. Other details of the proposed definition require further clarification.

Our members also seek more specific clarifications related to the following aspects of the proposed outpatient hospital definition:

- CMS should confirm that rehabilitative services currently considered outpatient hospital services under Medicare would continue to be considered outpatient hospital services under Medicaid, clarifying potentially inconsistent guidance in the preamble and proposed regulations.[34]

- CMS should clarify that this Proposed Rule, in conjunction with current inpatient service regulations, would not prohibit state Medicaid agencies from reimbursing hospitals for services provided discharged patients waiting for an available skilled nursing facility (SNF) bed as hospital services (either outpatient or inpatient) under the state plan.[35]

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[30] 72 Fed. Reg. at 55161.

[31] *See* SSA § 1905(a)(12) (42 U.S.C. § 1396d(a)(12) ("prescribed drugs, dentures, and prosthetic devices...").

[32] *See id.* § 1905(a)(3) (42 U.S.C. § 1396d(a)(3)) ("other laboratory and X-ray services"). It is possible that this reference could be interpreted to include only those services other than lab services provided as outpatient hospital services in (a)(2) (or inpatient in (a)(1)), and therefore that outpatient hospital lab services are not a distinct service category.

[33] *See id.* §§ 1905(a)(11) ("physical therapy and related services"), 1905(a)(13) ("other diagnostic, screening, preventive, and rehabilitative services...").

[34] The text of proposed section 440.20(a) explicitly defines outpatient hospital services to continue to include "rehabilitative services," and Medicare reimburses hospitals under an "alternate payment methodology" for therapy provided by hospital outpatient departments, in accordance with proposed section 447.321(a)(4)(i). In the preamble, however, CMS states that rehabilitative services may be an example of "non-traditional outpatient hospital services." 72 Fed. Reg. at 55160; *see also* 72 Fed. Reg. at 55159 ("outside the normal responsibility of outpatient hospitals").

[35] In at least one state, the Medicaid program pays hospitals based on a SNF rate for these patients, though Medicare apparently does not reimburse hospitals for these services. Covering these services under the Medicaid SNF benefit does not adequately address the issue for these hospitals, as they may then be faced with the substantial administrative burden of pursuing state licensure as a SNF in order to provide what would newly be defined as "non-hospital" services to these patients.

II. Restriction of the Outpatient Hospital and Clinic Upper Payment Limits

(II.E. Background, Upper Payment Limits—Proposed Rule; II.B. Provisions of the Proposed Rule)

A. The proposed outpatient hospital UPL methodologies are too prescriptive.

NAPH objects to the limitations that the Proposed Rule would impose on state flexibility in calculating the upper payment limit for outpatient hospital services provided by private hospitals. The flexibility available under the current regulation[36] permits states to accurately capture the costs (or payments) made to hospitals for outpatient care while ensuring compliance with statutory requirements. CMS could clarify the requirements for calculating the UPL by describing examples of acceptable methodologies, i.e. cost-to-charge and payment-to-charge calculations, without precluding the use of other methodologies. A state should be permitted to develop another methodology more tailored to its circumstances if it is a reasonable approximation of what would be paid under Medicare payment principles.

1. CMS should permit adjustments to the Medicare allowable costs on the cost report.

The Proposed Rule would require that services appear on the outpatient-specific Medicare cost report worksheets in order to be included in the outpatient hospital UPL,[37] and would not permit adjustment of these costs.[38] NAPH is extremely concerned that in dictating the specific sections of the Medicare cost report that a state may use in calculating cost information for the outpatient UPL, CMS effectively excludes GME costs from the outpatient costs that a state can include. The preamble explicitly references the "cost-to-charge ratios as found on Worksheet C, Column 9. . . of the CMS 2552-96."[39] However, the cost-to-charge ratios contained at Worksheet C, Column 9 are calculated by taking information from Worksheet B, Column 27—which explicitly excludes all costs related to interns, residents, and supervising physicians. Given that Medicare pays for GME separately from outpatient (and inpatient) reimbursement, it makes sense that for Medicare purposes these costs would not be included in the outpatient cost-to-charge ratios. Similarly, the Medicare outpatient cost-to-charge ratio also excludes costs for teaching physicians for those hospitals that have chosen the election under Title 42, Section 415.160 of the CFR. Although Medicare reimburses these costs separately, they remain outpatient hospital costs that should be reimbursable through Medicaid. Federal law does not prohibit states from covering these costs as part of Medicaid outpatient reimbursement.

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[36] *See* 42 C.F.R. § 447.321. Under current regulations, CMS has avoided a specific formal UPL, and instead negotiated UPL methodologies with states as long as payments to all private hospitals on an aggregate basis do not exceed a "reasonable estimate of the amount that would be paid for services furnished by the group of facilities under Medicare payment principles."

[37] Proposed 42 C.F.R. § 447.321(b)(1)(i)(A), 72 Fed. Reg. at 55166.

[38] 72 Fed. Reg. at 55162.

[39] *Id.*

Recommendation: CMS should clarify that outpatient costs related to interns, residents, and supervising physicians, as well as costs related to cost-based reimbursement for teaching physicians, can be included in calculating the private outpatient hospital UPL.[40]

In addition, some members have expressed concern that the cost report references specified by CMS may not be capturing all Medicare-covered outpatient hospital payments and charges, specifically related to physical therapy and durable medical equipment. ***NAPH requests that CMS review these references to ensure that the payments and charges for all outpatient hospital services reimbursed by Medicare under the OPPS or alternative methodologies are captured by these references.***

2. *CMS must make allowances for "flat rate" hospitals that have exceptions for Medicare cost reporting purposes.*

CMS' methodology, by prescriptively referencing the Medicare cost report methodology, is particularly inappropriate where Medicare has permitted exceptions to its cost report methodology. In particular, Medicare has allowed "flat rate" hospitals with alternative charge structures to complete their Medicare cost report by using statistics to allocate costs instead of using the cost-to-charge methodology usually used in the Medicare cost report. The rationale for these exceptions is because the cost-to-charge calculation does not make sense where the charge structure is not consistently maintained. A payment-to-charge ratio would be similarly distorted. CMS' inflexible proposed UPL methodologies appear not to not allow an exception where Medicare itself has allowed an exception from the rigorous use of charges.

Recommendation: CMS should allow states to use an alternative methodology to calculate the UPL related to flat rate hospitals.

3. *CMS should clarify that the cost methodology proposed for UPL calculations does not apply to DSH cost limits.*

CMS should confirm that the cost calculation described in this Proposed Rule for the purposes of calculating an outpatient hospital UPL is not mandatory for purposes of calculating either the DSH limit or the limit under the Cost Limit Rule. DSH explicitly covers a full range of covered and uncovered Medicaid services for both Medicaid recipients and the uninsured, and the restrictions imposed on the calculation of hospital costs for purposes of the outpatient UPL would be completely inappropriate with respect to DSH.

Recommendation: CMS should confirm that this role has no impact on DSH limit calculations.

[40] We reiterate the point made earlier, that the exclusion of intern, resident, and supervising physician costs from the UPL violates the Moratorium.

B. Elimination of Cost-Based Reimbursement for Private Clinics

NAPH is extremely concerned that the limited methodologies permitted for calculating the UPL for private clinic services under the Proposed Rule would in effect prohibit states from paying private clinics cost-based rates.[41] CMS provides no justification for allowing a cost-based UPL for hospitals but not clinics, simply stating that "Medicare does not typically pay for clinic services on the basis of cost as reported by the facility."[42] Furthermore, CMS does not appear to have considered that a cost-based UPL would be the most reasonable for services, such as dental services, that are not reimbursed under Medicare. Instead, CMS' proposed dental component of the UPL, defining the UPL as "that amount that Medicaid would pay,"[43] is circular and, in effect, is no limit at all.

Recommendation: CMS should revise the proposed regulation to permit a cost-based UPL for private clinics.

C. Other UPL Clarifications

1. *The Proposed Rule fails to clarify the scope of the category of private providers that would be subject to the UPL during the period of the Moratorium.*

This Proposed Rule would apply a more restrictive UPL to "privately operated facilities," defined under Section 447.321 as revised by the cost limit rule. CMS should clarify that if this rule is finalized during the period of the Moratorium, the proposed, restrictive UPL will apply only to those hospitals and clinics considered private prior to issuance of the Cost Limit Rule. Specifically, ***CMS should clarify that the more flexible governmental UPL, not this revised UPL, will continue to apply to state or non-state government-owned and privately operated facilities until the expiration of the Moratorium.***[44]

2. *CMS should clarify that the provisions of this Rule will apply prospectively.*

CMS claims in the preamble that they currently require compliance with one of these outpatient hospital UPL methodologies when states submit State Plan Amendments related to outpatient hospital services.[45] CMS should clarify that the requirements of this Proposed Rule will only be prospectively applied after proper issuance of a final rule. Given the significant policy changes required by this proposed rule, it would be improper to implement these requirements without notice and comment rulemaking.

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[41] *See* Proposed 42 C.F.R. § 447.321(b)(1)(ii), 72 Fed. Reg. at 55166.
[42] 72 Fed. Reg. at 55163.
[43] Proposed 42 C.F.R. § 447.321(b)(1)(ii)(C), *Id.* at 55166.
[44] We reiterate the point made above that CMS' modifications to the categories of providers subject to the UPL violates the Moratorium.
[45] 72 Fed. Reg. at 55162.